Queensland Cancer Register (QCR) Surgical and Inpatient Event Notification – Approved Form (Version 1.0; 31 March 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.

Surgical and inpatient procedure cancer notifications are required to be provided containing the following information:

- Treatment facility identifier and name.
- Patient identification and demographic information.
- Cancer primary diagnosis information, including primary site code and histology where applicable.
- Treatment information, including admission/discharge dates, procedure type and elective status.

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 cancer related hospital inpatient episode. Submissions must occur no more than 120 days following discharge.

Notification to the QCR for cancer related surgical and inpatient events will be substituted by the Queensland Health Admitted Patient Data Collection (QHAPDC) on for public and private hospitals.

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

Data item	Description	Value set or format	Priority
Facility Details			
Facility number	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
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 day of birth is unknown, use ** and then enter the month and year. • If the month of birth is unknown, use ** for the month value. • 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).	Mandatory
Estimated date of birth flag	The Estimated date of birth flag indicates whether the patient's date of birth has been estimated	1 = patient's date of birth has been estimated	Conditional – Mandatory if patient's date of birth has been estimated
Sex at birth	The patient's sex recorded at birth.	1 = Male 2 = Female 3 = Other	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

Data item	Description	Value set or format	Priority
Occupation	See QHAPDC manual section 15.7.8		Optional
Country of birth	Record the country of birth of the patient using the numerical codes found in Appendix E of the QHAPDC manual	N(4)	Optional
Marital status	A Marital status is a person's current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage, as represented by a code.	1 = Never Married 2 = Married (registered and de facto) 3 = Widowed 4 = Divorced 5 = Separated 9 = Not stated/unknown	Optional
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
Address Line 1	All the elements of the address before the street number, for example: • a house, complex, building or property name • a flat or unit number	Up to 100 alphanumeric characters	Mandatory
Address Line 2	The street number, street name and street type or postal delivery details. If the address line is not known or cannot be established, record UNKNOWN.	Up to 100 alphanumeric characters	Mandatory

Data item	Description	Value set or format	Priority
Address – Locality	The locality name may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community.	Up to 100 alphanumeric characters	Mandatory
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
Admission details			
Admission date	Record the full date (that is, ddmmyyyy) of admission to hospital. Use leading zeros where necessary	Date (DDMMYYYY)	Mandatory
Discharge date	Record the full date (that is, ddmmyyyy) of discharge to hospital. Use leading zeros where necessary	Date (DDMMYYYY)	Mandatory
Admission number	Either the admission number is automatically by the system or is recorded from the Admission Register. Use leading zeros as necessary.	X(20)	Mandatory

Data item	Description	Value set or format	Priority
Care type	The term Care Type refers to the nature of the treatment/care provided to a patient during an episode of care. Only one type of care can be assigned at a time. In cases when a patient is receiving multiple types of care, the care type that best describes the primary clinical purpose or treatment goal should be assigned.	01 - Acute care 05 - Newborn care 06 - Other admitted patient care 07 - Organ procurement-posthumous 08 - Hospital Boarder 09 - Geriatric Evaluation and Management 10 - Psychogeriatric care 11 - Maintenance care 12 - Mental Health care 20 Rehabilitation care 30 - Palliative care	Mandatory
Treating doctor on admission	For all separations from 1 July 2015, it will be mandatory for all public hospitals to provide the code to identify the doctor (up to 6 characters) who is chiefly responsible for treating the patient on admission.	X(6) Practitioner code	Mandatory for public hospitals
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Mode of separation (discharge status)	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.	X(2) See QHAPDC Manual Section 7.31	Mandatory

Data item	Description	Value set or format	Priority
Transferring to facility	Record the facility number (extended source code) for the hospital, residential aged care service, or correctional facility to which the patient is transferred or referred to, as an admitted patient.		Conditional – Mandatory if mode of separation is: 12 - Correctional facility 16 - Transferred to another hospital 21 - Residential aged care service, which is not the usual place of residence 31 - Residential mental health care facility
Standard ward code	Public facilities are required to record the standard ward codes from the below pre-defined list.	X(4) See QHAPDC Manual Section 7.23	Mandatory
Elective patient status	An elective admission is an admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and which can be delayed for at least 24 hours. See QHAPDC Manual Section 7.16	1 = Emergency admission 2 = Elective admission 3 = Not assigned	Mandatory
Morbidity details			
Principal diagnosis	The principal diagnosis (PD) is defined as "the diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment	X(6) Must be a valid ICD-10-AM code Only include records with a cancer primary site code C00*-D99*, C44*+ M805-811/6, O01*, Q85.0	Mandatory

Data item	Description	Value set or format	Priority
Additional (other) diagnoses (sequelae, complications and supplementary chronic conditions)	Additional diagnoses are often described as co-morbidities and/or complications. A co-morbid condition is "A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment	X(6) Must be a valid ICD-10-AM code	Optional
External cause sequencing	The external cause (EX) describes the precipitating event or accident leading to a procedural complication, injury or poisoning. The external cause codes are listed in the range U50-U73 and V00-Y98 and are generally represented by three groups of codes sequenced in the following order (as required), External cause (V00-Y89), Place of occurrence (Y92), and Activity (U50-U73).	See QHAPDC Manual Section 9.5	Optional
Disease classification system version – diagnosis	The version of International Classification of Diseases (ICD) used to define primary and additional diagnosis ICD code(s).	X(20)	Mandatory
Morphology code	The morphology code for the primary cancer for which the patient is receiving treatment. For each neoplasm code, there should be a corresponding morphology code (M code)	X(6) Must be a valid ICD-10-AM morphology code	Optional
Disease classification system version - morphology	The version of Classification used to define morphology code.	X(20)	Optional

Data item	Description	Value set or format	Priority
Condition onset flag	The Condition onset flag (COF) is a data item that indicates the presence of a condition (diagnosis) on admission to an episode of admitted patient care. It is a means of differentiating those conditions which arise during, from those arising before, an admitted patient episode of care	1 - Condition present on admission to the episode of care 2 - Condition arose during the episode of care	Optional
ICD-10-AM/ACHI code identifier	The ICD-10-AM/ACHI code identifier indicates whether an ICD-10-AM/ACHI code is a principal or other diagnosis, external cause, morphology or intervention	PD - Principal Diagnosis OD - Other Diagnosis EX - External Cause M - Morphology PR - Intervention	Mandatory
Clinical intervention (procedure)	Clinical interventions (METeOR data element identifier 74666941) are coded using The Australian Classification of Health Interventions (ACHI). Whilst there is no limit to the number of procedures that can be recorded for an admitted patient episode of care.	X(8) Must be a valid ACHI procedure code	Mandatory
Date of procedure	This data element provides valuable information on the timing of the procedure in relation to the episode of care, and in particular allows accurate information on pre and post-operative lengths of stay.	Date (DDMMYYYY)	Mandatory