Queensland Cancer Register (QCR) Diagnostic Imaging Notification – Approved Form (Version 5.3 31 March 2025)

Notification about cancer related diagnostic imaging 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.**

Cancer notification diagnostic imaging reports must contain the following information:

- Diagnostic imaging provider organisation and facility/clinic where the imaging procedure was performed,
- Diagnostic imaging provider organisation that produced the report (if different from the organisation sending the notification),
- Patient identification and demographic information,
- Requesting provider and facility/practice information,
- Unique identification of the imaging request and each imaging procedure/exam,
- Observation date and time of the imaging procedure,
- The observation results comprising the validated diagnostic imaging report in formatted text. Images are not to be provided.
- Version control of the report, ensuring that any amendments are notified.

To meet these requirements, it is strongly recommended diagnostic imaging practices notify reports within a message file that conforms to the current HL7 Australia Diagnostic Messaging standard.

At the time of writing, the current normative standard is:

Australian Diagnostics and Referral Messaging - Localisation of HL7 Version 2.4 - HL7AUSD-STD-OO-ADRM-2021.1

Diagnostic imaging reports should be sent in HL7 messages with message type ORU^R01 and are expected to contain the values as described below. Practices must advise the QCR if their messages will deviate from the following list. Provision of the practice's interface specification is highly desirable, to ensure each data element is correctly interpreted.

Only validated diagnostic imaging reports (and updates to validated reports) in formatted text are required for QCR notification – images are not to be provided.

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

Version 5.3
Date 31 March 2025

Value name	Description	Expected HL7 segment/field	Examples of expected values	Max character length for the value	Priority
Message information	**Describes the file that contains the complete validated diagnostic imaging report, within a compliant HL7 message structure of type ORU^R01.**	**MSH**			
Field separator	Defines the character to be used as a field separator for the entire message content.	MSH-1	|	n/a	Mandatory
Encoding characters	This field contains the four encoding characters in the following order: the component separator, repetition separator, escape character, and subcomponent separator.	MSH-2	^~\&	n/a	Mandatory
Escape sequences	A set of characters used to replace and denote reserved characters and delimiters that have a pre-defined purpose in the message, as per the HL7 standard and encoding characters in use.	As required	Example: \T\ replaces sub-component delimiter '&'	n/a	Mandatory
Sending application	Uniquely identifies the information system that is the source of the message.	MSH-3	*Radiology Information System application name*	180	Mandatory
Sending facility	Identifies the facility (diagnostic imaging practice organisation) that is responsible for the sending application. Together, the sending facility and application uniquely identify the source of the message in the QCR environment.	MSH-4	*Diagnostic imaging organisation name*	180	Mandatory
Receiving application	Identifies the information system in the context of the receiving facility, that is intended to receive the message.	MSH-5	Queensland Cancer Register or QCR	180	Optional

Receiving facility	Identifies the facility that is responsible for the receiving application.	MSH-6	CAQ MSHHS	180	Optional
Date/time of message	Specifies the date/time that the sending system created the message.	MSH-7	Time stamp	26	Mandatory
Message type	Specifies the message type, trigger event, and the message structure ID for the message.	MSH-9	ORU^R01	15	Mandatory
Message control ID	Uniquely identifies the message (in the sender's context).	MSH-10	*Refer to HL7 Standard for recommended format.*	199	Mandatory
Patient information	**The patient is the subject of the imaging exam(s)**	**PID**			
Primary patient identifier with assigning authority	Uniquely identifies the patient in the sender's facility. Note: if the patient is a Queensland Health patient (i.e., the imaging procedure has occurred within a Queensland Health facility or as a service provided to a Queensland Health facility) then the Queensland Health Unit Record Number issued by that facility must be provided with the patient identifier list.	PID-3 (first repeat)	Examples: **07654321**^^^PAS^MR^00011; **20235839**^^^RIS^PT^N	250	Mandatory
Other patient identifiers	e.g., National health identifier - individual health identifier (IHI)	PID-3 (subsequent repeats)	Example: **8003608833357361**^^^AUSHIC^NI **1035468466**^^^QH^PT^EUID;	250	Conditional - mandatory if available
Medicare number	The patient's Medicare number at the time of reporting. Includes individual reference number as the final character.	PID-3 (subsequent repeats)	Example: **41556495371**^^^AUSHIC^MC^^^ 202509	250	Conditional - mandatory if available

