Queensland Cancer Register
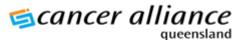
Notification of cancer in Queensland is a statutory requirement under the under the *Public Health Act (PHA) 2005*

PATIENT DETAILS

1. Hospital / Institution:

2. Medicare No.:   **3.** UR No.:

4. Surname:

5. Given Name:

6. Former Name / Alias:

7. Usual Street Address:

8. Suburb / Locality:

9. State: **10.** Postcode:

11. Date of Birth: ☐ Estimated?

12. Occupation (before retirement):

13. Sex: ☐ Male   ☐ Female

14. Country of Birth: ☐ Australia   ☐ Other (specify)

15. Marital Status: ☐ Never married   ☐ Married / Defacto   ☐ Widowed
☐ Divorced   ☐ Separated

16. Indigenous Status:
☐ Aboriginal but not Torres Strait Islander Origin
☐ Torres Strait Islander but not Aboriginal Origin
☐ Not Stated / Unknown
☐ Both Aboriginal and Torres Strait Islander Origin
☐ Neither Aboriginal nor Torres Strait Islander Origin

17a. Admission Date: **17b.** Separation Date:

18. Separation Mode:
☐ Discharged
☐ Transferred ➔ To Institution
☐ Died ➔ Was Autopsy Held?   ☐ Yes   ☐ No

19. Underlying Cause of Death:

CANCER DETAILS

20. Primary Site of Cancer:

21. Histological Type of Cancer:

22. Date of FIRST Diagnosis of this Cancer: ☐ Estimated?

23. Usual Suburb / Locality at FIRST Diagnosis of Cancer:

24. State: **25.** Postcode:

26. Laterality of Cancer: ☐ Right   ☐ Left   ☐ Bilateral   ☐ Unknown / Not Applicable

27. Is there more than one Primary Site?   ☐ Yes   ☐ No   *If YES, complete additional form(s)*

28a. Most valid basis of Diagnosis of Cancer at THIS Admission:
☐ Clinical Only
☐ Clinical Investigations
☐ Exploratory Surgery
☐ Spec. Biochemical or Immunology
☐ Cytology or Haematology
☐ Histology of Metastasis
☐ Histology of Primary
☐ Laboratory (specify)
☐ Autopsy and Histology
☐ Unknown

28b. Reasons for Clinical Diagnosis:
☐ Palliative Care Admission
☐ Doctor's Notes / Referral (specify doctor)
☐ Pathology (specify laboratory)
☐ Radiological Investigation (specify)
☐ Other Non-invasive Investigation (specify)
☐ Invasive Investigation (specify)
☐ Non Cancer Admission
☐ Other / Chemo / RT (specify)

29. Name of Treating Doctor:

30. Name of Person Completing this form:

Date: