QUEENSLAND CANCER REGISTER

INSTRUCTION MANUAL

FOR NOTIFYING CANCER

PUBLIC HOSPITALS

February 2022

Queensland Cancer Register
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CONTENTS

NOTE. Items above marked with an * are specific requirements of the cancer registration screen.

1. INTRODUCTION

1.1 Establishment of the Cancer Register

The Queensland Cancer Register (QCR) operates under the *Public Health Act 2005,* to receive information on cancer in Queensland. The Cancer Register is a population-based register and maintains a Register of all cases of cancer diagnosed in Queensland since the beginning of 1982. Cancer is a notifiable disease in all States and Territories and is the only major disease category from which an almost complete coverage of incidence data is available. It is also the only major cause of death in Australia that is continuing to increase. Through the National Cancer Statistics Clearing House – a collaborative enterprise of the Australian Association of Cancer Registries and the Australian Institute of Health and Welfare, Queensland data is used in the compilation of Australia-wide figures and can be compared with cancer statistics from other States.

1.2 Aims of the Register

The main aim of the Register is to collect data to describe the nature and extent of cancer in Queensland. This can be combined with related data to assist in the control and prevention of cancer. To this end, Queensland Cancer Register data is available for use:

- in research projects on the causes, treatment and prevention of cancer,
- in the planning and assessment of cancer treatment and prevention services,
- in monitoring survival times of cancer patients, and
- for the education of health professionals and members of the general public.

1.3 Notification and sources of data

Notification of cancer is a statutory requirement for all public and private hospitals, nursing homes and pathology services. Notifications are received for all persons with cancer separated from public and private hospitals and nursing homes. Queensland pathology laboratories provide copies of pathology reports for cancer specimens. Data on all persons who die of cancer or cancer patients who die of other diseases are abstracted from the mortality files of the Registrar of Births, Deaths and Marriages and linked to hospital and pathology data.

1.4 The Act and Regulations

The *Public Health Act 2005,* Division 3 – Notifications about cancer 234 and 235 that the person in charge of a hospital or residential care facility must give a notification to the chief executive of Queensland Health if a person known to be suffering from cancer who is a patient in the hospital or a resident of the residential care facility, or under the direction of the chief executive to Metro South Hospital and Health Service (‘the contractor’), within one month.

The legislation may be viewed on the following website:

https://www.health.qld.gov.au/system-governance/legislation/health-portfolio

1.5 Confidentiality of data

All unit record information collected by the Queensland Cancer Register is treated as strictly confidential. All information collected is used for statistical or research purposes only.

1.6 Enquiries

If you would like more information about the Queensland Cancer Register or you wish to obtain any publications you may contact the:

Senior Director
Cancer Alliance Queensland
Level 1, B2, 2 Burke St
Woolloongabba Q 4102

PH (07) 3176 4400
Email QCR@health.qld.gov.au

Further information about cancer may also be obtained from the following web sites:

www.qccat.health.qld.gov.au (Queensland Health site, QCR data)
www.aihw.gov.au/cancer/index.html (AIHW site, national data)

2 ELECTRONIC NOTIFICATION

2.1 Background

Since early 2002, the Queensland Cancer Register has been receiving cancer registrations from all Public Hospitals in Queensland electronically from HBCIS on a monthly basis.

For further details on the functionality of the HBCIS cancer module please go to the following: http://hbcis_support.health.qld.gov.au/help/whskin_homepage.htm

3 BUSINESS RULES

3.1 What hospitals should notify?

All public hospitals in Queensland are required to report cancer details to the Queensland Cancer Register.

3.2 What cancers should be notified?

All cancers as defined in Part 2 Division 1, Section 229 of the *Public Health Act* 2005 are to be notified. The Act defines cancer as:

(a) a neoplasm of human tissue—
  (i) in which cell multiplication is uncontrolled and progressive; and
  (ii) that, if unchecked, may invade adjacent tissues or extend beyond its site of origin; and
  (iii) that has the propensity to recur, either locally or remotely in the body;
(b) skin cancer and non-invasive carcinoma, other than skin cancer and non-invasive carcinoma of a type prescribed under a regulation.

Therefore, all invasive cancers are to be reported (excluding Basal Cell Carcinomas and Squamous Cell Carcinomas of the skin where the ICD-10-AM site code range is C44.0 to C44.9 and morphology is M805 to M811). Merkel cell tumours of the skin and Kaposi's Sarcoma are also to be reported.

Please report any cancer with uncertain behaviour.

Please notify **all** in-situ conditions as well. The Register collects for example, in-situ cancers of the cervix (CIN III - cervical intra-epithelial neoplasm), vagina (VAIN III - vaginal intra-epithelial neoplasm), vulva (VIN III - vulval intra-epithelial neoplasm), prostate (PIN - prostatic intra-epithelial neoplasm) bladder, breast and in-situ melanomas.

Benign central nervous system and brain tumours are also of interest to the Register and must be reported.

Non-malignant conditions, such as CIN I or II, VAIN I or II, VIN I or II, solar keratosis or keratoacanthoma, are outside the scope of the collection.

3.3 When should a notification should be completed?

A notification should be completed and filed **within 30 days** for each of the following events:

(i) at discharge or transfer of a patient being **first** diagnosed with cancer, or when a **new site** is diagnosed, or the same site but a **different histological type** of cancer is diagnosed.

(ii) a patient's **first** date of attendance in each calendar year for chemotherapy or radiotherapy. (Note that as per the Queensland Health admission policy patients should be admitted for chemotherapy.)

(iii) at the **death** of a patient suffering from or with a **history** of cancer, where the patient died within the hospital.

(iv) at discharge or transfer from the **first** admission for each calendar year for all other patients suffering from or with a history of cancer. This includes patients who may be being treated for their cancer at that admission or where the cancer is incidental to that admission. It is a requirement to follow current coding standards and to only code history of cancer in the ICD-10-AM diagnosis codes where it is relevant to the admission. It is desirable for the cancer register to still receive a notification through separately 'filing' a cancer registration notification.

A **separate notification** is required for each primary site.

Only notifications that have been filed will be forwarded as part of the extract. A print option is available for sites to use for retaining a record in their own charts. This is not a mandatory requirement of the Cancer Register. The print option also serves as a back-up if at any time the electronic notification process fails. The Register will notify hospitals if this is a required.

