ANY HOSPITAL
TUMOR REGISTRY DEPARTMENT
ADDRESS
CITY, STATE ZIP CODE

DATE LETTER SENT

An integral part of our hospital cancer program at (Enter hospital name) involves performing annual follow-up of our patients. We believe the following patient is being seen at your institution. Would you be so kind as to provide me with the following information for our registry.

Patient:
Date of Birth:

Primary Site:
Date of Diagnosis:
Accession Number:(enter your acc # to reference when the letter is returned)

Status of Patient

☐ Alive — Date of your last contact_____(MM/DD/YYYY)
( )Normal Activity w/o symptoms ( )Bedridden
( )Symptomatic but ambulatory ( )Unknown

☐ Deceased — Date of Death_____ (MM/DD/YYYY)
Cause of Death_____ Place of Death_____
Autopsy Performed____ (Y/N)

Cancer Status ( )Evidence ( )No evidence ( ) Unknown

Recurrence Date of Recurrence_____ (MM/DD/YYYY)
Type of Recurrence_____

Subsequent Treatment(s): Surgery Date _____ Chemotherapy Date_____
Radiation Date_____ Hormones Date _____
Immunotherapy Date_____ Other Date_____

Thank you for your assistance,

Name of contact and title
Name of your facility
Tumor Registry Department
Phone number