

HBCIS Technical Guide

For Public hospital notifiers

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Queensland Cancer Register

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Definition of terms

Term	Definition
ACS	Australian Coding Standards
BCC	Basal Cell Carcinoma
CCR	The historical system abbreviation used within HBCIS. Technically, CCR refers to the Central Cancer Registry, but within the HBCIS environment it is used simply to denote a cancer registration record. In practice, "CCR" and "cancer registration" are interchangeable terms for the purposes of data entry, review, and reporting.
HBCIS	Hospital Based Corporate Information System. The patient information system that facilitates the storage of patient, clinical and administrative data regarding patients admitted to the public hospitals in Queensland.
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
Notifier	Organisations required to report to the Queensland Cancer Register. Includes hospitals, day surgeries, pathology laboratories, medical imaging and treatment centres.
Patient administration system	The notifier's operational system used to record, manage, extract, and maintain patient demographic and clinical information, including cancer-related data.
QCR	Queensland Cancer Register
SCC	Squamous Cell Carcinoma

1. Purpose

The purpose of this document is to provide clinical coders and relevant hospital management staff with instructions for completing cancer registration activities within the Hospital Based Corporate Information System (HBCIS). It supports correct and timely completion of cancer registrations by outlining the required navigation pathways, data entry processes, and reporting functions used across Queensland public hospitals. Elements of this document reference the HOMER (HBCIS) module v9.4.2 to ensure alignment with current system functionality. The document aims to standardise practice, reduce data quality variation, and ensure compliance with statewide cancer reporting requirements.

2. Scope

This document applies to all clinical coders and authorised management personnel who use HBCIS to record, review, or manage cancer registration information. It covers:

- Accessing the Cancer Registration screen through both the inpatient coding workflow and the Cancer Menu.
- Completing a Cancer Registration including mandatory fields, data entry rules, and validation steps.
- Using print functions associated with cancer registration records.
- Management functions, including:
 - Running the Outstanding Cancer Registration Report.
 - Performing manual Extract File updates and downloads.

This document focuses on the operational use of HBCIS for cancer registration activities. It does not provide guidance on clinical coding standards or cancer registry processes outside the HBCIS environment. For broader reporting requirements and detailed definitions of each cancer data element, users should refer to the [QCR Notifier Guidelines for Hospitals](#), which provide comprehensive statewide guidance.

3. Cancer registration via inpatient coding screen

The user will be prompted to complete a cancer registration in the following situations:

- Deceased patients with an existing cancer registration, which has not been updated to include Cause of Death.
- For any site/morphology code combination that is not already registered (excludes combinations not to be reported e.g. Skin SCC/BCC)
- When the registered admission episode is in a prior calendar year.
- When discharged with a history of cancer and no existing cancer registration.

If the patient has a cancer registration there will be a flag (e.g. CCR2025) in the top right-hand corner of the inpatient coding screen. This displays the last year a patient cancer registration has been notified. You should check the Cancer Registration Screen details to see if a further notification is required. Check the last episode and dates. If you are required to report the patient (following the rules in section 3.2 of the QCR Notifier Guidelines) then you must check all cancer details (including for multiple primary sites) prior to filing the record.

3.1. Inpatient coding screen

```

REC2.S165                INPATIENT ICD CODING                434 LOGON-TEST
01 Patient No. 111111-1  SMITH, JOHN
    Admitted 01 APR 17  -> 30 JUN 17      LOS 90   State Average 1.3
    D.O.B 01 JAN 2009  Unit RMHC      Adm. Type 12  Srce. 01   MDC 009
    Sex M              Ward RMHC      Disc.Code 32   Rel. Weight 0.2376
DRG J69C SKIN MALIGNANCY, MINC                ECCS 1.0
                                           Page 1   of 1
02 ICD Code 03 CF 04 DCID Description                Block 05 Prc. Date
   █          █      █          █
1 PC43.5                MALIGNANT MELANOMA OF TRUNK
2 PM8720/2              MELANOMA INSIT

06 Admission Weight (grams) █          08 Smoking Status █
07 Duration of CVS █          09 Smoking pathway completed? Y/N/P █
Enter Field Number or Code F                Filed 395215 [31 MAY 23 11:03]
[4636] Cancer Registration required - continue (Y/N)? █
~  \  69+  END  OFF  █  █  █  █  █  █  █  █
    
```

On filing or grouping of the codes in the inpatient coding screen, if cancer codes have been entered on the coding screen, the following prompt will appear to enter a cancer registration -

- Cancer Registration required – continue (Y/N)?
- Answer 'N'. This will then automatically direct you to the Cancer Registration screen.