3.4 Amendments

Amendments can only be reported to the Register if the registration is refiled. If the record is refiled within a reporting period, only the most recent registration will be forwarded to the QCR.

3.5 Deletions

Deletions cannot be provided electronically. If a notification has been filed it will be reported through to the Register. A manual notification is required if the record is to be deleted from the QCR. This can be done by printing the notification prior to deleting or photocopying the relevant notification and crossing it with DELETED. If possible, a reason should be added, eg duplicate patient, not cancer, etc.

3.6 Further information required

After processing a cancer notification the Register may identify a need for further information. A response to the request for further information is required within 30 days and should be supplied electronically eg updated cancer notification and/or supporting information to email address QCR@health.qld.gov.au

It is recommended that hospitals maintain a record of the completion and dispatch of the responses to the requests for further information.

3.7 How can outstanding notifications be checked?

An Outstanding Cancer Registration Report should be run at the end of each month to ensure that all patients with a cancer code in their ICD-10-AM coding have a Cancer Registration. The layout of the report has been changed to include new fields and change the sequence of existing fields.

There is a new field '01 Date Selection', this field will allow the selection of a date range by 'discharge date' or 'coded date'.

Three new sort options have been added to field '04 Sort Sequence', these are User ID, Discharge Unit and Location.

Field '05 Method", changes to method '2 using the Primary Site of Cancer Codes Ref. File'. It will report four (4) types of patient episodes. It will report episodes with a History of Cancer, episodes where the primary site AND morphology combination are not registered, and episodes for the first presentation in a calendar year for a patient with an existing Cancer Registration. A new parameter has been added to exclude those neoplasms that are not required to be reported. Eg. Skin SCC/BCC, or benign cancers (except brain).

The report should be run for the period January (of the current year) to the current reporting month. The period checked will therefore be cumulative for a calendar year.

A manual check is required to identify those patients who have previously been registered and require reporting.

3.8 When should a notification be sent?

Notifications should be sent on a monthly basis.

An extract should be run on the 10th day of each month (this will happen automatically). The extract should include all notifications filed in the previous month.

If run manually, there must be no gaps in date ranges for the extract periods. Nor should there be dates duplicated within extract periods. If data is to be resupplied for a period this should be negotiated with the Cancer Register. It may require records to be refiled.

Each set of cancer registration extract files will contain a header (HDR) details file. The HDR file will provide counts of the total number of records for that facility (including nil returns).

3.9 Use of the cancer register flag

The CCR Number is no longer available on the Inpatient ICD Coding Screen. There is a flag (CCR2001) in the top right hand corner of this screen this displays the last year a patient cancer registration has been notified. You can get to the Cancer Registration Screen by simply entering CCR in the command line. This can be done regardless of whether there is a cancer code in the ICD coding. This simplifies the access to the Cancer Registration Screen for patients with a history of cancer.

The user will be prompted to complete a cancer registration in the following situations:

- Deceased patients with an existing cancer registration, which has not been updated to include Cause of Death.
- For any site/morphology code combination that is not registered (excludes combinations not to be reported eg Skin SCC/BCC)
- When the registered admission episode is in a prior calendar year.
- When discharged with a history of cancer and no existing cancer registration.

If the patient has a cancer registration you should check the Cancer Registration Screen details to see if a further notification is required. Check the last episode and dates. If you are required to report the patient (following the rules in section 3.3) then you must check all cancer details (including for multiple primary sites) prior to filing the record.

4 FACILITY DETAILS

4.1 Facility number

The facility number is a numerical code that uniquely identifies each health care facility.

Patients moving between these hospitals are counted as separate admissions and separations and are therefore reported by both facilities.

Nursing home residents should be reported under the facility number of the nursing home. Nursing home residents moving from a nursing home bed to an acute bed at another facility should be admitted as an acute patient from the date that they occupy the acute bed and reported as such.

This is not to be confused with a person's status as a nursing home type patient in an acute bed.

HBCIS hospitals allocate their facility number automatically when the data is extracted for the QCR. The facility will be identified using the discharge ward code for the linked admission episode. The ward code will be mapped to a campus code in the Ward Codes Reference File. The campus code will be mapped to a facility code in the Campus Codes Reference File.

5 PATIENT DETAILS

5.1 UR number (Patient Number) *

A unique number allocated to each patient by the hospital. Allocation might be done manually or automatically by the computer. The number is used for each admission to identify the patient within the facility.

Upon entry of a valid patient number the following patient details will be displayed and should be checked for accuracy:

- The patient's surname, given names and date of birth.
- The patient's current suburb and postcode of usual residence.
- A deceased flag (D) displays if a date of death is recorded for the patient.

5.2 Patient surname/family name

Upon entry of a valid patient number the patient surname/family name details will be displayed and should be checked for accuracy. It is derived from the surname field (02) on the Patient Registration Screen.

5.3 Given names

5.3.1 First name

Upon entry of a valid patient number the patient's first name details will be displayed and should be checked for accuracy. It is derived from the given names field (03) on the Patient Registration Screen.

5.3.2 Second name

Upon entry of a valid patient number the patient's second, name details will be displayed and should be checked for accuracy. It is derived from the given names field (03) on the Patient Registration Screen.

Record the second given name or initials of the patient if available but not previously recorded.

5.4 Former names/alias

Derived from the number of alias names entered on the Patient Alias screen. Record any previous surname or other names that the patient or resident is now or has previously been known as. Record the complete name (first name, second name and surname).

5.5 Sex

Upon entry of a valid patient number the patient sex details will be displayed and should be checked for accuracy. It is derived from the sex field (05) on the Patient Registration Screen.

To avoid problems with edits, transgender individuals undergoing gender conformation surgery should have their sex at the time of the hospital admission recorded.

Note that indeterminate will generally only be used for neonatal patients where the sex has not been determined.

5.6 Date of birth

Upon entry of a valid patient number the patient's date of birth details will be displayed and should be checked for accuracy. It is derived from the date of birth field (04) on the Patient Registration Screen.

Record the date of birth of patient using the full date (i.e. ddmmyyyy) and leading zeros where necessary.

- If the day of birth is unknown, use **.
- If the month of birth is unknown, use **.
- If the year of birth is unknown, estimate the year from the age of the patient.
- If the age of the patient is unknown and it is not possible to estimate an age and hence a year of birth (e.g. for unconscious patients, use the year 1900.

