Queensland Cancer Register (QCR) Radiation Oncology Treatment Cancer Notification – Approved Form (Version 1.0; dated 31/03/2025)

Notification about cancer-related treatment to the QCR will be required under the Public Health Act 2005 Queensland Cancer Register (QCR) Legislation Amendments. This legislation will commence in **May 2025.**

All invasive, insitu, uncertain/low malignant potential, benign brain/CNS and BCC/SCC skin cancers with lymphovascular invasion or perineural invasion or metastases are to be notified to the QCR.

Radiation oncology treatment cancer notifications are required to be provided in the approved form containing the following information:

- Treatment facility identifier and name.
- Patient identification and demographic information.
- Cancer primary diagnosis information, including primary site code and TNM stage where applicable.
- Treatment information, including dose, fractions, treatment intent and radiation therapy technique.

Each data item in the approved form is categorised as either:
Mandatory: Data item is mandatory for all courses of radiation therapy treatment
Conditionally Mandatory: Data item is mandatory under specified conditions
Optional: Data item is highly desired but not mandatory

To meet the legislation requirements cancer notification should be submitted for each course of treatment completed or discontinued. Submissions must occur no more than 120 days following the completion or discontinuation of a course of radiation therapy.

Various options for types of data extraction and secure transfer of radiation oncology treatment cancer notifications from facility source systems to the QCR are available and arrangements will be discussed with each facility.

For further information email QCR@health.qld.gov.aumailto: or phone 3176 4436

Data item	Description	Value set or format	Priority
Facility Details			
Facility code	The facility code is a numerical code that uniquely identifies each health care facility.	N(6) Find your facility code here. If your facility does not have a formal facility code please contact CAQ.	Mandatory
Facility name	The name by which a facility is declared, licensed, notified in legislation, registered or locally recognised.	A(250)	Mandatory
Patient Details			
Patient identifier (UR number)	The unique record number assigned to a person for the purpose of uniquely identifying them within a healthcare facility.	A(20)	Mandatory
Facility name identifier assigning authority	The name of the facility that assigned the patient identifier (UR number). The identifier is unique within that facility.	A(250)	Mandatory
National individual health identifier	The current national individual healthcare identifier for the patient, issued by the Australian Government.	N(16)	Conditional – Mandatory if available
Family name	The current family name of the patient.	A(40)	Mandatory
Given name	The current first name of the patient.	A(40)	Mandatory
Middle names	The current middle name(s) of the patient.	A(40)	Optional

Data item	Description	Value set or format	Priority
Date of birth	The patient's date of birth.	Date (DDMMYYYY) • If the date of birth is unknown, estimate the year from the age of the patient use 1506YYYY • If the age of the patient is unknown and it is not possible to estimate an age use unknown date 15061900	Mandatory
Sex at birth	The patient's sex recorded at birth.	1 = Male 2 = Female 3 = X/Indeterminate / Intersex 9 = Not stated/unknown	Mandatory
Gender	Gender relates to a person's social and cultural identity. It is about their experience as a man, woman or non-binary person. Non-binary is a term to describe gender identities that are not exclusively male or female. A person's gender may stay the same or can change over the course of their lifetime. Transgender is a broad term that can be used to describe people whose gender identity is different from the gender they were thought to be when they were born. (AIHW 2023)	1 = Male 2 = Female 3 = X 4 = Non-binary 5 = Prefer not to answer 9 = Not stated/inadequately described	Optional
Address Line 1	The patient's unit or apartment number of usual residence at time of treatment.	Up to 20 alphanumeric characters	Mandatory
Address Line 2	The patient's street number of usual residence at time of treatment.	Up to 20 alphanumeric characters	Mandatory
Address – Suburb/town	The patient's suburb of usual residence at time of treatment.	Up to 100 alphanumeric characters	Mandatory

Data item	Description	Value set or format	Priority
Address – Postcode	The patient's post code of usual residence at time of treatment.	4 numeric characters	Mandatory
Address – State or territory	The patient's State/Territory of usual residence at time of treatment.	0 = Overseas 1 = New South Wales 2 = Victoria 3 = Queensland 4 = South Australia 5 = Western Australia 6 = Tasmania 7 = Northern Territory 8 = Australian Capital Territory 9 = Unknown	Optional
Medicare number	The patient's Medicare number at time of treatment. Includes individual reference number as the final character.	N(11)	Conditional – Mandatory if available
Indigenous status	Indigenous status must only be assigned on the basis of self-identification or the identification by their next of kin, close family member, carer, guardian, or power of attorney. It should also be noted that identification for individuals can be changed for each admission, therefore the patient or their representative should be given the opportunity to identify each time they present.	1 = Aboriginal but not Torres Strait Islander origin 2 = Torres Strait Islander but not Aboriginal origin 3 = Both Aboriginal & Torres Strait Islander origin 4 = Neither Aboriginal nor Torres Strait Islander origin 9 = Not Stated	Optional
Cancer Diagnosis Details			

