Queensland Cancer Register (QCR) Systemic Therapy Treatment Cancer Notification – Approved Form (Version 1.0 dated 31/3/2025)

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.

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

- Treatment facility name and identifier.
- Patient identification and demographic information.
- Cancer primary diagnosis information, including primary site code and TNM stage at diagnosis where applicable.
- Treatment information, including protocol name and medicines, treatment intent, start and end dates.

This approved form applies to all public and private facilities using Charm, MOSAIQ, or an equivalent dedicated oncology information system for prescribing systemic therapy.

Each data item in the approved form is categorised as either:
Mandatory: Data item is mandatory for all courses of systemic 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 prescribing, dispensing or administration of an anti-cancer medication.

Various options for types of data extraction and secure transfer of systemic therapy 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.au 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	A person's sex as assigned 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
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.	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.	A(20)	Mandatory
Morphology code	The morphology code for the primary cancer for which the patient is receiving treatment.	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
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

Data item	Description	Value set or format	Priority
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 non-haematological and non-CNS Cancer 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
TNM Stage group at diagnosis	For AJCC and UICC staging system, refers to the stage of the cancer synthesised from the combination of TNM categories. Note: only valid values accepted, specific to the staging system specified. Note: TNM categories should be provided to the QCR for all solid cancers, even if they are not clinically important.	A(10) Must be a valid stage category for the specified diagnosis and TNM version	Conditional – Mandatory where the 'ICD-10-AM Code' is non-haematological and non-CNS Cancer code: C000-C69.9, C73-C76.8, C800)

Data item	Description	Value set or format	Priority
TNM stage protocol and edition at diagnosis	The version of the classification system or protocol referenced to specify 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 non-haematological and non-CNS Cancer code: C000-C69.9, C73-C76.8, C800)
Stage/Prognostic category (other staging or prognostic system)	Value that describes the prognosis of disease, as defined by the 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 system	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 – one record for each course of treatment. A course refers to the set of cycles over which a treatment protocol is administered for a given patient.			

Data item	Description	Value set or format	Priority
Course identifier	The facility unique identifier for the course of systemic therapy treatment administered to a specific person. A course refers to the set of cycles over which a treatment protocol is administered for a given patient.	A(10) This value should be unique for each administered treatment course.	Mandatory
Patient height at start of course	The patient's height in cm at the start if the course of treatment.	NNN.N	Optional
Patient weight at start of course	The patient's weight in Kg at the start if the course of treatment.	NNN.N	Optional
Treatment intent	The intent of the course of systemic therapy.	1 = Curative 2 = Palliative	Mandatory
Protocol name	The name of the protocol being administered during this course of treatment.	A(200)	Mandatory
Protocol description	The summary description of the protocol and associated dosing within the oncology information system.	A(500)	Optional
Clinical trial flag	Indicates whether the prescribed protocol is part of a clinical trial.	0 = Not a clinical trial 1 = Clinical trial	Mandatory
Planned start date	The planned start date for the protocol.	Date (DDMMYYYY)	Mandatory
Planned end date	The planned end date for the protocol.	Date (DDMMYYYY)	Mandatory
First administration date	The date of the first administration or dispensing of an anti-cancer medicine within the treatment course.	Date (DDMMYYYY)	Mandatory
Most recent administration date	The date of the most recent administration or dispensing of an anti-cancer medicine within the treatment course.	Date (DDMMYYYY)	Mandatory

Data item	Description	Value set or format	Priority
Number of planned treatment cycles	The number of cycles planned for the protocol.	Up to 10 alphanumeric characters	Conditional – Mandatory for curative non-haematological treatments
Number of administered treatment cycles	The number of cycles administered for the protocol.	Up to 10 alphanumeric characters	Mandatory
Planned cycle duration	The planned length of each treatment cycle in days.	NNN	Mandatory
Reason treatment not completed	If applicable, the primary reason the patient did not complete the planned course of treatment.	Toxicity Referred to palliative care Progressive disease Patient declined Other Myelosuppression Fatigue Deterioration of performance status Death Comorbidity Clinician decision	Optional
Performance status – ECOG	Result of the performance status (ECOG) of the patient undertaken prior to this systemic 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

Data item	Description	Value set or format	Priority
Date of performance status – ECOG	Date on which the performance status (ECOG) of the patient was undertaken prior to this systemic therapy course of treatment.	Date (DDMMYYYY)	Optional
Prescribing clinician	The name of the clinician who prescribed the course of treatment.	A(250)	Mandatory
Medicine – One record for each anti-cancer medication within the treatment protocol			
Course identifier	The unique identifier of the course to which the medicine belongs. This exists to link each medicine to the course it belongs to.	A(10)	Mandatory
Medication name	The name of a medication prescribed within the associated protocol.	A(100) (Australian Medicines Terminology description names preferred)	Mandatory
Medication product code	The code that identifies the medication in the Australian Medication value set (Australian Medicines Terminology product concepts).	A(20) (Australian Medicines Terminology concepts from the Australian Medications value set)	Conditional - Mandatory if an Australian Medications Code exists

Data item	Description	Value set or format	Priority
Route of administration	The route of administration of the medication.	1 = Intravenous 2 = Intravenous Infusion 3 = Intravenous Bolus 4 = Intrathecal 5 = Intraarterial 6 = Intracavitary 7 = Intramuscular 8 = Subcutaneous 9 = Injection 10 = Oral 11 = Topical 97 = Not Applicable 98 = Other 99 = Not Stated/Unknown	Mandatory