

**CAYMAN ISLANDS CANCER REGISTRY**  
**CAYMAN ISLANDS HEALTH SERVICES AUTHORITY**

P.O. Box 915, Grand Cayman KY1-1103, Cayman Islands  
 (345) 244-2560



**Your participation in the Cayman Islands Cancer Registry is voluntary. Should you choose to register, all information will be kept confidential and will be used for statistical purposes only.**

1. REGISTRY NO.           TO BE FILLED BY THE CICR

**Personal Information**

1.	Surname(s)			
2.	First name			3. Middle name(s)
4.	Date of Birth	<input type="text"/> / <input type="text"/> / <input type="text"/> [dd/mm/yyyy]		5. Age at time of diagnosis <input type="text"/>
6.	Country of Birth			7. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
8.	Mother's country of birth			9. Father's country of birth
10.	Are you a resident of the Cayman Islands	<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Year of immigration to Cayman (if applicable)	<input type="text"/> [yyyy]
12.	Length of residence in Cayman (years)	<input type="text"/> [years]		
13.	Are you Caymanian	<input type="checkbox"/> Yes <input type="checkbox"/> No	If No, Specify Nationality _____	
14.	Address at time of diagnosis	District _____ Island _____		
15.	Ethnic Origin	<input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Mixed <input type="checkbox"/> Other If Mixed or Other, Specify _____		
16.	Usual Occupation	17. Number of years in occupation		Years <input type="text"/>

**Tumour information**

18.	Type of cancer diagnosed			
19.	Date of first Diagnosis	<input type="text"/> / <input type="text"/> / <input type="text"/> [dd/mm/yyyy]		
20.	Country of diagnosis			
21.	Country of first treatment			
22.	First treatment received after diagnosis	<input type="checkbox"/> Surgery <input type="checkbox"/> Radiotherapy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Immunotherapy <input type="checkbox"/> Hormonal therapy <input type="checkbox"/> Cryotherapy <input type="checkbox"/> Laser therapy <input type="checkbox"/> Palliative therapy If other, specify _____		
23.	Morphology/ histopathological type	(IF UNKNOWN LEAVE BLANK)		
24.	Type of test used to confirm diagnosis	<input type="checkbox"/> Biopsy (histology of primary) <input type="checkbox"/> Surgery <input type="checkbox"/> Ultrasound <input type="checkbox"/> Cytology <input type="checkbox"/> Laboratory test –other <input type="checkbox"/> Other, please specify _____		

**\*\*\*PLEASE CONTINUE TO REVERSE SIDE\*\*\***

I give my consent to the Cayman Islands Cancer Registry (CICR) to review, extract, retain and utilize the data referenced in this document, and to track and locate any missing or incomplete data items referenced above. I understand the information obtained by the CICR is to be used for the sole purpose of research, statistic and programme development, and that any data utilized and released will be in aggregate format that cannot lead to the registrant's identification.

Date: / /   [dd/mm/yyyy] Contact Number(s): \_\_\_\_\_

Signature of registrant (required): \_\_\_\_\_

This form may be returned to the Cancer Registrar at the e-mail address, mailing address, or physical address listed below.

Phone: (345) 244-2560  
E-mail: Amanda.nicholson@hsa.ky

Mailing address: Amanda Nicholson, Cancer Registrar  
Cayman Islands Health Services Authority  
P.O. Box 915  
Grand Cayman KY1-1103  
Cayman Islands

Physical address: Health Services Authority, 95 Hospital Road, George Town

Received: \_\_\_\_\_

Verifier: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

CONFIDENTIAL