Although provision is made for recording an unknown date of birth (using **/**/1900), every effort should be made during the course of the admission to determine and record the patient's actual date of birth.

5.7 Address of usual residence

5.7.1 Number and street of usual residence

Derived from the address fields (15 and 16) on the Patient Registration Screen. Address details should be checked for accuracy.

If necessary record the building number and street name of the usual residential address of the patient. The usual residence is where the patient lives. For example, it is not the address where the patient might be staying temporarily before or after the period of hospitalisation.

Post Office box numbers or Mail Service Numbers should not be recorded. Use a building number and street name whenever possible. Even country properties have access roads that have names.

You may use standard abbreviations, for example:

- Alley - AL
- Approach – APP
- Arcade - ARC
- Avenue – AV
- Bend - BND
- Boulevard – BVD
- Break/Brook – BR
- Broadway – BWY
- Brow – BRW
- Bypass – BPS
- Centre – CTR
- Chase – CH
- Circle – CIR
- Circuit – CCT
- Circus - CRC
- Close – CL
- Concourse – CNC
- Copse – CPS
- Corner – CNR
- Corso - CSO
- Court – CT
- Courtyard – CYD
- Cove - COV
- Crescent – CR
- Crest – CST
- Cross – CS
- Crossing – CSG
- Dale – DLE
- Downs – DN
- Drive – DR
- Frontage – FR
- Garden/s – GDN
- Gate/s – GTE
- Glade – GLD
- Glen – GLN
- Grange – GRA
- Green – GRN
- Grove - GR
- Heights - HTS
- Highway – HWY
- Junction – JNC
- Lane – LA
- Link – LK
- Loop – LP
- Mall – ML
- Meander – MDR
- Mews – MW
- Motorway – MWY
- Nook – NK
- Outlook - OUT
- Parade – PDE
- Park – PK
- Parkway – PKY
- Pass – PS
- Pathway – PWY
- Place – PL
- Plaza – PLZ
- Pocket – PKT
- Port/Point – PT
- Promenade – PRM

• Edge – EDG • Elbow – ELB • Entrance – ENT • Esplanade – ESP • Expressway – EXP • Freeway – FWY • Retreat – RT • Ridge – RDG • Rise - RI • Road – RD • Roadway – RDY • Route – RTE • Square – SQ • Street – ST • Tarn – TN • Terrace – TCE • Tollway – TWY	• Quadrant – QD • Quay – QY • Ramble – RA • Reach – RCH • Reserve – RES • Rest – RST • Track – TR • Trail – TRI • Underpass – UPS • Vale – VA • View – VW • Vista – VST • Walk – WK • Walkway – WKY • Way – WY • Wynd - WYN

5.7.2 Suburb/Town of usual residence

Derived from the suburb field (17) on the Patient Registration Screen. Address details should be checked for accuracy.

If necessary, record the location of the usual residence of the patient as the suburb or town in which the patient usually lives. Do not record the location of temporary accommodation, or a (farm) property name in this field.

Interstate and overseas patients

If the patient lives interstate, the actual suburb or town of usual residence should be recorded.

If the patient is from overseas, also record the country in which he/she normally resides.

Patients diagnosed outside Queensland, while not reported by the Register, are recorded on the Register. This assists with identifying duplicate registrations, notifying interstate cases, and assists matching for subsequent treatment notifications.

5.7.3 Postcode of usual residence

Derived from the postcode field (18) on the Patient Registration Screen. Postcode details should be checked for accuracy.

Record the postcode of the usual residential address of the patient.

If the patient is not an Australian resident or has no fixed address, use one of the supplementary codes:

0989 = not stated/unknown
9301 = Papua New Guinea
9302 = New Zealand

9399 = Overseas - other (not PNG or NZ)
9799 = at sea
9899 = Australian External Territories
9989 = no fixed address

5.8 Medicare number

Derived from the Medicare number field (35) on screen 2 of the Patient Admission Screen. Medicare number details should be checked for accuracy.

If the patient is eligible for Medicare, record the Medicare number from the patient's Medicare card.

If the person does not have an Australian Medicare Number or if it is not available, leave this blank.

5.9 Marital status

Derived from the marital status field (07) on the Patient Registration Screen. Marital status details should be checked for accuracy.

Record the current marital status of the patient.

Separated means those people who are legally separated or socially separated, not persons who are temporarily living apart (e.g. construction workers living in hotels or camps).

5.10 Country of birth

Derived from the country field (06) on the Patient Registration Screen. Country of birth details should be checked for accuracy.

Record the country of birth of the patient using the appropriate numerical codes (as found on the HBCIS reference file).

- If the patient was born in Australia, use code 1101;
- If the patient was born in New Zealand, use code 1201.

5.11 Indigenous status

Derived from the indigenous status field (11) on the Patient Registration Screen. Indigenous status details should be checked for accuracy.

5.12 Occupation

Derived from the occupation field (21) on the Patient Registration Screen. Occupation details should be checked for accuracy.

Record the patient's occupation. Ideally the Register would like principal lifetime occupation. Only use pensioner/ housewife/retired if lifetime occupation is unable to be ascertained.

6 ADMISSION DETAILS

6.1 Admission number (Episode Number) *

This is allocated automatically by HBCIS and it is known as the episode number. The cancer registration must be linked to a specific admission number. Only admission numbers that are valid for the patient number may be entered. The episode number must be discharged.

Upon entry of a valid admission number the following details will be displayed and should be checked for accuracy:

- The admission date.
- The discharge date (if available*).
- The treating doctor initials (if available) or given names (if initials are not available) and surname for the doctor code current at the time of discharge (or system date if undischarged*).
- The code and description for the principal diagnosis code, as assigned on the Inpatient ICD Coding screen.

It will only be possible for converted registrations to be linked to the undischarged episode. An edit on screen filing will prevent such a cancer registration from being re-filed.

6.2 Admission date

Upon entry of an episode number that is valid for the patient number the patient's admission date details will be displayed and should be checked for accuracy. It is derived from the admission date field (62) on screen 3 of the Patient Admission Screen for the linked admission episode.
Record the full date (that is, ddmmyyyy) of admission to hospital. Use leading zeros where necessary.

6.3 Separation date

Upon entry of an episode number that is valid for the patient number the patient's separation date details will be displayed and should be checked for accuracy. It is derived from the discharge date field (02) on the Patient Discharge Screen for the linked admission episode.

