QCR
Queensland Cancer Register

QCR Approved Form

Systemic Therapy Treatment Notifiers

Version: 3.0

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Queensland Cancer Register

Cancer Alliance Queensland

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Purpose

This Approved Form defines the data requirements for all systemic therapy treatment notifications submitted to the Queensland Cancer Register (QCR). It replaces any previous guidance related to systemic therapy data requirements and serves as the authoritative technical specification for systemic therapy treatment notifications under the Public Health Act 2005 (Qld).

The purpose of this Approved Form is to ensure that all systemic therapy treatment providers submit validated systemic therapy data consistently to enable accurate, reliable and automated processing of cancer-related treatment notifications. It establishes a uniform, technically compliant standard to support the timely and correct integration of systemic therapy information into QCR systems.

This document specifies the required data elements, value sets, formats, and conditional reporting rules for all systemic therapy notifications, including treatment facility identifiers, patient demographics, cancer diagnosis details, staging information, protocol and cycle-level data, and medication-level dosing information.

Scope

This Approved Form applies to all public and private healthcare facilities that prescribe or administer systemic therapy for cancer and that use Charm Evolution, MOSAIQ, or an equivalent dedicated oncology information system. It covers all cancer-related systemic therapy treatment delivered via any route of administration, including intravenous, oral, and other systemic modalities.

All participating facilities must ensure that their submissions comply with the technical specifications and formatting standards defined in this document.

Queensland Cancer Register (QCR) Systemic Therapy Treatment Cancer Notification – Approved Form (Version 2.3 dated 19/01/2026)

Notification about cancer-related treatment to the QCR is required under the Public Health Act 2005 Queensland Cancer Register (QCR) Legislation Amendments. This legislation commenced in **3 May 2025.**

Cancer related treatment for all invasive, in situ, uncertain/low malignant potential, benign brain/CNS tumours 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 names and identifiers.
- Patient identification and demographic information.
- Primary diagnosis information, including primary site code, laterality, morphology and stage at diagnosis (where applicable).
- Treatment information, including protocol name, treatment intent, planned and administered cycle dates, medicines administered or dispensed, and their dosing information.

The data items contained in the approved form are described in the table below. Each data item in the approved form is defined using the following columns:

- Data item – The name of the data group or data element within the notification.
- Description – A description of the purpose or meaning of the data item.
- Value set or format – A description of the valid values or format of the data in the given data item. The formats used include:
    - N (X) – A numeric value with a maximum of X digits
    - A (X) – A string value with a maximum of X characters
    - Date (YYYYMMDD) – A numeric value with 8 digits, representing the year, month, and day on which an event occurred.

    - DateTime (YYYYMMDDHHMM[SS[.S[S[S[S]]]]]) – A string of numbers, representing the year, month, day, hour, minute, and optionally seconds, milliseconds, etc.
- Priority – An indication of the obligation to report on a given data item. Priorities include:
    - Mandatory – The data element is required for all rows in the given file, or the file is required for all patients etc (as specified).
    - Conditional mandatory – The field/file is required when the stated condition is true.
    - Optional – The field/file is highly desired but may be omitted if not available.
- Cardinality – Represents the number of times that the given data item may appear in the notification.

The approved form requires that cancer treatment notifications should be submitted for each course of treatment completed, discontinued, or in progress. 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 provider. The preference of the QCR is to receive notifications via a JSON formatted extract.

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

Data item	Description	Value set or format	Priority	Cardinality
Header Information	**Information (metadata) about the set of notifications in the given file.**	**Data Group**	**Mandatory**	**1..1 (exactly one Header per file)**
Sending application	The name of the software application whose records were used to generate the given set of notifications. (e.g., Charm, MOSAIQ)	A(10)	Mandatory	1..1 (exactly one)
Sending application instance	The code identifying the software instance (or database), whose records were used to generate the given set of notifications. This code must be unique across different instances of a given software application.	A(10)	Mandatory	1..1 (exactly one)
Facility list	A list of all the facilities, which use this application instance to prescribe systemic therapy treatment.	Data Group	Mandatory	1..* (one to many)
Facility code	The Queensland Health (QH) code of a facility, which uses this application instance to prescribe systemic therapy treatment.	N(6) Find your facility code here. If your facility does not have a formal facility code please contact CAQ.	Mandatory	1..1 (exactly one)
Facility name	The name of the facility with the given facility code.	A(250)	Mandatory	1..1 (exactly one)
Reporting period start date	The start date of the reporting period for this notification. All treatment cycles and observations in this notification must be completed or discontinued after (or on) this date.	YYYYMMDD	Mandatory	1..1 (exactly one)