Note 1: If you answer 'Y' to this prompt, then you will bypass the Cancer Registration screen and continue to file/ group as per usual. This will result in missing cancer notifications.

Note 2: Enter CCR at the command line of the coding screen to enter the cancer registration screen. This is useful if you are not intending to code a cancer for this admission however would still like to complete a cancer registration (e.g. recording a

cancer registration for a cancer that additional diagnosis rules do not allow you to code.)

3.2. Cancer registration screen

```

REC2.S180                CANCER REGISTRATION                434 LOGON-TEST

01 Patient Number      111111 SMITH, JOHN
   Date of Birth 01 JAN 2009 Sex M Current Addr HERSTON 4006
02 Admission Number    1 Admitted 01 APR 17 --> 30 JUN 17
   Treating Doctor     SB BALKEY
   Diagnosis at Sep.   C43.5 MALIGNANT MELANOMA OF TRUNK
03 Autopsy Held?      
04 Cause of Death     _____
05 Primary Site        of 
06 Primary Site Code  _____
07 Morphology         _____
08 Laterality         
09 Date of 1st Diag.  _____ 10 Estimated? 
11 Suburb at 1st Diag. _____ 12 Postcode _____
13 Basis of Diagnosis at this admission 
14 Reasons for Clinical Diagnosis  of 
15 Code              _____
16 Details           _____
17 Lab. Facility No.  _____
18 Lab. Specimen No.  _____
19 Comments          _____
Enter Field Number or Code                Filed
~ \| 69+ END OFF _____
    
```

NB: F5 key can be used to access help on any field.

On entry of the Cancer Registration screen the following fields will be defaulted automatically and should be checked for accuracy -

(01) Patient demographic details

- Patient Number - Derived from the patient number field (01) on the Cancer Registration screen.
- Surname - Derived from the surname field (02) on the Patient Registration screen.

- Given name/s - Derived from the given names field (03) on the Patient Registration screen.
- Date of Birth - Derived from the date of birth field (04) on the Patient Registration screen.
- Sex - Derived from the sex field (05) on the Patient Registration screen.
- Current address - Derived from the address fields (15 and 16) on the Patient Registration screen.

(02) Admission details

- Admission number - Derived from the admission number field (02) on the Cancer Registration screen.
Note: The admission number that is currently linked to the cancer registration at the time of creating the extract file will be reported.
- Admission Date - Derived from the admission date field (62) on screen 3 of the Patient Admission screen, for the linked admission episode.
- Separation Date - Derived from the discharge date field (02) on the Patient Discharge screen, for the linked admission episode.
- Treating Doctor - Derived from the code entered in the treating doctor field (75) on screen 3 of the Patient Admission screen, for the linked admission episode.
- Diagnosis at Separation - Derived from the first diagnosis code, as assigned in the ICD code field (02) on the Inpatient ICD Coding screen for the linked episode.

Press enter for these to default.

The remainder of the fields on this screen require data entry. Please also refer to the Cancer Registration Data Dictionary (Appendix A of the *QCR Notifier Guidelines - Public and Private Hospitals*) for more detailed descriptions of these data fields.

(03) Autopsy Held?

- **Y** to indicate that an autopsy has been performed for a patient who died in hospital.
- **N** or RETURN to indicate that an autopsy has not been performed.
- Mandatory if patient died.

Note: Access to this field is only allowed for patients with a discharge code flagged as "death".

(04) Cause of Death

- Description of the patient's cause of death if the patient died in hospital.
- RETURN to default to the primary ICD Diagnosis as entered in the Inpatient ICD option for the linked Admission Number.
- Mandatory if patient died.

Note: Access to this field is only allowed for patients with a discharge code flagged as "death".

(05) Primary site

- Multi-value loop to enter more than 1 primary site if necessary.
- Press enter for 1 of 1 to default.
- If more than 1 primary site is to be entered, enter 2, etc.

(06) Primary site code

- Primary site code from coding screen.
- Mandatory

(07) Morphology

- Morphology code from coding screen.
- Mandatory
- Do not register with a behaviour - '6' or '9'. Use the primary cancer site & morphology - behaviour '3'.

(08) Laterality

- Valid options -
R = Right
L = Left
B = Bilateral
N = Not applicable (default, press RETURN)
U = Unknown

(09) Date of 1st diagnosis

- Date the patient was first diagnosed.