At separation, record the full date (that is, ddmmyyyy), using leading zeros where necessary. This is the date that the patient was discharged, transferred or died.

6.4 Mode of separation (Discharge Status)

Derived from the discharge code field (04) on the Patient Discharge Screen for the linked admission episode.

The mode of separation (discharge status) indicates the place to which a patient is referred immediately following formal separation from hospital or indicates whether this is a statistical separation due to a change in the type of episode of care.

If the patient died in hospital (Code 05), please record the appropriate details for whether an autopsy was held and cause of death details.

6.5 Transferring to facility

Derived from the destination field (06) on the Patient Discharge Screen for the linked admission episode.

Record the facility number (extended source code) for the hospital, nursing home or correctional facility to which the patient is referred as an admitted patient.

6.6 Treating doctor

Derived from the code entered in the treating doctor field (75) on screen 3 of the Patient Admission Screen for the linked admission episode. The doctor's initials (03), doctor's given names (05) and surname (04) from the Doctor Codes Reference File will be reported.

To assist in improving the quality of this data, all fields should be completed.

Record the hospital code to describe the individual doctor chiefly responsible for treating the patient e.g. the Senior Treating Medical Officer, Specialist or Consultant in charge of the care. This is not the registrar or resident medical officer.

6.7 Cause of death *

If the linked admission episode is flagged as "death" (ie the patient died in the hospital) the description for the principal diagnosis code, as entered in the Inpatient ICD coding screen, is automatically displayed in this field. Check and update the text details as required.

Please only complete the cause of death if the patient dies in the hospital.

A single entry for cause of death is stored for each cancer registration, even if there are multiple primary site items.

Cause of death details will no longer be able to be recorded for patients who die after discharge from the hospital.

6.8 Autopsy held *

Record whether an autopsy or coroners inquiry is to be/has been undertaken with a Y or N.

Please only complete the autopsy held item if the patient dies in the hospital.

A single entry for autopsy flag is stored for each cancer registration, even if there are multiple primary site items.

6.9 Diagnosis at separation

This is derived from the first diagnosis code assigned in the ICD code field (02) on the Inpatient ICD Coding screen for the linked admission episode.

7 CANCER DETAILS

7.1 Multiple primary site *

This is a two digit multivalued item field, allowing entry of multiple primary sites of cancer for any single patient.

The following fields are maintained independently for each primary site and must be checked prior to filing a cancer registration as all primary sites are notified on each filing.

- Primary Site of Cancer

- Morphology
- Date of First Diagnosis
- Date of First Diagnosis Flag
- Suburb/Locality at First Diagnosis
- Postcode at First Diagnosis
- Laterality
- Basis of Diagnosis
- Reasons for Clinical Diagnosis
- Comments

7.2 Primary site of cancer *

A primary site is defined as the site at which a neoplasm originated. Thus, a cancer CASE includes each primary site in a cancer patient, and a patient with two primary sites is considered as being two different cases of cancer. A patient with one primary site and one or more secondary sites is one case of cancer only.

See Section 3.2 for the cancers in the scope of the collection.

Where possible be specific when coding the primary site, for example, if known, code site as "upper lobe of lung" or "upper-inner quadrant of breast".

If the initial diagnosis is a secondary tumour, report the primary tumour site if possible. This may be indicated by the morphology or clinical notes. If it is not possible to identify the primary tumour, then code the cancer as an unknown primary site.

Details such as whether the cancer has metastasised (and to which site) should be included in the comments field.
Also include details in the comments field if a more precise description exists for the cancer than can be coded in ICD-10-AM. This may include more precise topography for melanomas, connective and soft tissue sites, meninges and brain, insitu cancers, etc. The Register codes in ICD-O and has to convert or recode the ICD-10-AM codes. Any information that can assist this process would be useful.

7.3 Morphology *

See Section 3.2 for the cancers in the scope of the collection.

The behaviour code (5th digit) should relate to the primary cancer. While the Register does not collect information on secondary sites, details such as whether the cancer has metastasised (and to which site) should be included in the comments field.

Also include details in the comments field if a more precise description exists for the type of cancer than can be coded in ICD-10-AM. This may include more precise details for lymphomas and leukaemias, etc. The Register codes in ICD-O and records details down to the descriptor level. ICD-10-AM codes have to be converted or recoded to ICD-O. Any information that can assist this process would be useful.

7.4 Date of first diagnosis *

Try to accurately identify the full date of original diagnosis for this cancer where possible. Where unknown, please provide best estimate and enter Y in the Estimated field. If you are unable to provide an estimate, enter 15 JUN 1900 and enter Y in the Estimated field.

7.5 Date of first diagnosis flag *

Where the full date of original diagnosis is unknown enter Y in the Estimated field. If the date of diagnosis is known enter an N. This is the default value.

7.6 Suburb/Locality at first diagnosis *

Name of suburb or town of usual residence at the time of first diagnosis of this cancer. Although the field will reference the Suburb Codes Reference File, an invalid suburb may be entered. The system will accept the data as free text. This is to allow for the fact that the diagnosis may well have been some years ago and the Reference file contains only current suburbs. Extra care is therefore required for patients diagnosed prior to the current admission.

The entry of AA will be valid in the suburb field and will cause the system to automatically refresh the patient's current suburb and postcode, as displayed at the top of the screen. Use this default only when the patient is diagnosed in this admission. Do not update this field with current address details unless that is where the person lived at the time of diagnosis.

If precise details of the suburb are not known but the State is, then include 'Not stated/unknown' as the suburb descriptor and the relevant default State supplementary postcode. This enables us to identify cases diagnosed outside Queensland.

Supplementary suburb/postcodes:

0989 = not stated/unknown
1989 = New South Wales
2989 = Victoria
3989 = Queensland
4989 = South Australia
5989 = Western Australia
6989 = Tasmania
7989 = Northern Territory
8989 = Australian Capital Territory
9301 = Papua New Guinea
9302 = New Zealand
9399 = Overseas - other (not PNG or NZ)
9799 = at sea
9899 = Australian External Territories
9989 = no fixed address

7.7 Postcode at first diagnosis *

Australian postcode corresponding to address of usual residence at the time of first diagnosis of cancer. Upon entry of a valid suburb, the postcode will automatically be refreshed. The user can backtrack to modify the postcode to any number. This should be done if the postcode at diagnosis is different to that on the current Suburb Codes Reference File. This is to allow for the fact that the diagnosis may well have been some years ago and the Reference file contains only current suburb postcode combinations. Extra care is therefore required for patients diagnosed prior to the current admission.