Data item	Description	Value set or format	Priority	Cardinality
Reporting period end date	The end date of the reporting period for this notification. All treatment cycles and observations in this notification must be completed or discontinued before (or on) this date.	YYYYMMDD	Mandatory	1..1 (exactly one)
Report generated date time	The date and time at which the data in this cancer notification was extracted from the source system.	YYYYMMDDHHMM[SS]	Mandatory	1..1 (exactly one)
Number of notifications	The number of notifications included in this extract. Each included protocol/pathway/regimen should be submitted (and counted) as its own notification.	NNNNNN	Mandatory	1..1 (exactly one)
Systemic Therapy Notification	**A notification of a single course of systemic therapy treatment.**	**Data group**	**Mandatory**	**1..* (one to many notifications per file)**
Patient	**Relevant identifiers and demographic information for the patient receiving systemic therapy** [Queensland Health, Person and Provider Identification Data Set-Definitions, version 4.1, July 2025]**.**	**Data Group**	**Mandatory**	**1..1 (exactly one patient per notification)**
Patient identifier	The internal identifier used to uniquely identify this patient within the sending application and this notification.	A(50)	Mandatory	1..1 (exactly one)
UR number list	A list of all the UR numbers used to identify this patient at any of the facilities associated with this extract.	Data Group	Mandatory	1..* (one to many)
UR number	A unique record number assigned to the patient for the purpose of uniquely identifying them within the given healthcare facility.	A(20)	Mandatory	1..1 (exactly one)

Data item		Description	Value set or format	Priority	Cardinality
	Assigning authority code	The code of the facility or organisation that has assigned the given UR number. The UR number is unique within this facility or organisation.	N(6) Find your facility code here. If your facility does not have a formal facility code please contact CAQ.	Mandatory	1..1 (exactly one)
	Assigning authority name	The name of the facility or organisation that assigned the patient identifier (UR number). The identifier is unique within that facility or organisation.	A(250)	Mandatory	1..1 (exactly one)
National individual health identifier		The current national individual healthcare identifier for the patient, issued by the Australian Government. (Note: If the patient does not have an IHI on the national Health Identifier Service, then provide a blank value)	N(16)	Conditional – Mandatory if available	0..1 (at most one)
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	0..1 (at most one)
Family name		The current family name of the patient.	A(100)	Mandatory	1..1 (exactly one)
Given name		The current first name of the patient.	A(100)	Mandatory	1..1 (exactly one)
Middle names		The current middle name(s) of the patient.	A(100)	Optional	0..1 (at most one)

Data item	Description	Value set or format	Priority	Cardinality
Date of birth	The date of birth of the person, expressed as YYYYMMDD.	Date (YYYYMMDD) • If the day is unknown, use YYYYMM** • If the month is unknown, use YYYY**** • If the year is unknown, estimate the year from the age of the patient	Mandatory	1..1 (exactly one)
Date of birth estimated flag	A flag which indicates whether or not the patient's date of birth has been estimated.	Y = Yes (the patient's date of birth has been estimated) N = No (the patient's exact date of birth is known and has not been estimated)	Optional	1..1 (exactly one)
Sex	The patient's sex, based on their sex characteristics such as their chromosomes, hormones and reproductive organs. While typically based upon the sex characteristics observed and recorded at birth or infancy, this may change over the course of a patient's lifetime (Australian Bureau of Statistics, 2020)	1 = Male 2 = Female 3 = Other 9 = Not stated/ inadequately described	Mandatory	1..1 (exactly one)

Data item	Description	Value set or format	Priority	Cardinality
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	0..1 (at most one)
Address line 1	The first line of the patient's residential address at the time of treatment. This may include the address's unit or apartment number and/or the street number and name.	A(100)	Mandatory	1..1 (exactly one)
Address line 2	The second line of the patient's residential address (if required) at the time of treatment. This may include the address's street number and name, if this is not included in Address line 1.	A(100)	Optional	0..1 (at most one)
Address suburb/town	The patient's suburb of usual residence at time of treatment.	A (100)	Mandatory	1..1 (exactly one)
Address postcode	The patient's post code of usual residence at time of treatment.	N(4)	Mandatory	1..1 (exactly one)

