Svenska barncancerregistret – VCTB
Notification of cancer / tumor data - formulär

Report date: | 2 | 0 |___|___|___|___|___|___|
Forename:
Surname:
Date of Birth: | 2 | 0 |___|___|___|___|___|___| - |___|___|___|___|
Gender: ☐ Female ☐ Male
Home adress:
City:
Country:

Select the type of registration

Select the type of registration (one option)

- ☐ Both notification of cancer and quality registry
- ☐ Only notification of cancer
- ☐ Only quality registry

If only notification of cancer has been chosen, please specify reason below (one option)

- ☐ Opposes participation (Opt-out)
- ☐ Inclusion criteria unfulfilled

Notification of cancer/Tumor

Clinic reporting notification of cancer

_____

Date of diagnosis

\| 2 \| 0 \|___\|___\|___\|___\|___\|___\|

Basis of cancer diagnosis (one option)

- ☐ Clinical examination
- ☐ X-ray, scintigraphy, ultrasound, MRI, CT or other clinical investigations
- ☐ Biopsy or surgery including histologic examination of tissue
- ☐ Autopsy including histologic examination of tissue
- ☐ Cytology
- ☐ Surgery without histologic examination of tissue
- ☐ Autopsy without histologic examination of tissue
- ☐ Other basis of diagnosis

If Basis of cancer diagnosis is Biopsy or surgery including histologic examination of tissue, Autopsy including histologic examination of tissue or Cytology, please fill in below

Diagnosing pathology service: _____

Sample number: _____

Sample year: _____

Primary tumor site: _____

ICD-10-code: _____

Morphologic diagnosis: _____

If Morphologic diagnosis is Medulloblastoma, please specify Medulloblastomas genetically defined below

Medulloblastomas genetically defined (one option)

- ☐ Medulloblastoma, WNT-activated 9475/3
- ☐ Medulloblastoma, SHH-activated and TP53-mutant 9476/3
- ☐ Medulloblastoma, SHH-activated and TP53-wildtype 9471/3
- ☐ Medulloblastoma, non-WNT/non-SHH 9477/3
- ☐ Medulloblastoma, group 3
- ☐ Medulloblastoma, group 4
- ☐ Other

ICCC3 diagnosis: _____

Left or right side (one option)

- ☐ Left
- ☐ Right
- ☐ Midline
- ☐ Bilateral
- ☐ Data missing

District: _____

LKF at diagnosis: _____

If the patient is referred to another healthcare facility/clinic, specify which clinic (*Only fills in if select the type of registration is Only notification of cancer or both notification of cancer and quality registry*)

_____

Was the tumor detected at an autopsy?

☐ Yes ☐ No

Date of notification of cancer

| 2 | 0 |__|__|__|__|__|__|

Name of physician: _____