Name	This field contains the names of the patient, the primary or legal name of the patient is reported first. The given name and second and further names must be appropriately delimited from one another. All names should be correctly classified using the Name Type value. For example, a preferred name that is not the legal name of the patient may have Alias (A) name type.	PID-5	Example: **CITIZEN ^John^Paul** ^^MR^^**L**	200	Mandatory
DOB	Specifies the patient's date of birth, or the date and time of birth.	PID-7	Time stamp (YYYYMMDD)	26	Mandatory
Sex	Refers to 'Administrative sex' and reflects the patient's genetic, hormonal and physical characteristics (sex characteristics). This field should not be used to reflect the patient's Gender Identity. Note: The referenced standard does not specify the presentation of definitive Sex- and Gender-related data elements, such as Gender Identity and Sex for Clinical Use. If other data elements are available, please advise QCR so that the values can be accurately recorded.	PID-8	**Code - Description** 1 or M - Male 2 or F - Female 3 or A - X, intersex or indeterminate 9 or U - Not stated/inadequately described	1	Mandatory
Indigenous status	The patient's indigenous status, represented by codes defined by AIHW METEOR, Queensland Health, or the relevant HL7 standard. This value is required for the national cancer data collection.	PID-10	**Code - Description** 1 - Aboriginal but not Torres Strait Islander origin 2 - Torres Strait Islander but not Aboriginal origin 3 - Both Aboriginal and Torres Strait Islander origin 4 - Neither Aboriginal nor Torres Strait Islander	1	Conditional – mandatory if available

			origin 9 - Not stated/unknown		
Address	The home address or mailing address of the patient, and includes street address, state, post code and country code.	PID-11	Example: **100 James Street^^Fair Hills^QLD^4995^AUS^**H	250	Mandatory
Phone number	The primary contact phone number for the patient	PID-13	0400200123	250	Optional
Patient Visit Information	**Information that is specific to a patient visit**	**PV1**			
Request number	The visit number represents the identifier for the patient's visit to the imaging facility, for one or more imaging exams on a service request. This value can be used to link multiple exams to one service request.	PV1-19	Example: 12345678^MIQ	250	Mandatory
Servicing facility	This field is used in an environment where the medical imaging organisation has multiple facilities where imaging services are provided. In the diagnostic imaging context, this represents the facility where the imaging procedure took place. Provider-specific user-defined values must be supplied within the provider's interface specification.	PV1-39	Examples: GCUH; 21 Radiology Road, Palm Springs.	100	Mandatory
Order control information	**Information about the imaging exam request**	**ORC**			
Order control ID	The status of an order group from an imaging procedure request.	ORC-1	RE	2	Optional
Placer order number	The string of characters assigned by the placer system when it creates the imaging procedure request. It uniquely identifies the order within the placer system.	ORC-2	123456	250	Optional

Filler order number	The string of characters assigned by the filler system that uniquely identifies the order within the filler system of the diagnostic imaging practice environment.	ORC-3	6543216500	250	Optional
Placer group number	The string of characters that is assigned by the placer system, to identify the group of (one or more) orders belonging to one service request, submitted to the diagnostic imaging practice.	ORC-4	ABC123456	250	Optional
Order status	Specifies the status of an order to enable communication of status change.	ORC-5	CM	2	Optional
Ordering provider	The individual healthcare provider who created the request.	ORC-12	7654321A^Brown^Julie^^^Dr^^^AUSHICPR	250	Optional
Order information	**Describes the order and the set of (one or more) observations that are provided in the message. Each message may contain one or more orders.**	**OBR**			
Order Set ID	This field identifies the OBR segment within the message and is required if more than one OBR is sent in one message. Set ID numbering must begin at 1 with increasing integers for each additional OBR segment in the message.	OBR-1	1	4	Mandatory
Placer order number	The string of characters assigned by the placer system when it creates the imaging procedure request. It uniquely identifies the order within the placer system.	OBR-2 (OBR-2 must = ORC-2 if both are supplied)	123456	250	Optional
Filler order number	The string of characters assigned by the filler system that uniquely identifies the order (imaging exam) within the filler system of the diagnostic imaging practice environment. The filler system refers to the radiology information system.	OBR-3 (OBR-3 must = ORC-3 if both are supplied)	6543216500	250	Mandatory