- Unknown date of first diagnosis use – 15/06/1900
- Known year, unknown day/ month (e.g. dx in 2007) use 15th day and 6th month of year e.g. – 15/06/2007
- Known month/ year, unknown day (e.g. dx in May 2008) use 15th day of month e.g. – 15/05/2008

(10) Estimated?

- Y/N
- Is date of first diagnosis estimated or not? If any part of the date is estimated select Y.

(11) Suburb at first diagnosis

- Where the patient was living at first diagnosis.
- Please be as specific as possible. This is used by investigators/ researchers to investigate cancer clusters/ occurrence of cancer.
- Free text identifying the patient's suburb at the time of the first diagnosis of the cancer. The postcode will not automatically display.
- Enter **AA** to display the suburb and postcode displayed in the Current Address field.
- If suburb unknown or diagnosed interstate or overseas, please use one of the following supplementary suburb/postcodes –

0989 = Not stated/ unknown

1989 = New South Wales

2989 = Victoria

3989 = Queensland

4989 = South Australia

5989 = Western Australia

6989 = Tasmania

7989 = Northern Territory

8989 = Australian Capital Territory

9310 = Papua New Guinea

9302 = New Zealand

9399 = Overseas – other (not PNG or NZ)

9799 = at sea

9899 = Australian External Territories

9989 = no fixed address

(12) Postcode at first diagnosis

- Postcode where living at first diagnosis of cancer.
- If unknown or diagnosed interstate, please refer to supplementary suburb/postcodes above.
- Upon entry of a valid suburb, the postcode will automatically be refreshed.
- The user can backtrack to modify the postcode to any number. This should be done if the postcode at diagnosis is different to that on the current Suburb Codes Reference File. This is to allow for the fact that the diagnosis may well have been some years ago and the Reference file contains only current suburb postcode combinations. Extra care is therefore required for patients diagnosed prior to the current admission.

(13) Basis of Diagnosis

- Basis of diagnosis AT THIS ADMISSION.
- If more than 1 diagnostic technique is used, then select the higher number.

01 = Unknown (e.g. dx & treated elsewhere/no info – use rarely)

02 = Clinical only (e.g. clinical examination/ doctors notes)

03 = Clinical investigations (e.g. bloods/ radiology/ endoscopy)

04 = Exploratory surgery (e.g. laparotomy without bx)

05 = Specific biochemical and immunological testing (e.g. PSA)

06 = Cytology (e.g. FNA without bx)

07 = Histology of metastasis

08 = Histology of primary

09 = Autopsy with histology

(14) Reasons for clinical diagnosis

- Multi-value loop that allows more than 1 reason for clinical diagnosis to be entered.
- Press enter to default 1 of 1.

Note: Access to this field is only allowed if the Basis of Diagnosis is flagged as “Clinical” (i.e. basis = 02 or 03).

(15) Code

- Mandatory if 02 or 03 selected as basis of diagnosis.

- 01 = Palliative care admission
- 02 = Doctors notes/ referral
- 03 = Previous pathology
- 04 = Radiological investigation
- 05 = Other non invasive investigation
- 06 = Invasive investigation
- 07 = Non cancer admission
- 09 = Other

(16) Details

- Enter further descriptive text if necessary for the reasons for clinical diagnosis.

Note: Access to this field is only allowed if the Reason for Clinical Diagnosis is flagged as “Text Required”.

(17) Lab. Facility No.

- Mandatory when 06, 07, 08 or 09 entered as a basis of diagnosis

- 01 = Auslab
- 02 = S&N
- 03 = QML
- 04 = Private laboratory
- 05 = Other

(18) Lab Specimen No.

- Enter the laboratory specimen no.
- NB: DO NOT USE COMMAS IN THIS FIELD
- This field becomes enabled when 06, 07, 08 or 09 entered as a basis of diagnosis.
- Non mandatory free text field.

(19) Comments

- Enter additional comments to provide further details about the cancer. E.g. metastases/ differentiation.
- RETURN to leave the field blank.

Before registrations are filed, please check to see all relevant details are filled in correctly.

When all fields on the Cancer Registration screen have been completed – File the Cancer Registration screen. Then group &/or File the Inpatient coding screen. After the registration is filed, the system retains the user details and the completion date.

4. Cancer registration via cancer menu

This option can be used if the cancer registration is not done at the same time as the inpatient coding, or to enter any cancer registrations that have been missed. This can also be done via the inpatient coding screen using CCR at the command line.



