

QCR Approved Form

Radiation Oncology Treatment Notifiers

Version: 2.0

Date: May 2026

Queensland Cancer Register

Cancer Alliance Queensland (CAQ)

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Purpose

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

The purpose of this Approved Form is to ensure that all radiation oncology treatment providers submit radiation 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 radiation therapy information into QCR systems.

This document specifies the required data elements, value sets, formats, and conditional reporting rules for all radiation oncology notifications, including treatment facility identifiers, patient demographics, cancer diagnosis details, staging information, course-level treatment data, and site-specific dose and fractionation information.

Scope

This Approved Form applies to all public and private healthcare facilities that prescribe or deliver radiation therapy for cancer and that use MOSAIQ, ARIA or an equivalent dedicated oncology information system. It covers all cancer-related radiation therapy treatments, including external beam radiation therapy, brachytherapy, unsealed sources, and other recognised radiation therapy 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) Radiation Oncology Treatment Cancer Notification – Approved Form (Version 2.0; dated 12/05/2026)

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 commenced on **3 May 2025**.

All invasive, in situ, 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.

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 or discontinued. Submissions must occur no more than 120 days following the completion or discontinuation of treatment.

Various options for types of data extraction and secure transfer of radiation 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., ARIA, 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 radiotherapy treatment.	Data Group	Mandatory	1..* (one to many)
	Facility code	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
Reporting period start date	The start date of the reporting period for this notification. Treatment must be completed or discontinued after (or on) this date.	YYYYMMDD	Mandatory	1..1 (exactly one)

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)
Radiation Treatment Notification	A notification of a single course of radiation treatment.	Data group	Mandatory	1..* (one to many notifications per file)
Patient	Relevant identifiers and demographic information for the patient receiving radiation treatment [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)

	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. The facility or organisation code is a numerical code that uniquely identifies each health care 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)
	Date of birth	The date of birth of the person, expressed as YYYYMMDD.	Date (YYYYMMDD) <ul style="list-style-type: none"> If the day is unknown, use YYYYMM** If the month is unknown, use YYYY***** 	Mandatory	1..1 (exactly one)

		<ul style="list-style-type: none"> If the year is unknown, estimate the year from the age of the patient 		
Date of birth estimated flag	A flag which indicates whether the patient's date of birth has been estimated.	<p>Y = Yes (the patient's date of birth has been estimated)</p> <p>N = No (the patient's exact date of birth is known and has not been estimated)</p>	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)	<p>1 = Male</p> <p>2 = Female</p> <p>3 = Other</p> <p>9 = Not stated/ inadequately described</p>	Mandatory	1..1 (exactly one)
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)	<p>1 = Male</p> <p>2 = Female</p> <p>3 = X</p> <p>4 = Non-binary</p> <p>5 = Prefer not to answer</p> <p>9 = Not stated/inadequately described</p>	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	A(100)	Optional	0..1 (at most one)

	the address's street number and name, if this is not included in Address line 1.			
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)
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)

Cancer Diagnosis Details	The cancer diagnosis being treated by the radiation therapy.	Data Group	Mandatory	1..1 (exactly one)
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 (8 th edition) ICD10AM9 = ICD-10-AM (9 th edition) ICD10AM10 = ICD-10-AM (10 th edition) ICD10AM11 = ICD-10-AM (11 th edition) ICD10AM12 = ICD-10-AM (12 th edition) ICD10AM13 = ICD-10-AM (13 th edition) ICDO3T = ICD-O-3 Topography code ICDO31T = ICD-O-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	Optional	0..1 (at most one)

		using a WHO (ICD-O) morphology code, please use the value "ICDO32M".		
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-O-3.1 Morphology code ICDO32M = ICD-O-3.2 Morphology code ICDO4M = ICD-O-4 Morphology code ICD10AM8 = ICD-10-AM (8 th edition) ICD10AM9 = ICD-10-AM (9 th edition) ICD10AM10 = ICD-10-AM (10 th edition) ICD10AM11 = ICD-10-AM (11 th edition) ICD10AM12 = ICD-10-AM (12 th edition) ICD10AM13 = ICD-10-AM (13 th 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)	Mandatory	1..1

		<ul style="list-style-type: none"> 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 ***** 		(exactly one)
Date of diagnosis estimated flag	A flag which indicates whether the date of diagnosis has been estimated.	<p>Y = Yes (the date of diagnosis has been estimated)</p> <p>N = No (the date of diagnosis is known and has not been estimated)</p>	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”)	<p>1 = At diagnosis</p> <p>2 = At start of treatment</p> <p>3 = Treatment in progress</p> <p>4 = After treatment</p> <p>5 = On progression of the cancer</p>	Mandatory	1..1 (exactly one)

		6 = On recurrence of the cancer 99 = Not stated/unknown		
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 diagnosis. <i>Note:</i> 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 diagnosis. <i>Note:</i> 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 diagnosis (in terms of presence or absence of distant metastases).	A(10) Must be a valid stage category for the specified diagnosis and TNM version	Conditional	0..1 (at most one)

	<i>Note: only valid values accepted, specific to the staging group for the primary cancer.</i>		(only if 'TNM stage edition' is populated)	
TNM stage group	For AJCC and UICC staging system, refers to the stage of the cancer synthesised from the combination of TNM categories. <i>Note: only valid values accepted, specific to the staging system specified.</i> <i>Note: TNM categories should be provided to the QCR for all solid cancers, even if they are not clinically important.</i>	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	Conditional – Mandatory if 'TNM stage edition' is not provided	0..1 (at most one)

