PHYSICIAN NAME
PHYSICIAN ADDRESS
CITY, STATE 99999

DATE LETTER SENT

Patient Name:
Date of Birth: MM/DD/YYYY
Hist: type code Site: type top code
Dx Date: MM/DD/YYYY Last Seen: MM/DD/YYYY
Acc Nbr:

Dear Dr. :

The Oncology Data Center performs annual follow-up on patients, as required by the American College of Surgeons. Your assistance allows us to gather valuable treatment, recurrence and quality of life information on our patients. Even if your patient is not being seen for a cancer-related illness, please complete the last date you had any contact with the patient. All information is strictly confidential.

Sincerely,

Name of contact
Tumor Registry Department
Phone number of contact

Last Date of Contact: _____ / _____ / _____
If you are unable to complete this form, please refer us to the patient's current Physician:
_____

Patient Status:__ Alive __ Deceased Date of death: _____ / _____ /_____
Place of death (if known): _____
Cause of death (if known): _____

Cancer Status: __ No Evidence __ Evidence __ Unknown

Thank you for your assistance.