

CCC Coder ID: _____

Member ID: _____ - _____ - _____ Case #: _____ CCC ID: _____

Other Case #s: _____ Date completed: ____/____/____ (MM/DD/YY)

Site: _____

1. What type of provider diagnosed the patient’s first incident melanoma?

- ₁ Primary care provider
- ₂ Dermatologist or dermatologic surgeon
- ₉ Unknown
- ₈ Other (Specify): _____

2. Was any cancer-directed surgery done as part of primary treatment for melanoma?

- ₉ Unknown if cancer-directed surgery performed (e.g., death certificate ONLY)
 - ₀ No
 - ₁ Yes
- } → Go to Question 3.

2.1 Type of surgery: (Mark all that apply.)

- ₁ Local tumor destruction
 - Photodynamic therapy
 - Electrocautery
 - Cryosurgery
 - Laser ablation
- ₃ MOHS surgery
- ₄ Wide local excision or re-excision
- ₈ Other surgery: _____

(NO TUMOR SAMPLE AVAILABLE)

- ₂ Local tumor excision
 - Excisional biopsy
 - Polypectomy
 - Laser excision
 - Shave biopsy
 - Punch biopsy

2.2 Surgery Date: ____/____/____ ₁ Exact ₂ Estimated ₉ Unknown
Month Day Year

2.3 Surgical margins:

Narrowest radial margin of final excision by microscopic pathology report (e.g., “The tumor extends to within “X” cm of nearest margin”). (Mark one.)

_____ cm

- ₁ <0.1 cm
- ₂ 0.1 - 0.49 cm
- ₃ 0.5-.99 cm
- ₄ ≥ 1 cm
- ₅ No residual tumor detected
- ₆ Margins positive
- ₇ Not applicable (including lesions excised by MOHS micrographic surgery)
- ₉ Unknown

2.4 Residual disease after final excision (e.g., microscopic or gross)

₀ No

₁ Yes, surgical margins involved, microscopic disease

₂ Yes, gross disease remaining

₃ Yes, NOS

₄ Not applicable

₉ Unknown

3. Was molecular testing of the tumor documented in the medical records (e.g., BRAF, c-KIT) for participants with regional or distant disease at diagnosis? (Note: Record for localized disease if incidentally discovered.)

₁ Yes ₀ No

₂ Recommended, unknown if done

₉ Unknown

→ **Go to Question 4.**

3.1 Test:	Result:	Date:			
_____	_____	___/___/___	<input type="checkbox"/> ₁ Exact	<input type="checkbox"/> ₂ Estimated	<input type="checkbox"/> ₉ Unknown
_____	_____	___/___/___	<input type="checkbox"/> ₁ Exact	<input type="checkbox"/> ₂ Estimated	<input type="checkbox"/> ₉ Unknown
_____	_____	___/___/___	<input type="checkbox"/> ₁ Exact	<input type="checkbox"/> ₂ Estimated	<input type="checkbox"/> ₉ Unknown

4. Was a test for lactate dehydrogenase (LDH) level in the blood performed?

₁ Yes ₀ No

₂ Recommended, unknown if done

₉ Unknown

→ **Go to Question 5.**

4.1	Result: _____	date: ___/___/___	<input type="checkbox"/> ₁ Exact	<input type="checkbox"/> ₂ Estimated	<input type="checkbox"/> ₉ Unknown
4.2	Result: _____	date: ___/___/___	<input type="checkbox"/> ₁ Exact	<input type="checkbox"/> ₂ Estimated	<input type="checkbox"/> ₉ Unknown
4.3	Result: _____	date: ___/___/___	<input type="checkbox"/> ₁ Exact	<input type="checkbox"/> ₂ Estimated	<input type="checkbox"/> ₉ Unknown
4.4	Result: _____	date: ___/___/___	<input type="checkbox"/> ₁ Exact	<input type="checkbox"/> ₂ Estimated	<input type="checkbox"/> ₉ Unknown
4.5	Result: _____	date: ___/___/___	<input type="checkbox"/> ₁ Exact	<input type="checkbox"/> ₂ Estimated	<input type="checkbox"/> ₉ Unknown

5. Was radiation therapy given as part of the first course of therapy to the primary tumor and/or a metastatic site?

- ₁ Yes
 - ₀ No
 - ₂ Recommended, unknown if done
 - ₉ Unknown
- Go to Question 6.