Do not update this field with current address details unless that is where the person lived at the time of diagnosis.

If precise details of the postcode are not known but the State is, then use the relevant default State supplementary postcode. This enables us to identify cases diagnosed outside Queensland.
Supplementary suburb/postcodes:

0989 = not stated/unknown
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2989 = Victoria
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4989 = South Australia
5989 = Western Australia
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7989 = Northern Territory
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9301 = Papua New Guinea
9302 = New Zealand
9399 = Overseas - other (not PNG or NZ)
9799 = at sea
9899 = Australian External Territories
9989 = no fixed address

7.8 Laterality of cancer *

Where possible, for cancers of paired organs, such as Breast (C50), Lung (C34), Kidney (C64), Ovary (56), Eyes (C69), Arms (C76.4, C44.6, C49.1, C47.1, C40.0, C77.3), Legs (C76.5, C44.7, C49.2, C47.2, C40.2, C77.4), Ears (C44.2, C49.0, C30.1), Testicles (C62) indicate the side affected by the tumour.

The valid inputs are:

L	Left
R	Right
B	Bilateral
U	Unknown
N	Not applicable

Bilateral cancers are extremely rare. Includes organs that are bilateral as a single primary (e.g. bilateral retinoblastoma (M9510/3, C69.2), (M9511/3, C69.2), (M9512/3, C69.2), (C69.6, C48.0), bilateral Wilms tumours (C64.9, M8960/3)).

Unknown: It is unknown whether, for a paired organ, the origin of the cancer was on the left or right side of the body.

Not applicable is the default value. This should be recorded for all non-paired organ sites.

7.9 Basis of diagnosis *

Refers to the most valid basis of diagnosis AT THIS ADMISSION. The following notes may assist.

Note that the basis of diagnosis is hierarchical from 1 (least definitive) to 9 (most definitive). If more than one diagnostic technique is employed during this admission, select the higher number.

1. **Unknown**

Usually refers to a tumour which was diagnosed and treated elsewhere and the current hospital has no information regarding that treatment. This code would only apply if the current admission is unrelated to the cancer (ie a history of cancer only admission). Please provide details explaining unknown codes in the comments field. Any indication of where the person was diagnosed would avoid further follow-up.

2. **Clinical only**

When a tumour has been diagnosed by clinical examination (eg palpation) only at this admission or where the tumour has been diagnosed at a previous admission or different hospital and the diagnosis is supported only by clinical evidence at this admission.

3. **Clinical investigations**

When a tumour is diagnosed at this admission without invasive surgical procedures but may include diagnostic radioscopy and endoscopy.

4. **Exploratory surgery**

When a tumour is diagnosed at this admission by exploratory surgery without biopsy and histology. Include here an incidental autopsy finding of cancer without biopsy and histology.

5. **Specific biochemical or immunological testing**

Tumour diagnosed using particular laboratory techniques only, eg. Prostate specific antigen (PSA) for prostate.

6. **Cytology or haematology**

Tumour diagnosed using particular laboratory techniques only, eg. Fine needle aspiration without biopsy.

7. **Histology of metastasis**

When a histology is performed on a tissue sample of secondary tumour. Please identify the primary tumour if possible.

8. **Histology of primary**

When histology is performed on a tissue sample of primary tumour. NB: Bone marrow aspirates are considered to be histology - basis of 08.

9. **Autopsy and histology**

When histology is performed on a tissue sample taken during an autopsy.

7.10 Reasons for clinical diagnosis *

Refers to reasons why a patient may be admitted to hospital where a clinical only or clinical investigations basis of diagnosis is given as the most valid basis of diagnosis. This item has been designed to reduce the number of queries back to hospitals. Multiple reasons may be completed. Some codes for the Reasons for Clinical Diagnosis require further detail to be supplied in the Details field. The codes are as follows:

01 Palliative Care Admission
02 Doctor's Notes/Referral (Provide doctor details)
03 Previous Pathology (Provide laboratory details)
04 Radiological Investigation (Specify investigation details)
05 Other Non-invasive Investigation (Specify investigation details)
06 Invasive Investigation (Specify investigation details)
07 Non Cancer Admission (Specify details)
09 Other (Specify details)

Patients with a clinical admission for chemotherapy should be recorded with a code 09 and chemotherapy specified.

7.11 Details for clinical diagnosis *

This free text field allows the user to provide the relevant details as outlined above in Reasons for Clinical Diagnosis.

7.12 Comments *

This free text field allows the user to provide any other relevant details regarding the cancer that may assist the register staff or reduce queries for the hospital.

This may include a more precise description of the cancer than is able to be coded in ICD-10-AM. Also include any indication as to whether the cancer has metastasised and to which site.

Where possible, specify grading or differentiation - that is:

1	Grade I	(Well) differentiated
2	Grade II	Moderately (well) differentiated
3	Grade III	Poorly differentiated
4	Grade IV	Undifferentiated, anaplastic

7.13 Laboratory facility number *

This field becomes mandatory when the codes of 06, 07, 08 or 09, is entered into field 13 (Basis of Diagnosis).

The laboratory facility number field displays the laboratory where the specimen was sent to. It is linked to a reference file. The codes are as follows:

01 Auslab
02 S & N
03 QML
04 Private Laboratory
05 Other

7.14 Laboratory specimen number *

The lab specimen number will record the specimen lab number (e.g. report number) and any other comments required (e.g. if Other lab is recorded, then the user can record the actual lab name along with the Laboratory specimen number). This is a non-mandatory free text field, and only becomes enabled when the codes of 06, 07 08 or 09 is entered into field 13.

7.15 Registration filed by *

The user details are kept when the registration is filed.

7.16 Filed by date *

The date that the registration was completed. Before registrations are filed, please check to see all relevant details are filled in correctly.

Appendix A – File formats

All fields are to be provided in the extract in the format specified in the Requested Format column, unless otherwise stated in the Source/Description column. The files will be supplied in ascii comma delimited format with double quotes as a text delimiter. Field which are reported with double quotes as text delimiters will have any embedded double quotes replaced by single quotes. Other punctuation, including commas, will not be stripped from the data.