Data item	Description	Value set or format	Priority	Cardinality
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	Mandatory	1..1 (exactly one)
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	Mandatory	1..1 (exactly one)

Observation	**The results of any relevant observation made about the patient, including height, weight, body surface area (BSA), performance status (ECOG), and creatinine clearance.**	**Data Group**	**Optional**	**0..* (zero to many observations per notification)**
Type	The type of observation performed. For example, “Height”, “Weight”, “BSA”, “ECOG”, “Creatinine clearance”.	A(50)	Mandatory	1..1 (exactly one)
Result value	The value that results from the observation. For example, “174”, “4: Confined to bed or chair”.	A(250)	Mandatory	1..1 (exactly one)
Units	The UCUM units used to measure the result value, when this is a quantitative result. For example, “cm”, “kg”.	A(10)	Optional	0..1 (at most one)
Date of observation	The date on which the observation was performed.	Date (YYYYMMDD)	Conditional – Mandatory if an observation has been provided	1..1 (exactly one)
Cancer diagnosis	**Information about the principal cancer diagnosis that the systemic therapy is intended to treat. This should always refer to a reportable cancer.**	**Data Group**	**Mandatory**	**1..1 (exactly one diagnosis per notification)**
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-10-AM code or ICD-O topography code.	Mandatory	1..1 (exactly one)

Disease classification system version – primary site	The version of International Classification of Diseases (ICD) used to define primary site.	A(20) Value set (extensible): ICD10AM8 = ICD-10-AM (8th edition) ICD10AM9 = ICD-10-AM (9th edition) ICD10AM10 = ICD-10-AM (10th edition) ICD10AM11 = ICD-10-AM (11th edition) ICD10AM12 = ICD-10-AM (12th edition) ICD10AM13 = ICD-10-AM (13th edition) ICDO3T = ICD-O-3 Topography code ICDO31T = ICD-0-3.1 Topography code ICDO32T = ICD-O-3.2 Topography code ICDO4T = ICD-O-4 Topography code	Mandatory	1..1 (exactly one)
Morphology code	The morphology code for the primary cancer for which the patient is receiving treatment.	A(6) Must be a valid ICD-10-AM or ICD-O code. Note: If you are using a WHO (ICD-O) morphology code, please use the value “ICDO32M”.	Optional	0..1 (at most one)

Disease classification system version - morphology	The version of Classification used to define morphology code.	A(20) Value set (extensible): • ICDO3M = ICD-O-3 Morphology code • ICDO31M = ICD-0-3.1 Morphology code • ICDO32M = ICD-O-3.2 Morphology code • ICDO4M = ICD-O-4 Morphology code • ICD10AM8 = ICD-10-AM (8th edition • ICD10AM9 = ICD-10-AM (9th edition) • ICD10AM10 = ICD-10-AM (10th edition) • ICD10AM11 = ICD-10-AM (11th edition) • ICD10AM12 = ICD-10-AM (12th edition) • ICD10AM13 = ICD-10-AM (13th edition)	Optional	0..1 (at most one)
Laterality	Which side of a paired organ is the origin of the cancer being treated.	Value set: LEFT RIGHT BILATERAL	Conditional (Mandatory if primary site is a paired organ)	0..1 (at most one)

Date of diagnosis	Date of diagnosis of primary cancer.	Date (YYYYMMDD) • If the day is unknown, use YYYYMM** • If the month is unknown, use YYYY**** • If the year is unknown, estimate the year or (if it is not possible to estimate) use ********	Mandatory	1..1 (exactly one)
Date of diagnosis estimated flag	A flag which indicates whether the date of diagnosis has been estimated.	Y = Yes (the date of diagnosis has been estimated) N = No (the date of diagnosis is known and has not been estimated)	Optional	1..1 (exactly one)