		<p>8 = International Staging System (ISS) for myeloma</p> <p>9 = Revised International Staging System (R-ISS) for myeloma</p> <p>10 = Australian Clinico-pathological Staging (ACPS) system for colorectal cancer</p> <p>11 = Other</p> <p>12 = Unknown</p>		
Other stage or 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)
Course Treatment Details	A course of treatment is defined as a planned series of radiation therapy events with a defined start and end date (usually specified in a single treatment plan).	Data Group	Mandatory	
Course identifier	The facility (or OIS instance) unique identifier for the course of radiation therapy treatment as recorded by the source system.	A(50)	Mandatory	1..1 (exactly one)
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	1..1 (exactly one)

Treatment type	The primary radiation therapy technique being used	<ul style="list-style-type: none"> 1 External Beam 2 Brachytherapy 3 Unsealed Radioisotope - Iodine 131 8 Unsealed Radioisotope - Other 10 Tomotherapy 11 Intensity Modulated Arc Therapy (IMAT) 12 Intensity Modulated Radiation Therapy (IMRT) 13 Volumetric Modulated Arc Radiation Therapy (VMAT) 14 Stereotactic Radiation Therapy (SRT) 15 Stereotactic Radiosurgery (SRS) 16 Stereotactic Ablative Radiation Therapy (SABR) 17 Stereotactic Body Radiation Therapy (SBRT) 18 Gamma Knife 19 Total Body Electrons (TBE) 20 Total Body Irradiation (TBI) 21 Selective Internal Radiotherapy (SIRT) 	Mandatory	1..1 (exactly one)
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		22 HDR Brachytherapy 23 PDR Brachytherapy 24 Beta plaque brachytherapy 25 Superficial X-ray / Kilovoltage 98 Other Radiotherapy 99 Not Stated/Unknown		
Course Start date	The date on which the radiation therapy course of treatment started.	Date (DDMMYYYY)	Mandatory	1..1 (exactly one)
Course End date	The date on which the radiation therapy course of treatment was completed or discontinued.	Date (DDMMYYYY)	Mandatory	1..1 (exactly one)
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	0..1 (at most one)
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)	Conditional - Mandatory if a performance status has been provided	0..1 (at most 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	Mandatory	1..1 (exactly one)

		formal facility code please contact CAQ .		
Prescribing Facility name	The name of the facility where the treatment course was prescribed.	A(250)	Mandatory	1..1 (exactly one)
Prescribing Radiation Oncologist	The name of the radiation oncologist who prescribed the course of treatment.	A(250)	Mandatory	1..1 (exactly one)
Site Treatment Details	Details for each anatomical body site being treated within the same course of radiation therapy.	Data Group	Mandatory	1..1 (exactly one)
Course identifier	The facility (or OIS instance) unique identifier for the course of radiation therapy treatment to which the site treatment details belong, as recorded by the source system.	A(10)	Mandatory	1..1 (exactly one)
Target site	The body site that is 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 (Note: This list can be extended and mapped based on facility/systems specifications)	Mandatory	1..1 (exactly one)
Target site laterality	The side of the body, which is being treated, relative to the vertical midline. In the case of a paired organ, this identifies which side is being treated.	Value set: LEFT RIGHT BILATERAL MIDLINE	Optional	0..1 (at most one)
Dose prescribed	The total dose prescribed for the patient for the site of treatment - in Gray (Gy).	NNN.NN	Mandatory	1..1 (exactly one)

Fractions prescribed	The total number of fractions prescribed for the patient for the site of treatment.	N(2)	Mandatory	1..1 (exactly one)
Dose received	The total dose received by the patient for the site of treatment - in Gray (Gy).	NNN.NN	Mandatory	1..1 (exactly one)
Fractions received	The total number of fractions received for the patient for the site of treatment.	N(2)	Mandatory	1..1 (exactly one)

Appendix A: Allowable target sites

Abdomen	Head	Ovary	Soft tissue
Adrenal gland	Heart	Pancreas	Spinal cord
Anus	Hemi body	Parotid gland	Spine
Appendix	Hip	Penis	Spleen
Bladder	Hypopharynx	Pelvic bones	Stomach
Bone - extremity	Kidney	Peritoneum	Testis
Brain	Liver	Pituitary gland	Thigh
Breast	Lower leg	Pleura	Thoracic spine
Cervical spine	Lumbar spine	Prostate	Thyroid
Cervix	Lung	Rectum	Tongue
Chest	Lymph nodes	Ribs	Trachea
Colon	Mediastinum	Sacrum	Upper Arm
Duodenum	Nasal cavity	Salivary gland	Uterus
Eye	Nasopharynx	Seminal vesicle	Vagina
Fallopian tube	Neck	Shoulder	Vulva
Foot	Oesophagus	Sinuses	Whole body
Forearm	Oral cavity	Skin	
Glottis	Orbit	Skull	
Hand	Oropharynx	Small bowel	

Version control

Version no.	Date	Created/modified by	Modifications made
V1.0	03/05/2025	Julie Moore	Approved Form created to support amendment to the Public Health Act 2005 Queensland Cancer Register (QCR) Legislation Amendments .
V2.0	11/05/2026	Alexander Dunn / Linda Bird	Alignment with the Systemic Therapy Approved Form, addition of laterality to Cancer diagnosis and Treatment site, revision of Treatment type values and Allowable target sites