Ministry of Health
&
Social Development

CONFIDENTIAL

CANCER NOTIFICATION FORM
SEYCHELLES NATIONAL CANCER REGISTRY, HEALTH DEPARTMENT

REGISTRY NUMBER: ☐☐☐☐ ☐☐☐☐

PATIENT

Surname...**Other Names**..
(Use *block letters please*)

Previous names (if *any*)..

National Identity Number:

☐☐☐-☐☐☐☐-☐-☐-☐☐

Date of Birth:

☐☐-☐☐-☐☐☐☐(DD/MM/YYYY)

Age: ☐☐

Sex: ☐ M ☐ F ☐ Unknown

Nationality: ☐ Seychellois ☐ Non-Seychellois ☐ Unknown

Birthplace *(country)*

....

....

Full Residential Address:

....

....☐☐

Telephone:

Home..

Office..

Mobile..

Occupation:

....

....☐☐☐

Habit:

Tobacco ☐ Yes ☐ No ☐ Unknown

Alcohol ☐ Yes ☐ No ☐ Unknown

Family History of Tumours:

☐ Yes ☐ No ☐ Unknown

If Yes, specify..

Other illnesses/conditions *(please specify)*

....

....

....

SOURCE OF INFORMATION

Patient File Number..**Data Source** ....☐☐

CURRENT TUMOUR *(one notification form for each primary tumour)*

Date of diagnosis: ☐☐-☐☐-☐☐☐☐ (DD/MM/YYYY)

Basis of diagnosis (*please circle one or more*):

0 = Death Certificate only 1 = Clinical Only 2 = Clinical Invest/Ultrasound 3 = Surgery 4 = Biochem/immuno test
5 = Cytology/Haematology 6 = Histology of Mets 7 = Histology of Primary 8 = Autopsy with histology 9 = Unknown ☐

Primary Site (topography) .... C ☐☐.☐

Morphology (type of tumour).. ☐☐☐☐/☐

Extent of Disease *(please circle one)*

0 = In-situ 1 = Localized 2 = Local Extension Only 3 = Local Extension + Regional Nodes
4 = Regional Nodes Only 5 = Distant Mets 8 = Not Applicable (e.g. KS & hematological malignancies)
9 = Unknown ☐

Grade

.... ☐

Stage (In-situ, Stage I/IA/IB/IC, Stage II/IIA/IIB/IIC, Stage III/IIIA/IIIB/IIIC, Stage IV/IVA/IVB/IVC, Unknown)

.... ☐

T: **N:** **M:**

T = Primary tumour, N =Regional lymph nodes, M = Distant Metastasis

PREVIOUS CANCER

☐ Yes ☐ No ☐ Unknown **(If yes) Date of diagnosis:** ☐☐-☐☐-☐☐☐☐

Previous Topography .... C ☐☐.☐

Previous Morphology.. ☐☐☐☐/☐

TREATMENT *(please select)*

	Yes	No	Unknown		Yes	No	Unknown
Surgery	☐	☐	☐	**Hormone Therapy**	☐	☐	☐
Chemotherapy	☐	☐	☐	**Palliative Treatment**	☐	☐	☐
Radiotherapy	☐	☐	☐	**Other treatment**	☐	☐	☐ (If yes,

specify) ....

FOLLOW UP

Date of last contact/death: ☐☐-☐☐-☐☐☐☐(DD/MM/YYYY)

Patient Status: ☐ Alive ☐ Dead ☐ Unknown

If Alive: ☐ Remission ☐ Relapse ☐ Recurrence ☐ Unknown

If dead, cause of death:

☐ Cancer related

☐ Non-cancer cause

☐ Unknown

Direct cause of death

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Remarks if any

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Notified By...

(Name & post title)

Signature.. **Date**..