Staging	**The process of determining how much cancer is in the body and how far it has spread, at a particular point in the patient's cancer journey (e.g. at diagnosis). Must be recorded using a recognised cancer staging system, e.g. AJCC version 9.**	**Data Group**	**Mandatory**	**1..* (one to many stagings per notification)**
Staging date	The date that the stage categories and/or stage group was determined.	Date (YYYYMMDD)	Mandatory	1..1 (exactly one per staging)
Staging timing	The point in the patient's treatment journey when this stage was determined. Note that for each diagnosis there must be a staging at diagnosis (i.e. Staging timing = "D")	1 = At diagnosis 2 = At start of treatment 3 = Treatment in progress 4 = After treatment 5 = On progression of the cancer 6 = On recurrence of the cancer 99 = Not stated/unknown	Mandatory	1..1 (exactly one)
Staging basis	Specifies whether the stage information is determined from a clinical or pathological investigation.	P = Pathological C = Clinical N = Not stated/unknown	Mandatory	1..1 (exactly one)
TNM stage edition	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 diagnosis refers to a cancer that is staged using a TNM staging system	0..1 (at most one)

T category	The T category that specifies the stage of the primary cancer (size and spread) at or near the time of staging. *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	Conditional (only if 'TNM stage edition' is populated)	0..1 (at most one)
N category	The N category that specifies the stage of the cancer (spread to regional lymph nodes) at or near the time of staging. *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	Conditional (only if 'TNM stage edition' is populated)	0..1 (at most one)
M category	The M category that specifies the stage of the cancer at or near the time of staging (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	Conditional (only if 'TNM stage edition' is populated)	0..1 (at most one)
TNM stage group	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 (only if 'TNM stage edition' is populated)	0..1 (at most one)

Other staging or prognostic system	The classification system or protocol (besides AJCC or UICC) 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 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 'TNM stage edition' is not provided	0..1 (at most one)

Other stage/prognostic group	A value that describes the prognosis of disease, as defined by a non-TNM staging system (i.e. not AJCC or UICC).	A(10) Must be a valid stage group for the specified cancer and stage system.	Conditional – Mandatory if 'Other staging or prognostic system' is provided	0..1 (at most one)
Prognostic factor for staging	**A characteristic of the cancer that helps to assign a stage to the patient's cancer, e.g. grade, ER, PR, HER2.**	**Data Group**	**Optional**	**0..* (zero to many prognostic factors per staging)**
Type	The type of prognostic factor measured. For example, Estrogen receptor (ER) status, Progesterone receptor (PR) status, Human epidermal growth factor receptor 2 (HER2) status	A(50)	Mandatory	1..1 (exactly one)
Value	The result or interpretation of the given prognostic factor. For example, ER positive, PR negative, HER2 positive.	A(250)	Mandatory	1..1 (exactly one)
Prognostic factor date	The date on which the given prognostic factor was determined.	Date (YYYYMMDD)	Mandatory	1..1 (exactly one)
Course of treatment	**A set of cycles over which a treatment protocol is administered for a given patient. This may be referred to as a treatment 'course', 'pathway', 'regimen', or 'protocol'.**	**Data Group**	**Mandatory**	**1..1 (exactly one treatment per notification)**

Treatment course id	The code, which uniquely identifies the course (or pathway) of systemic therapy treatment administered to a specific person, within the sending system. A course (or pathway) refers to the set of cycles over which a treatment protocol is administered for a given patient.	A(10)	Mandatory	1..1 (exactly one)
Prescribing clinician HPII	The national Healthcare Provider Identifier-Individual for the clinician who was responsible for prescribing this course of treatment. This is typically a 16-digit number.	A(20)	Conditional (Mandatory if available)	0..1 (exactly one)
Prescribing clinician name	The name of the clinician who was responsible for prescribing the course of treatment.	A(250)	Mandatory	1..1 (exactly one)
Prescribing Facility code	The code of the facility where the treatment course was prescribed.	N(6) Find your facility code here. If your facility does not have a formal facility code please contact CAQ.	Mandatory	1..1 (exactly one)
Prescribing Facility name	The name of the facility where the treatment course was prescribed.	A(250)	Mandatory	1..1 (exactly one)
Treatment intent	The intent of the course of systemic therapy.	1 = Curative 2 = Palliative (non-curative) 3 = Prophylactic 9 = Unknown	Mandatory	1..1 (exactly one)
Local protocol id	The code used to identify the systemic therapy protocol (or pathway) in the local system's regimen library.	A(15)	Mandatory	1..1 (exactly one)