Header Details (HDR) File

Data Item	Requested Format	Source/Description
Facility number	5 num Right adjusted and zero filled from left	The facility code for the set of files being reported.
Number of CAD records	5 num Right adjusted and zero filled from left; zero if null	Total number of cancer admission records for that facility.
Number of CAN records	5 num Right adjusted and zero filled from left; zero if null	Total number of cancer primary site records for that facility.
Number of FAN records	5 num Right adjusted and zero filled from left; zero if null	Total number of former/alias name records for that facility.
Number of CDX records	5 num Right adjusted and zero filled from left; zero if null	Total number of reasons for clinical diagnosis records for that facility.

Cancer Admission Details (CAD) File

Data Item	Requested Format	Source/Description
Patient Identifier	8 char Right adjusted and zero filled from left	Derived from the patient number field (01) on the Cancer Registration screen.
Admission Number	12 char Right adjusted and zero filled from left	Derived from the admission number field (02) on the Cancer Registration screen. Maximum length in HOMER is 4 digits and therefore, will be zero filled to 12 digits. The admission number that is currently linked to the cancer registration at the time of creating the extract file will be reported.
Multiple Primary Site Count	2 num Right adjusted and zero filled from left	Derived from the primary site field (05) on the Cancer Registration screen. The total number of primary sites for the cancer registration (ie. for the patient) will be reported. Only a single CAD file will be reported for the cancer registration, even if there are multiple primary sites.
Medicare Number	11 num Blank if not available or if null	Derived from the Medicare number field (35) on screen 2 of the Patient Admission screen. The field will not be zero or space filled.
Patient Surname	24 char	Derived from the surname field (02) on the Patient Registration screen. Maximum length in HOMER is 23 characters. The field will not be zero or space filled. . Double quotes will be used as a text delimiter.
Patient First name	15 char Blank if null	Derived from the given names field (03) on the Patient Registration screen. If more than one given name is entered on the Patient Registration screen, then only the first name will be used to populate the patient first name field in the CAD record. The second and subsequent given names entered on the Patient Registration screen will be used to populate the patient second name field in the CAD record. The patient's first name will be assumed to start at character 1 and finish where the first space is entered. The second and subsequent names will be assumed to start after the first space. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Patient Second name	15 char Blank if null	Derived from the given names field (03) on the Patient Registration screen. Refer to patient first name field (above) for further details. The field will not be zero or space filled.

Data Item	Requested Format	Source/Description
		Double quotes will be used as a text delimiter.
Address of Usual Residence	50 char Blank if null	Derived from the address fields (15 and 16) on the Patient Registration screen. Only the address with the highest priority address type code (eg. 0 or 1) will be reported. The data from the two 25 character address fields will be merged into the one 50 character field in the extract. Unnecessary spaces after the data value in both fields will be stripped. The field will not be zero or space filled. Double quotes will be used as a text delimiter. The address will be reported as entered in these fields for the highest priority address type (eg. with text "PO Box 123" or "Windsor House, 18 Lea St" etc.)
Location (suburb/ town) of Usual Residence	40 char	Derived from the suburb field (17) on the Patient Registration screen. Maximum length in HOMER is 25 characters. The field will not be zero or space filled. Double quotes will be used as a text delimiter
Postcode of Usual Residence	4 num	Derived from the postcode field (18) on the Patient Registration screen. There will be no translation of this data before inclusion in the extract file. Therefore, supplementary codes (eg. 9399 = overseas – other or 9989 = no fixed address) will only be reported if entered as such on the Patient Registration screen. The field will not be zero or space filled.
Date of Birth	9 date ddmmmctyy	Derived from the date of birth field (04) on the Patient Registration screen. If the patient's DOB is estimated (ie. entered with asterisks), then it will be reported in the extract file as displayed on the Patient Registration screen, with ** for the day and/or *** for the month. (The year can not be entered as asterisks in HOMER.)
Occupation (before retirement) Description	50 char Left adjusted, blank if null	Derived from the occupation field (21) on the Patient Registration screen. Maximum length in HOMER is 26 characters. The field will not be zero or space filled. Double quotes will be used as a text delimiter. There will be no translation of this data before inclusion in the extract file.
Sex	1 char	Derived from the sex field (05) on the Patient Registration screen. There will be no

Data Item	Requested Format	Source/Description
		translation of this data before inclusion in the extract file.
Country of Birth Code	4 num Right adjusted and zero filled from left	Derived from the country field (06) on the Patient Registration screen. There will be no translation of this data before inclusion in the extract file.
Marital Status	2 char	Derived from the marital status field (07) on the Patient Registration screen. There will be no translation of this data before inclusion in the extract file. The field will not be zero or space filled.
Indigenous Status	2 num	Derived from the indigenous status field (11) on the Patient Registration screen. There will be no translation of this data before inclusion in the extract file. The field will not be zero or space filled.
Admission Date	9 date ddmmmctyy	Derived from the admission date field (62) on screen 3 of the Patient Admission screen, for the linked admission episode.
Separation Date	9 date ddmmmctyy	Derived from the discharge date field (02) on the Patient Discharge screen, for the linked admission episode.
Mode of Separation	4 char	Derived from the discharge code field (04) on the Patient Discharge screen, for the linked admission episode. There will be no translation of this data before inclusion in the extract file. The field will not be zero or space filled.
Transferring to Facility	5 char	Derived from the destination field (06) on the Patient Discharge screen, for the linked admission episode, if available. There will be no translation of this data before inclusion in the extract file. The field will not be zero or space filled.
Autopsy Flag	1 char Blank if null	Derived from the autopsy held field (03) on the new Cancer Registration screen, if available.
Cause of Death	50 char Left adjusted, blank if null	Derived from the cause of death field (04) on the new Cancer Registration screen, if available. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Treating Doctor Title	4 char Left adjusted, blank if null	Derived from the code entered in the treating doctor field (75) on screen 3 of the Patient Admission screen, for the linked admission episode. The doctor's title as defined in field

Data Item	Requested Format	Source/Description
		02 in the Doctor Codes Reference File (if available) is reported. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Treating Doctor Initials	9 char Left adjusted, blank if null	Derived from the code entered in the treating doctor field (75) on screen 3 of the Patient Admission screen, for the linked admission episode. The doctor's initials as defined in field 03 in the Doctor Codes Reference File (if available) are reported. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Treating Doctor Given Names	55 char Left adjusted, blank if null	Derived from the code entered in the treating doctor field (75) on screen 3 of the Patient Admission screen, for the linked admission episode. The doctor's given names as defined in field 05 in the Doctor Codes Reference File (if available) are reported. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Treating Doctor Surname	29 char Left adjusted	Derived from the code entered in the treating doctor field (75) on screen 3 of the Patient Admission screen, for the linked admission episode. The doctor's surname as defined in field 04 in the Doctor Codes Reference File (if available) is reported. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Diagnosis at Separation	9 char Left adjusted	Derived from the first diagnosis code, as assigned in the ICD code field (02) on the Inpatient ICD Coding screen for the linked episode. If a prefix is assigned to the code (eg. "P") this will be stripped prior to reporting, however, the first alpha character of the actual code will not be stripped. Punctuation will not be stripped from the code. The field will not be zero or space filled.