5.1 What type of radiation was administered? (Mark all that apply.)

- ₁ External beam radiation therapy (EBRT) at tumor site (rare)
- ₂ External beam radiation therapy (EBRT) to regional nodes or distant sites
- ₈ Other (Specify): _____
- ₉ Unknown

5.2 Was radiation therapy adjuvant or palliative treatment?(Mark all that apply.)

- ₁ Adjuvant
- ₂ Neoadjuvant
- ₃ Palliative
- ₉ Unknown

5.3 Start date: ____/____/____ ₁ Exact ₂ Estimated ₉ Unknown
Month Day Year

Stop date: ____/____/____ ₁ Exact ₂ Estimated ₉ Unknown
Month Day Year

Total dosage of radiation received: _____ cGy/Rad ₉ Unknown

6. Was systemic chemotherapy, immune-modulating, or targeted therapy administered as part of the first course of therapy?

- ₁ Yes
 - ₀ No
 - ₂ Recommended, unknown if done
 - ₉ Unknown
- Go to Question 7.

6.1 Regimen Name: _____ Code: _____

Type: ₁ Adjuvant therapy ₂ Neoadjuvant therapy

Start date: ____/____/____ ₁ Exact ₂ Estimated ₉ Unknown
Month Day Year

Administration route: ₁ Oral ₈ Other: _____

(Mark all that apply.) ₂ IV ₉ Unknown

6.2 Regimen Name: _____ Code: _____

Type: ₁ Adjuvant therapy ₂ Neoadjuvant therapy

Start date: ___/___/___ ₁ Exact ₂ Estimated ₉ Unknown
Month Day Year

Administration route: ₁ Oral ₈ Other: _____
(Mark all that apply.) ₂ IV ₉ Unknown

6.3 Regimen Name: _____ Code: _____

Type: ₁ Adjuvant therapy ₂ Neoadjuvant therapy

Start date: ___/___/___ ₁ Exact ₂ Estimated ₉ Unknown
Month Day Year

Administration route: ₁ Oral ₈ Other: _____
(Mark all that apply.) ₂ IV ₉ Unknown

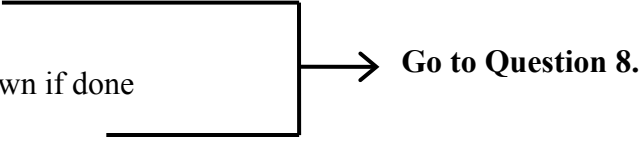
6.4 Regimen Name: _____ Code: _____

Type: ₁ Adjuvant therapy ₂ Neoadjuvant therapy

Start date: ___/___/___ ₁ Exact ₂ Estimated ₉ Unknown
Month Day Year

Administration route: ₁ Oral ₈ Other: _____
(Mark all that apply.) ₂ IV ₉ Unknown

7. Was **local** chemotherapy or other targeted therapy administered only **at the site of the primary tumor** (i.e., topical application, intralesional injection, isolated limb perfusion) as part of the first course of therapy?

- ₁ Yes ₀ No
₂ Recommended, unknown if done
₉ Unknown
- 

<p>7.1 Regimen Name: _____ Code: _____</p> <p>Start date: ___/___/___ <input type="checkbox"/>₁ Exact <input type="checkbox"/>₂ Estimated <input type="checkbox"/>₉ Unknown <small>Month Day Year</small></p> <p>Administration route: <input type="checkbox"/>₁ Topical <input type="checkbox"/>₈ Other: _____</p> <p>(Mark all that apply.) <input type="checkbox"/>₂ Intralesional injection <input type="checkbox"/>₉ Unknown</p> <p style="padding-left: 40px;"><input type="checkbox"/>₃ Isolated limb perfusion during surgery</p>
<p>7.2 Regimen Name: _____ Code: _____</p> <p>Start date: ___/___/___ <input type="checkbox"/>₁ Exact <input type="checkbox"/>₂ Estimated <input type="checkbox"/>₉ Unknown <small>Month Day Year</small></p> <p>Administration route: <input type="checkbox"/>₁ Topical <input type="checkbox"/>₈ Other: _____</p> <p>(Mark all that apply.) <input type="checkbox"/>₂ Intralesional injection <input type="checkbox"/>₉ Unknown</p> <p style="padding-left: 40px;"><input type="checkbox"/>₃ Isolated limb perfusion during surgery</p>
<p>7.3 Regimen Name: _____ Code: _____</p> <p>Start date: ___/___/___ <input type="checkbox"/>₁ Exact <input type="checkbox"/>₂ Estimated <input type="checkbox"/>₉ Unknown <small>Month Day Year</small></p> <p>Administration route: <input type="checkbox"/>₁ Topical <input type="checkbox"/>₈ Other: _____</p> <p>(Mark all that apply.) <input type="checkbox"/>₂ Intralesional injection <input type="checkbox"/>₉ Unknown</p> <p style="padding-left: 40px;"><input type="checkbox"/>₃ Isolated limb perfusion during surgery</p>
<p>7.4 Regimen Name: _____ Code: _____</p> <p>Start date: ___/___/___ <input type="checkbox"/>₁ Exact <input type="checkbox"/>₂ Estimated <input type="checkbox"/>₉ Unknown <small>Month Day Year</small></p> <p>Administration route: <input type="checkbox"/>₁ Topical <input type="checkbox"/>₈ Other: _____</p> <p>(Mark all that apply.) <input type="checkbox"/>₂ Intralesional injection <input type="checkbox"/>₉ Unknown</p> <p style="padding-left: 40px;"><input type="checkbox"/>₃ Isolated limb perfusion during surgery</p>