Data item	Description	Value set or format	Priority
Primary site ICD code	The primary site is the site of origin of the tumour, as opposed to the secondary or metastatic sites. It is described by reporting the anatomical position of the tumour. The use of this information is to support linking of treatment to the definitive diagnosis recorded in the QCR. This is especially helpful in cases where a person has multiple primary sites of cancer.	A(6) Must be a valid ICD code	Mandatory
Disease classification system version – primary site	The version of International Classification of Diseases (ICD) used to define primary site ICD code.	A(20)	Mandatory
Morphology code	The morphology code for the primary cancer for which the patient is receiving treatment. The use of this information is to support linking of treatment to the definitive diagnosis recorded in the QCR. This is especially helpful in cases where a person has a skin cancer diagnosis (eg Squamous Cell Carcinoma or Merkel cell carcinoma).	A(6) Must be a valid ICD-10, ICD-O or WHO morphology code	Optional
Disease classification system version - morphology	The version of Classification used to define morphology code.	A(20)	Optional
Date of diagnosis	Date of diagnosis of primary cancer.	Date (DDMMYYYY) • If the date of diagnosis is unknown, estimate the year if mentioned 1506YYYY • If the date of diagnosis is unknown and it is not possible to estimate use unknown date 15061900	Mandatory

Data item	Description	Value set or format	Priority
TNM stage at diagnosis date	The date that the TNM stage at diagnosis categories and/or stage group was determined.	Date (DDMMYYYY) • If the date of stage is unknown, estimate the year if mentioned 1506YYYY • If the date of stage is unknown and it is not possible to estimate use unknown date 15061900	Optional
TNM staging basis at diagnosis	Specifies whether the stage information is determined from a clinical or pathological investigation.	1 = Pathological 2 = Clinical 9 = Not Stated/Unknown	Conditional – Mandatory where the 'ICD-10-AM Code' is an adult (>16 years of age) non-haematological and non-CNS Cancer ICD code: C000-C69.9, C73-C76.8)
T category at diagnosis	The T category that specifies the stage of the primary cancer (size and spread) at or near the time of diagnosis. Note: only valid values accepted specific to the staging group for the primary cancer.	A(10) Must be a valid stage category for the specified diagnosis and TNM version	Optional
N category at diagnosis	The N category that specifies the stage of the cancer (spread to regional lymph nodes) at or near the time of diagnosis. Note: only valid values accepted specific to the staging group for the primary cancer.	A(10) Must be a valid stage category for the specified diagnosis and TNM version	Optional
M category at diagnosis	The M category that specifies the stage of the cancer at or near the time of diagnosis (in terms of presence or absence of distant metastases). Note: only valid values accepted, specific to the staging group for the primary cancer.	A(10) Must be a valid stage category for the specified diagnosis and TNM version	Optional

Data item	Description	Value set or format	Priority
TNM stage group at diagnosis	TNM stage grouping code that defines the anatomical extent of disease at diagnosis based on coded T, N and M stage categories. It is part of the AJCC or UICC TNM cancer staging system. Note: only valid values accepted, specific to the staging system specified.	A(10) Must be a valid stage category for the specified diagnosis and TNM version	Conditional – Mandatory where the 'ICD-10-AM Code' is an adult (>16 years of age) non-haematological and non-CNS Cancer code: C000-C69.9, C73-C76.8, C80)
TNM stage protocol and edition at diagnosis	The edition of the classification system or protocol referenced to determine the stage group.	1 = AJCC 7th Edition 2 = AJCC 8th Edition 3 = AJCC Version 9 4 = UICC 7th Edition 5 = UICC 8th Edition	Conditional – Mandatory where the 'ICD-10-AM Code' is an adult (>16 years of age) non-haematological and non-CNS Cancer code: C000-C69.9, C73-C76.8, C80)
Stage/Prognostic category (other staging or prognostic system)	Value that describes the prognosis of disease, as defined by another staging system specified (not TNM staging system by AJCC or UICC).	A(10) Must be a valid category stage for the specified cancer and stage system.	Optional

