Text Documenting Tips

*Indicates latest update from the ASCR

1. Physical Exam field: Include patient **race, age, sex** and **any history of other reportable cases**. (Ex. 65 YRW/F who noticed a mass in her rt breast at the end of Nov. Mammo, bx, surgery was done and pt presented at hosp for chemo tx. Pt also has a history of adenocarcinoma of the colon diagnosed 12/2007 by Hospital XYZ or by Dr. QRS in Montgomery, AL.

2. Indicate patient **vital status** in documentation (place/date of death).

3. Path report: include final diagnosis, lymph node removal, tumor size, and margins (helpful to copy entire path report into path field of abstract).

4. Identify **sub-site** in documentation: ex. Breast RUQ, 3 o'clock position, etc.

5. Document **laterality, grade.**

6. **CS Extent:** document and code based on extent in pathology report rather than just assigning "T" staging code.

7. **CS Lymph Nodes**: document **specific lymph node chain** involved.

8. Treatment: **be specific** on date first course of therapy began, type of surgery/treatment done, # of nodes resected, single vs multi-agent chemo

9. Laboratory findings: document date, type, and results (ER, PR, CEA, etc.) (negative, positive, etc.)

10. Staging: document clinical and/or pathologic AJCC stage.

11. **Make sure your text information supports your assigned code.**

*********BE SPECIFIC*********