Cancer Details (CAN) File

Data Item	Requested Format	Source/Description
Patient Identifier	8 char Right adjusted and zero filled from left	Derived from the patient number field (01) on the Cancer Registration screen
Admission Number	12 char Right adjusted and zero filled from left	Derived from the admission number field (02) on the Cancer Registration screen. Maximum length in HOMER is 4 digits and therefore, will be zero filled to 12 digits. The admission number that is currently linked to the cancer registration at the time of creating the extract file will be reported.
Multiple Primary Site Number	2 num Right adjusted and zero filled from left	Derived from the primary site field (05) on the Cancer Registration screen. Each primary site for the cancer registration (ie. for the patient) will be reported in a separate CAN record. Therefore, the patient may have one or many CAN records.
Primary Site of Cancer Code	9 char Left adjusted	Derived from the primary site code field (06) for that primary site item, on the new Cancer Registration screen. Punctuation will not be stripped from the code. The field will not be zero or space filled.
Primary Site of Cancer Description	40 char Left adjusted	Derived from the code entered in the primary site code field (06) on the new Cancer Registration screen. The description as defined in field 02 in the Primary Site of Cancer Codes Reference File is reported. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Morphology Code	7 char	Derived from the morphology field (07) on the new Cancer Registration screen. Punctuation will not be stripped from the code. The field will not be zero or space filled.
Date of First Diagnosis	9 date ddmmmctyy	Derived from the date of first diagnosis field (09) on the new Cancer Registration screen. If the date is unknown, the users will be required to enter 15 JUN 1900 in this field. There will be no conversion of this data before inclusion in the extract file.
Date of First Diagnosis Flag	1 char Blank if null	Derived from the estimated field (10) on the new Cancer Registration screen.
Location (suburb/ town) of usual residence at diagnosis	40 char	Derived from the suburb at 1st diagnosis field (11) on the new Cancer Registration screen. Maximum length in HOMER is 25 characters. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

Data Item	Requested Format	Source/Description
Postcode of Usual Residence at Diagnosis	4 num	Derived from the postcode field (12) on the new Cancer Registration screen There will be no translation of this data before inclusion in the extract file. Therefore, supplementary codes (eg. 9399 = overseas – other or 9989 = no fixed address) will only be reported if entered as such on the Cancer Registration screen. The field will not be zero or space filled.
Laterality of Cancer	1 char	Derived from the laterality field (08) on the new Cancer Registration screen. There will be no translation of this data before inclusion in the extract file.
Basis of Diagnosis	2 num	Derived from the basis of diagnosis field (13) on the new Cancer Registration screen. There will be no translation of this data before inclusion in the extract file. The field will not be zero or space filled.
Comments	50 char Left adjusted, blank if null	Derived from the comments field (19) on the new Cancer Registration screen. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Laboratory Facility No.	2 char	Derived from the comments field (17) on the new Cancer Registration screen. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Laboratory Specimen No.	50 char	Derived from the comments field (18) on the new Cancer Registration screen. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

Former/Alias Names (FAN) File

Data Item	Requested Format	Source/Description
Patient Identifier	8 char Right adjusted and zero filled from left	Derived from the patient number field (01) on the Cancer Registration screen.
Admission Number	12 char Right adjusted and zero filled from left	Derived from the admission number field (02) on the Cancer Registration screen. Maximum length in HOMER is 4 digits and therefore, will be zero filled to 12 digits. The admission number that is currently linked to the cancer registration at the time of creating the extract file will be reported.
Former/Alias Name Identifier	2 num Right adjusted and zero filled from left	Derived from the number of alias names entered on the Patient Alias screen. Each alias entered for the patient will be reported in a separate FAN record. Therefore, the patient may have none, one or many FAN records. The alias details in HOMER are linked to an individual patient but are not linked to an individual admission for that patient. Therefore, when the alias details are reported in the FAN record/s, each alias that exists for that patient at the time of creating the extract will be reported, regardless of the admission episode number reported. As above, the admission episode number that is reported will be the episode that is linked to the cancer registration at the time of creating the extract.
Patient Surname	24 char Left adjusted	Derived from the alias surname field (02) for that alias item, on the Patient Alias screen. Maximum length in HOMER is 23 characters. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

Data Item	Requested Format	Source/Description
Patient First Name	15 char Left adjusted	Derived from the alias given names field (03) for that alias item, on the Patient Alias screen. If more than one given name is entered for that alias item, then only the first name will be used to populate the patient first name field in the FAN record. The second and subsequent given names entered for that alias item will be used to populate the patient second name field in the FAN record. The patient's first name will be assumed to start at character 1 and finish where the first space is entered. The second and subsequent names will be assumed to start after the first space. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Patient Second Name	15 char Left adjusted	Derived from the alias given names field (03) for that alias item, on the Patient Alias screen. Refer to patient first name field (above) for further details. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