Protocol name	The name of the protocol (or pathway or regimen) upon which this course of treatment is based.	A(200)	Mandatory	1..1 (exactly one)
Protocol description	A summary of the protocol (or pathway) and associated dosing within the oncology information system.	A(500)	Optional	0..1 (at most one)
eviQ id	The identifier and version of the associated cancer treatment protocol, as defined in eviQ (https://www.eviq.org.au).	A(10)	Optional	0..1 (at most one)
Clinical trial flag	Indicates whether the prescribed protocol (or pathway) is part of a clinical trial.	0 = Not a clinical trial 1 = Clinical trial	Mandatory	1..1 (exactly one)
Protocol planned start date	The planned start date for the protocol.	Date (YYYYMMDD)	Mandatory	1..1 (exactly one)
Protocol planned end date	The planned end date for the protocol. For continuous, ongoing treatment protocols, do not include a protocol planned end date.	Date (YYYYMMDD)	Conditional – Mandatory if protocol is for a fixed duration	1..1 (exactly one)
Number of planned treatment cycles	The number of cycles planned for the given protocol (or pathway). For ongoing treatment, with no defined end, use “999”.	NNN	Mandatory	1..1 (exactly one)
Number of administered treatment cycles	The number of cycles administered for the given protocol (or pathway).	NNN	Mandatory	1..1 (exactly one)
Treatment status	An indication of whether the treatment course (or pathway) is still in progress, has been completed by the patient, or was discontinued prior to completion.	P = In progress C = Completed D = Discontinued	Mandatory	1..1 (exactly one)

Discontinued date	The date on which the given treatment was discontinued. For a discontinued treatment, this is the date of the last medication administration for that protocol/pathway.	Date (YYYYMMDD)	Conditional (Mandatory if Treatment status = D)	0..1 (exactly one)
Reason treatment discontinued	If applicable, the primary reason the patient did not complete the planned course of treatment.	A(200)	Conditional (Mandatory if Treatment status = D)	0..1 (at most one)
Treatment modification flag	An indication of whether the treatment has been modified from the planned protocol/pathway (e.g. dose changes, frequency changes, or drugs added or deleted).	0 = Protocol/pathway not modified 1 = Protocol/pathway modified	Conditional (Mandatory if available)	1..1 (exactly one)
Cycle	**A period of systemic therapy treatment defined by a set pattern of treatment days and rest days.**	**Data Group**	**Mandatory**	**1..* (one to many cycles for each Cancer treatment)**
Cycle number	The sequential order of the cycle within the treatment.	NNN	Mandatory	1..1 (exactly one)
Cycle planned start date	The date on which the treatment cycle was planned to start.	Date (YYYYMMDD)	Mandatory	1..1 (exactly one)
Cycle planned end date	The date on which the treatment cycle was planned to end.	Date (YYYYMMDD)	Mandatory	1..1 (exactly one)

Cycle actual start date	The date on which the treatment cycle started.	Date (YYYYMMDD)	Mandatory	1..1 (exactly one)
Cycle actual end date	The date on which the treatment cycle ended.	Date (YYYYMMDD)	Conditional – Mandatory if cycle has been completed	0..1 (at most one)
Cycle length	The total number of days in the treatment cycle, including treatment days and rest days.	NNN	Mandatory	1..1 (exactly one)
Cycle status	An indication of whether the treatment cycle is still in progress, has been completed, was discontinued prior to completion, or was cancelled prior to commencing.	P = In progress C = Completed X = Cancelled	Mandatory	1..1 (exactly one)
Cycle Day	**A day within the given treatment cycle.**	**Data Group**	**Mandatory**	**1..* (one to many Cycle days per Treatment cycle)**
Cycle day number	The day number within the cycle on which this medication was administered or dispensed. The first day of the cycle has a cycle day of "1".	NNN	Mandatory	1..1 (exactly one)
Cycle day status	An indication of whether this day of the treatment cycle has been completed or was cancelled.	C = Completed X = Cancelled	Mandatory	1..1 (exactly one)