Local service identifier code and name	The code (with coding system) and name that identifies the imaging exam or group of exams, that has been requested, within the filler system. This field uses the order code and name that is known within the diagnostic imaging practice environment and order catalogue.	OBR-4	Example: CTCAP^CT of chest, abdomen and pelvis without contrast^RIS	120	Mandatory
Universal service identifier code and name	The code (with coding system) and name that universally identifies the imaging exam or group of exams, that has been requested, i.e., the order identifier endorsed by the Royal Australian and New Zealand College of Radiologists (RANZCR), if available. Note: the RANZCR Standardised Terminology for Radiology eReferrals is currently under review to enable the Australian eRequesting data for interoperability.	OBR-4	Example: 393161000119104^CT of chest, abdomen and pelvis without contrast^SCT	120	Conditional - mandatory if available
Requested date and time	The date and time at which the imaging exam was requested.	OBR-6	Time stamp	26	Conditional - mandatory if available
Observation date and time	The date and time at which the observation was obtained from the patient, i.e., when the imaging exam was performed. This is also known as the 'collection date and time'.	OBR-7	Time stamp	26	Mandatory
Relevant clinical information	Clinical information about the patient or imaging exam(s) that can assist the diagnostic provider with interpretation of observation results.	OBR-13	Example: Review suspicious mass pancreatic head; Staging study for known NSCLC.	300	Conditional - mandatory if available

Ordering provider	Refers to the individual healthcare provider who created the request. Same value as ORC-12 (if present).	OBR-16	7654321A^Brown^Julie^^ ^Dr^^^AUSHICPR	250	Mandatory
Result status change date and time	Specifies the date and time that the results were reported, or the status of the results changed, and subsequently triggered a new message to send.	OBR-22	Time stamp	26	Mandatory
Diagnostic service section ID	Specifies the diagnostic service department or discipline where the observations were processed and resulted.	OBR-24	Example: RAD	10	Mandatory
Result status	Specifies the collective status of all observations in the order. Together with the unique filler order number (OBR-3), and result status change date and time (OBR-22), this value enables version control of reports received and subsequently amended. Final results and updates to final results only.	OBR-25	**Code - Description** F - Final result, C - Correction or amendment to one or more observations in the set, X - no results available – order cancelled.	1	Mandatory
Observation information	**Describes each of the observation results in the message**	**OBX**			
Sequence number (Set ID)	Specifies the order in which the observations are listed, as intended by the sender. Sequence numbers must begin at 1 with increasing integers for each additional OBR segment in the message.	OBX-1	1	4	Mandatory
Result value data type	Specifies the format of the observation result value (the report) in OBX-5.	OBX-2	FT	3	Mandatory
Local observation identifier and name	The code and name that identifies the observation (individual exam) within the filler system, i.e. the imaging examination code and name that is known within the diagnostic provider's environment.	OBX-3	Example: CTCAP^CT Chest and Abdomen and Pelvis WO contrast^RIS	120	Mandatory

Universal observation identifier and preferred term	The code (with coding system) and name that universally identifies the observation, i.e., the imaging exam that is described in OBX-5; LOINC or SNOMED CT preferred.	OBX-3	Example: 72253-8^CT Chest and Abdomen and Pelvis WO contrast^LN	120	Optional
Observation value	The report: the observations for the imaging exam performed, presented according to the data type specified in OBX-2 (FT). The complete report should be provided as a display segment comprised of formatted text. No PDF or other file types can be accepted. No images to be sent.	OBX-5	Report presented as formatted text.	Up to 64kb	Mandatory
Observation result status	This value specifies the stage in the diagnostic provider's processing, where the individual observation resulting is up to. Final results and updates to final results only.	OBX-11	**Code - Description** F – Final result C – Corrected result D – Instruction to delete the result W – Instruction to flag previous result as wrong X – Result cannot be obtained	1	Mandatory
Analysis date and time	Specifies the date and time the report was created.	OBX-14	Time stamp	26	Mandatory
Producers ID	The unique identifier of the responsible producing service; i.e., the diagnostic imaging provider organisation who authored the report. When this field is null, CAQ assumes that the report was produced by the sending organisation.	OBX-15	*Name of diagnostic imaging reporting service*	250	Conditional - mandatory if applicable