8. Has the participant ever been disease free since her initial diagnosis/treatment?

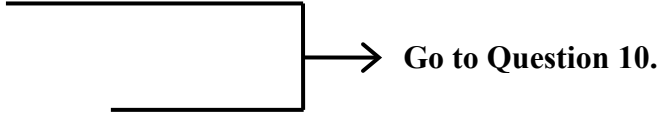
- ₁ Yes →
- ₀ No
- ₉ Unknown

8.1 Date as documented in the medical records *: <input type="text"/> / <input type="text"/> / <input type="text"/> <div style="display: flex; justify-content: space-around; font-size: small;"> Month Day Year </div>

* If no evidence of recurrence or metastasis: Record **most recent** documented disease free date.
 If documented recurrence or metastasis: Record **first** known disease free date.

9. Was there a new or recurrent **invasive** melanoma of the skin diagnosed after a documented disease free interval?

- ₁ Yes
- ₀ No
- ₉ Unknown



9.1	Site: _____	<input type="checkbox"/> ₁ Same	<input type="checkbox"/> ₂ Different	<input type="checkbox"/> ₉ Unknown	
	Laterality: _____	<input type="checkbox"/> ₁ Same	<input type="checkbox"/> ₂ Different	<input type="checkbox"/> ₃ Not applicable	<input type="checkbox"/> ₉ Unknown
	Histology: _____	<input type="checkbox"/> ₁ Same	<input type="checkbox"/> ₂ Different	<input type="checkbox"/> ₉ Unknown	
	Histology code: _____				
	Diagnosis date: _____	<input type="checkbox"/> ₁ Exact	<input type="checkbox"/> ₂ Estimated	<input type="checkbox"/> ₉ Unknown	
		Month	Day	Year	
9.2	Site: _____	<input type="checkbox"/> ₁ Same	<input type="checkbox"/> ₂ Different	<input type="checkbox"/> ₉ Unknown	
	Laterality: _____	<input type="checkbox"/> ₁ Same	<input type="checkbox"/> ₂ Different	<input type="checkbox"/> ₃ Not applicable	<input type="checkbox"/> ₉ Unknown
	Histology: _____	<input type="checkbox"/> ₁ Same	<input type="checkbox"/> ₂ Different	<input type="checkbox"/> ₉ Unknown	
	Histology code: _____				
	Diagnosis date: _____	<input type="checkbox"/> ₁ Exact	<input type="checkbox"/> ₂ Estimated	<input type="checkbox"/> ₉ Unknown	
		Month	Day	Year	
9.3	Site: _____	<input type="checkbox"/> ₁ Same	<input type="checkbox"/> ₂ Different	<input type="checkbox"/> ₉ Unknown	
	Laterality: _____	<input type="checkbox"/> ₁ Same	<input type="checkbox"/> ₂ Different	<input type="checkbox"/> ₃ Not applicable	<input type="checkbox"/> ₉ Unknown
	Histology: _____	<input type="checkbox"/> ₁ Same	<input type="checkbox"/> ₂ Different	<input type="checkbox"/> ₉ Unknown	
	Histology code: _____				
	Diagnosis date: _____	<input type="checkbox"/> ₁ Exact	<input type="checkbox"/> ₂ Estimated	<input type="checkbox"/> ₉ Unknown	
		Month	Day	Year	