Medication	**A medicinal product administered or dispensed to the patient on the given day of the treatment cycle.**	**Data Group**	**Conditional (Mandatory if Cycle day status is Completed)**	**0..* (zero to many Medications for each Cycle day)**
Medication name	The name of a medication prescribed within the associated protocol. This should include all active ingredients in the medication.	A(100) (Australian Medicines Terminology description names preferred)	Mandatory	1..1 (exactly one)
Medication product code	The SNOMED CT concept identifier that identifies the medication in the Australian Medication value set (Australian Medicines Terminology product concepts). It must be a subtype of 373873005 |Pharmaceutical biologic product| in SNOMED CT-AU.	A(20) (Australian Medicines Terminology concepts from the Australian Medications value set)	Conditional - Mandatory if available	0..1 (at most one)
Route of administration	The route of administration of the medication. For example, intravenous, oral, topical.	A(255)	Mandatory	1..1 (exactly one)
Route of administration code	The SNOMED CT concept identifier for the given route of administration. This must be a subtype of 284009009 |Route of administration value (qualifier value)| in SNOMED CT-AU.	A(18)	Optional	0..1 (at most one)

Planned dose rule value	The planned dose rule value for this medication on this day of the cycle, based on the intended treatment regimen. For example, "50" – the unit corresponding to this value would be entered in the 'Planned dose rule units' field.	NNNN.NN	Mandatory	1..1 (exactly one)
Planned dose rule units	The planned dose rule unit for this medication on this day of the cycle, based on the intended treatment regimen. For example, "mg/m2"	A(20)	Mandatory	1..1 (exactly one)
Actual dose rule value	The actual dose rule value for this medication on this day of the cycle, based on the intended treatment regimen. For example, "50" – the unit corresponding to this value would be entered in the 'Actual dose rule units' field.	NNNN.NN	Mandatory	1..1 (exactly one)
Actual dose rule unit	The actual dose rule unit for this medication on this day of the cycle, based on the intended treatment regimen. For example, "mg/m2"	A(20)	Mandatory	1..1 (exactly one)
Actual dose value	The actual dose value for this medication on this day of the cycle, that was administered or dispensed to the patient.	NNNN.NN	Mandatory	1..1 (exactly one)
Actual dose units	The actual dose units for this medication on this day of the cycle, that was administered or dispensed to the patient.	A(20)	Mandatory	1..1 (exactly one)
Administration start time	The date and time at which the medication administration started.	YYYYMMDDTHHMMSS	Optional	0..1 (exactly one)
Administration end time	The date and time at which the medication administration ended.	YYYYMMDDTHHMMSS	Optional	0..1 (exactly one)

Dosing instructions	The sentence that describes how the medication is to be administered to the patient, including its frequency.	A(250)	Mandatory	1..1 (exactly one)
Administration facility code	The code of the facility at which the medication administration event occurred (if relevant).	N(6) Find your facility code here. If your facility does not have a formal facility code please contact CAQ.	Conditional – Mandatory if administration occurred at a facility	0..1 (at most one)
Administration facility name	The name of the facility at which the medication administration event occurred (if relevant).	A(250)	Conditional – Mandatory if Administration facility code is recorded	0..1 (at most one)
Medication status	An indication of whether the administration/dispensing of this medication on this cycle day has been completed or was cancelled.	C = Completed X = Cancelled	Mandatory	1..1 (exactly one)
Dose modification flag	An indication of whether the dosing for this medication has been modified from the planned protocol/pathway (e.g. dose changes, frequency changes).	0 = Dosing not modified 1 = Dosing modified	Mandatory	1..1 (exactly one)

Dose modification reason	The reason that the dose (frequency or quantity) has been modified. If multiple reasons have been recorded, then concatenate these into a single string, separated by pipes "|". For example: "Toxicity|Disease progression".	A(600)	Conditional – Mandatory if dose has been modified	0..1 (at most one)

Version control

Version no.	Date	Created/modified by	Modifications made
V1.0	05/03/2025	Julie Moore	Approved Form created to support Public Health Act 2005 Queensland Cancer Register (QCR) Legislation Amendments.
V2.0	18/11/2025	Alexander Dunn / Linda Bird	Updates to incorporate new notification requirements for cycle-level treatment data.
V3.0	19/01/2026	Alexander Dunn / Linda Bird	Consultation with notifiers and system vendors following new notification requirements.