Physician Reporting of Cancer Cases to the Ohio Department of Health
Ohio Cancer Incidence Surveillance System

Physician Information

Last Name: _____ First Name: _____

Practice Name: _____

Address: _____

Phone Number: _____

Business E-Mail Address: _____

Business Website (if applicable): _____

National Provider Identification Number: _____

Physician License Number: _____

Primary Office Contact (if different from above)

Last Name: _____ First Name: _____

Title: _____

Phone Number: _____

Business E-Mail Address: _____

Practice Information

1. How would you describe your practice? (check one)

   ____ Solo practice

   ____ Medical group or partnership

   Please list the name of the group or partnership: _____

   Please list names of other physicians in this medical group or partnership: _____

   _____

   _____

   ***Please note:** For group/partnership please fill out the survey only for the physician to whom the survey was sent, unless the information requested is the same for all the physicians in the group. In that case, please indicate that the survey responses apply to the entire group by checking the box to the right. ☐

   ____ Other: _____

   ____ I am retired (If you are retired, thank you for completing this survey. Please return it to the address listed on the last page of the survey).

2. Please estimate the number of patients you see in a typical month. _____

3. Are you affiliated with a hospital?

_____ Yes

If yes, please list names of hospitals with which you are affiliated: _____
_____

_____ No

4. Do you diagnose and/or treat persons with cancer? (check one)

_____ Yes
_____ No (If you do not diagnose and/or treat persons with cancer, thank you for completing this survey Please return it to the address listed on the last page of the survey).

5. What types of cancer do you diagnose and/or treat? (please check all that apply)

_____ Brain	_____ Head/Neck	_____ Prostate
_____ Breast	_____ Hematopoietic	_____ Pancreatic
_____ Colon/Rectum	_____ Liver	_____ Skin
_____ Digestive	_____ Lung	_____ Thyroid
_____ Endocrine	_____ Lymphoma	_____ Urologic
_____ Gynecologic	_____ Other (please specify): _____	

6. Do you currently report cancer cases to the Ohio Cancer Incidence Surveillance System (OCISS)?

_____ Yes, my office directly reports cases through data entry into the OCISS Gateway
_____ Yes, my office directly reports cases electronically through file upload
_____ Yes, my office directly reports cases on paper reporting forms
_____ Yes, my office uses a contractor
If yes, name of contractor: _____
_____ No
If no, why not? _____

If your office reports cancer cases please indicate your **OCISS reporting source number**: _____

7. Do you have internet access in your practice?

_____ Yes _____ No

8. Do you use an electronic health record (EHR) system in your practice?

_____ Yes
If yes, what is the name of your EHR system? _____
_____ No (Skip to Question 10)

9. If you use an EHR in your practice, do you know if it can generate a Health Level 7 (HL7) or Clinical Document Architecture (CDA) export file?

_____ Yes, HL7	_____ No
_____ Yes, CDA	_____ Don't Know
_____ Yes, both	

10. If you do not use an EHR system in your practice, do you have plans to implement one?

_____ Yes, within the next 12 months
_____ Yes, within the next 1-2 years
_____ Yes, within the next 3-5 years
_____ No

11. Would you be interested in piloting reporting cancer cases to OCISS using an abbreviated reporting form for physician reporting?

_____ Yes
If yes, name of person for OCISS to contact: _____
Email address or phone number:_____
_____ No

12. If you are not already doing so, would you be interested in piloting reporting cancer cases to OCISS electronically through either direct data entry or file upload?

_____ Yes
If yes, name of person for OCISS to contact: _____
Email address or phone number:_____
_____ No

13. Would you like to receive more information about OCISS registry reporting?

_____ Yes ____ No

14. What is your preferred method of communication?

____ Phone ____ E-mail ____ Mail

Name of person completing this survey: _____
Phone number: _____
E-mail address: _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS SURVEY!

Please return by FAX, E-MAIL or MAIL (pre-addressed envelope enclosed) to:

The Ohio Department of Health
Ohio Cancer Incidence Surveillance System
Center for Public Health Statistics and Informatics
Attn: Patricia Turner
246 N. High Street
Columbus, Ohio 43215
Phone (614) 752-2689
Fax (614) 644-8028
ociss@odh.ohio.gov