

Childhood Cancer Case Report Form

Province: _____

Hospital: _____

Date of Report: dd / mm / yy

Patient details

Patient's Name: _____

Patient's sex: Male Female

Mother's Name: _____

Patient's date of birth: dd / mm / yy

Father's Name: _____

Patient's age: years ___ months ___

Parent's mobile telephone number: _____

Hospital Medical Record Number: _____

Type and details of cancer (circle or identify correct responses)

Date of diagnosis: dd / mm / yy

Date of onset of symptoms: dd / mm / yy

Diagnosis

Acute lymphoblastic leukaemia (ALL)

Acute Myeloid leukaemia (AML)

Wilms tumour

Burkitt lymphoma

Retinoblastoma

Neuroblastoma

Retinoblastoma

Brain tumour

Other (specify)

Diagnosis based on

Clinical grounds only

Clinical and histological confirmation

Bone marrow aspirate diagnosis**Tissue biopsy****Treatment received**

Chemotherapy Y N

Palliative care Y N

Treatment outcome

Treatment completed according to PNG cancer protocol

Date treatment completed: dd / mm / yy

Treatment not completed (specify why)

Patient died during treatment

Patient defaulted or ceased treatment

Inadequate drugs to complete treatment

Outcome

Date of last follow-up dd / mm / yy

Survived treatment, well and in remission

Ongoing treatment

Died

Describe any difficulties in providing cancer treatment