Reason for Clinical Diagnosis (CDX) File

Data Item	Requested Format	Source/Description
Patient Identifier	8 char Right adjusted and zero filled from left	Derived from the patient number field (01) on the Cancer Registration screen.
Admission Number	12 char Right adjusted and zero filled from left	Derived from the admission number field (02) on the Cancer Registration screen. Maximum length in HOMER is 4 digits and therefore, will be zero filled to 12 digits. The admission number that is currently linked to the cancer registration at the time of creating the extract file will be reported.
Multiple Primary Site Number	2 num Right adjusted and zero filled from left	Derived from the primary site field (05) on the Cancer Registration screen, for the reason for clinical diagnosis being reported. Each reason for clinical diagnosis for each primary site for the cancer registration will be reported in a separate CDX record. Therefore, the patient may have none, one or many CDX records and the patient may have none, one or many CDX records for a given primary site.
Reasons for clinical diagnosis code	2 num Right adjusted and zero filled from left	Derived from the code field (15) for the reason for clinical diagnosis item being reported. There will be no translation of this data before inclusion in the extract file. The field will not be zero or space filled.
Reasons for clinical diagnosis text	50 char Blank if reasons for clinical diagnosis code = 01	Derived from the details field (16) for the reason for clinical diagnosis item being reported, if available. Functionality in the new Cancer Registration screen will force the entry of the details when relevant for the reason for clinical diagnosis code/s. Therefore, the extract will not include any functionality to include or exclude details based upon the code. The extract will simply include the details if available for that reason for clinical diagnosis item or leave the field in the CDX record blank if the details field is blank for that reason for clinical diagnosis item. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

Appendix B – Public HBCIS hospital notification form example

QUEENSLAND CANCER REGISTER – HBCIS FORM
CANCER REGISTRATION REGULATIONS, PUBLIC HEALTH ACT 2005

Page 1 of 2

1	Name of Hosp/Inst	12345 iSOFT General Hosp
2	Medicare Number	XXXXXXXXXX
3	UR Number	0000000001
4	Surname	X
5	Given Name(s)	X
6	Date of Birth	XX XXX XXXX
7	Estimated?	N
8	Former Names/Alias	XXXXXXXX XXXXX
9	No. and Street	X/XX XXXXXXXXX TCE
10		XXXXXXXX HOUSE
11	Suburb/Locality	XXXXXX
12	Postcode	4010
13	Occupation	XXXXXXXXXXX
14	Sex	F FEMALE
15	Country of Birth	1100 AUSTRALIA NOS
16	Marital Status	NM NEVER MARRIED
17	Indigenous Status	14 NOT INDIGENOUS
18	Date of Admission	XX XXX 2001
19	Date of Separation	XX XXX 2001
20	Separation Mode	01 HOME/USUAL RESIDENCE
21	Transfer Destination	
22	Diag at Separation	B05.9 MEASLES WITHOUT COMPLICATION
23	Treating Doctor	DR XXXXXXXXX
24	Autopsy Held?	
25	Cause of Death	
26	Multiple Primary Sites	Y
27	Primary Site 1	C18.4 MALIGNANT NEOPLASM OF TRANSVERSE COLON
28	Morphology	M8140/3 ADENOCARCINOMA NOS
29	Date of 1st Diagnosis	XX XXX 1996
30	Estimated?	N
31	Suburb at 1st Diag	XXXXXX
32	Postcode at 1st Diag	4010
33	Laterality	N Not Applicable
34	Basis of Diagnosis	03 CLINICAL INVESTIGATION
35	Reasons for Clin Diag	02 DOCTOR'S NOTES/REFERRAL
36	Details	ADENOCARCINOMA DOCUMENTED IN REFERRAL LTR FROM GP
35	Reasons for Clin Diag	01 PALLIATIVE CARE ADMISSION
36	Details	
35	Reasons for Clin Diag	04 RADIOLOGICAL INVESTIGATION
36	Details	ULTRASOUND OF ABDOMEN NOTED LARGE NEOPLASM
37	Comments	NO FURTHER DETAILS AVAILABLE

QUEENSLAND CANCER REGISTER – HBCIS FORM
CANCER REGISTRATION REGULATIONS, PUBLIC HEALTH ACT 2005

1	Name of Hosp/Inst	12345 iSOFT General Hosp
2	Medicare Number	XXXXXXXXXXX
3	UR Number	0000000001
4	Surname	XXXXXXXX
5	Given Name(s)	XXXXXX
6	Date of Birth	XX XXX XXXX
7	Estimated?	N
27	Primary Site 2	C45.0 MESOTHELIOMA OF PLEURA
28	Morphology	M9050/3 MESOTHELIOMA, MALIGNANT
29	Date of 1st Diagnosis	XX XXX 1990
30	Estimated?	N
31	Suburb at 1st Diag	XXXXXXXXXX
32	Postcode at 1st Diag	4012
33	Laterality	L LEFT
34	Basis of Diagnosis	06 CYTOLOGY OR HAEMATOLOGY
35	Reasons for Clin Diag	
36	Details	
37	Lab. Facility No.	[2] 30XXXXXXXXXXXXXXXXX
38	Lab. Specimen No.	[50XXXXXXXXXXXXXXXXXXXXX
39	Comments	
40	Registration Filed By	JSJ XXXXXX
41	Date	XX XXX 2001

Appendix C – ICD-10-AM neoplasm site codes required to be notified to the QCR

All hospitals are required to notify QCR for the following:

- All invasive cancers
- All cancers with an uncertain behaviour
- All in-situ conditions
- Benign central nervous system and brain tumours

- Do NOT need to notify Basal Cell Carcinomas and Squamous Cell Carcinomas of the Skin

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A prompt appears if any of the following required ICD-10-AM neoplasm site codes are entered on the screen.

(The following site codes ARE NOT required and therefore these are not in the above list:
C44 with morphology M805-8110 – BCC and SCC of skin
C77, C78 and C79 – secondary sites
D10-D31.9 – Benign, not brain
D34 – D36.9 – Benign, not brain)

These are the ranges in the ICD-10-AM neoplasm site codes (as above) that ARE required:

Invasive

C00.0 – C76.8
C80.0 – C96.9
and exclude C44.0 to C44.9 AND M80500 to M81109 (Skin SCC's and BCC's)

Insitu and Benign Brain/CNS

D00.0 – D09.9
D32.0 – D33.9
D18.02 Benign brain
and exclude D04.0 to D04.9 AND M80500 to M81109 (Skin SCC's and BCC's)

Uncertain

D37.0 to D48.9
and exclude D48.5 AND M80500 to M81109 (Skin SCC's and BCC's)

Personal history of malignant neoplasm

Z85.0, Z85.1, Z85.2, Z85.3, Z85.4, Z85.5, Z85.6, Z85.7, Z85.8

We also require ICD-10-AM Site Codes:
Q85.0
D76.0

FOR MORE INFORMATION

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Metro South
Queensland Health
Tel: (+61) (07) 3176 4400
Email: CancerAllianceQld@health.qld.gov.au
https://qccat.health.qld.gov.au