Data item	Description	Value set or format	Priority
Other staging or prognostic scheme group at diagnosis	The classification system or protocol referenced to specify the Stage/Prognostic group.	1 = FIGO staging system of gynaecological malignancy 2 = Masaoka staging for thymic cancers 3 = Limited/Extensive 2-stage system for Small-Cell Lung Cancer 4 = Binet Staging Classification for Chronic Lymphocytic Leukaemia 5 = Breslow system for melanoma staging 6 = Rai staging system for Chronic Lymphocytic Leukaemia 7 = Ann Arbor lymphoma staging system 8 = International Staging System (ISS) for myeloma 9 = Revised International Staging System (R-ISS) for myeloma 10 = Australian Clinico-pathological Staging (ACPS) system for colorectal cancer 11 = Other 12 = Unknown	Conditional – Mandatory if an 'Other staging of prognostic system' score has been supplied
Cancer Treatment Details (Consultation will occur with each facility regarding specifications for notification of a course of radiation therapy)			

Data item	Description	Value set or format	Priority
Course identifier	The facility unique identifier for the course of radiation therapy treatment as recorded by the source system. A course of treatment is defined as a continuous episode of radiation therapy (usually specified in a treatment plan).	A(10)	Mandatory
Treatment intent	The intended purpose of the course of radiation therapy. (Further guidance on how to classify treatments will be defined from consultations with each facility).	1 = Curative 2 = Palliative	Mandatory
Treatment modality	The primary radiation therapy modality being used.	1 = External Beam 2 = Brachytherapy 3 = Unsealed sources 4 = Other	Mandatory

Data item	Description	Value set or format	Priority
Treatment technique	The primary radiation therapy technique being used	1 = Unsealed Radioisotope - Iodine 131 2 = Unsealed Radioisotope – Other 3 = Tomotherapy 4 = Intensity Modulated Arc Therapy (IMAT), Volumetric Modulated Arc Radiation Therapy (VMAT) or Intensity Modulated Radiation Therapy (IMRT) 5 = Stereotactic Radiosurgery (SRS) 6 = Stereotactic Ablative Radiation Therapy (SABR) 7 = Gamma Knife 8 = Total Body Electrons (TBE) 9 = Total Body Irradiation (TBI) 10 = Selective Internal Radiation therapy (SIRT) 11 = Other Radiation therapy 12 = Superficial X-ray / Kilovoltage 13 = HDR Brachytherapy 14 = PDR Brachytherapy 15 = Beta plaque Brachythereapy 16 = Not Stated/Unknown	Optional

Data item	Description	Value set or format	Priority
Target sites	The body sites that are the target of the radiation therapy delivered to the patient during treatment.	A(50) Must be a valid body site as listed in Appendix A (this list can be extended and mapped based on facility/systems specficiations)	Mandatory
Start date	The date on which the radiation therapy course of treatment started.	Date (DDMMYYYY)	Mandatory
End date	The date on which the radiation therapy course of treatment was completed or discontinued.	Date (DDMMYYYY)	Mandatory
Dose prescribed	The total dose prescribed for the patient for the radiation therapy course of treatment – in Gray (Gy).	NNN.NN	Mandatory
Fractions prescribed	The total number of fractions prescribed for the patient for the radiation therapy course of treatment.	N(2)	Mandatory
Dose received	The total dose received by the patient during the radiation therapy course of treatment – in Gray (Gy).	NNN.NN	Mandatory
Fractions received	The total number of fractions received by the patient during the radiation therapy course of treatment.	N(2)	Mandatory

Performance status – ECOG	Result of the performance status (ECOG) of the patient undertaken prior to this radiation therapy course of treatment.	0 = Fully active 1 = Ambulatory - capable of light work 2 = Bed < 50% - self caring - not working 3 = Bed > 50% - partially self-caring 4 = Confined to bed or chair	Optional
Date of performance status – ECOG	Date on which the performance status (ECOG) of the patient was undertaken prior to this radiation therapy course of treatment.	Date (DDMMYYYY)	Optional
Prescribing Radiation Oncologist	The name of the radiation oncologist who prescribed the course of treatment.	A(250)	Mandatory

Appendix A: Allowable target sites

Adrenal	Fallopian tube	Nasopharynx	Pituitary	Spleen
Anus	Foot	Neck lymph nodes	Pleura	Stomach
Appendix	Forearm	Oesophagus	Prostate	Testis
Axillary lymph nodes	Hand	Oral cavity	Rectum	Thigh
Brain	Heart	Oropharynx	Rib cage	Thoracic spine
Bladder	Inguinal lymph nodes	Ovary	Sacrum	Thyroid
Breast	Kidney	Pancreas	Salivary gland	Tongue
Cervical spine	Liver	Paraaortic lymph nodes	Seminal vesicle	Trachea
Cervix	Lower leg	Paranasal sinuses	Shoulder	Upper Arm
Chest Wall	Lumbar Spine	Penis	Skin	Uterus
Colon	Lung	Pelvic bones	Skull	Vagina

Duodenum	Mediastinum	Pelvic lymph nodes	Small bowel	Vulva
Eye	Nasal cavity	Peritoneum	Spinal cord	