- Select 2. Medical Records – Cancer Menu from the Medical Records Main Menu



- Select 1. Cancer Registration from the Medical Records – Cancer Menu
- This takes you to the Cancer Registration screen.

```

REC2.S180                                CANCER REGISTRATION                                434 LOGON-TEST

01 Patient Number      [ ]
   Date of Birth       Sex      Current Addr
02 Admission Number   [ ] Admitted      -->
   Treating Doctor
   Diagnosis at Sep.
03 Autopsy Held?     [ ]
04 Cause of Death    [ ]
05 Primary Site      [ ] of [ ]
06 Primary Site Code [ ]
07 Morphology        [ ]
08 Laterality        [ ]
09 Date of 1st Diag. [ ]          10 Estimated? [ ]
11 Suburb at 1st Diag. [ ]          12 Postcode   [ ]
13 Basis of Diagnosis at this admission [ ]
14 Reasons for Clinical Diagnosis [ ] of [ ]
15 Code              [ ]
16 Details           [ ]
17 Lab. Facility No. [ ]
18 Lab. Specimen No. [ ]
19 Comments          [ ]

Enter Field Number or Code                                Filed
~  \|  69+  END  OFF  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]
    
```

- The Cancer Registration screen is exactly the same as accessed through the inpatient coding screen. The only difference is the need to search for the patient record via the patient search facility.
- Enter all the relevant cancer details as per Section 3.2 Cancer Registration Screen.
- If the inpatient coding has not yet been completed for the patient, the only field that will not default will be the Diagnosis at Separation field.

5. Cancer Menu – Follow up entry (NOT USED)

This option allows you to enter the names and addresses of a cancer registered patient’s local doctor and display preferred contact details.

6. Cancer Menu – Cancer Reports

The reporting functions outlined in this section are intended for management staff or designated personnel responsible for overseeing cancer-related reporting within their facility. These functions enable authorised staff to validate data quality, track registration activity, and ensure adherence to statewide cancer reporting requirements.

This menu allows you to review and print the following –

- Cancer Registration Form
- Outstanding Cancer Registration Report
- Cancer Follow Up Report (NOT USED)

```
R2.8,P9401          DB2 - FUTURE RELEASE - TEST          434 LOGON-TEST
20 FEB 26          CANCER REPORTS MENU                      REC2.3

1. Cancer Registration Form

2. Outstanding Cancer Registration Report

3. Cancer Follow Up Report

Enter selection or 'OFF' to logoff

~  ||  69+  END  OFF  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]
```



```

REC2.P46          OUTSTANDING CANCER REGISTRATION REPORT          434 LOGON-TEST

01 Date Selection  1  (1) Use Discharge Date
                   (2) Use Coded Date

02 Start Date     01 JAN 26

03 End Date       31 JAN 26

04 Volume Prefix  █

05 Sort Sequence  3  (1) Terminal Digit
                   (2) Patient Name
                   (3) Patient Number
                   (4) User ID
                   (5) Discharge Unit
                   (6) Location

06 Method         2  (1) Using the neoplasm flag in the ICD Codes Ref. File
                   (2) Using the Primary Site of Cancer Codes Ref. File

Enter Field Number or Code          Filed

~  \|  69+  END  OFF  █  █  █  █  █  █  █  █
    
```

- Date Selection –
 - Select discharge date or coded date to determine missing notifications. (The monthly extract sent to QCR is based on coded date)
- Start Date & End Date –
 - Enter the period that you wish to check outstanding notifications.
- Sort Sequence –
 - Select parameter that you wish the report to be sorted on.
- Method –
 - Select the method for determining an outstanding notification.
 1. Using the neoplasm flag in the ICD Codes Ref file
 2. Using the Primary Site of Cancer Codes Ref file

Note: The preferred method to use is 2. Primary Site of Cancer codes reference file as this will provide the missing cancer site and the admission no. to which it relates.

6.3. Cancer Follow up Report

Not used

7. Extract file update and download

A Cancer Registry Extract is run automatically every month (on the 10th of each month) to extract data to the Queensland Cancer Register for the previous month. I.e. On 10/1/2025 the extract will run and report all cancer notifications that had been registered between 1/12/25 – 31/12/25.

This extract is usually set up to run automatically on the 10th of each month through Report Monitor in HBCIS.

If, for some reason the monthly extract for your facility did not run correctly, or was not received by the Cancer Registry, you may be contacted to run the extract manually. This function is to be carried out by authorised staff only.

```
R2.8_P9401                DB2 - FUTURE RELEASE - TEST                451 LOGON-TEST
09 MAR 26                MEDICAL RECORDS - CANCER MENU                REC2

      1. Cancer Registration

      2. Follow Up Entry

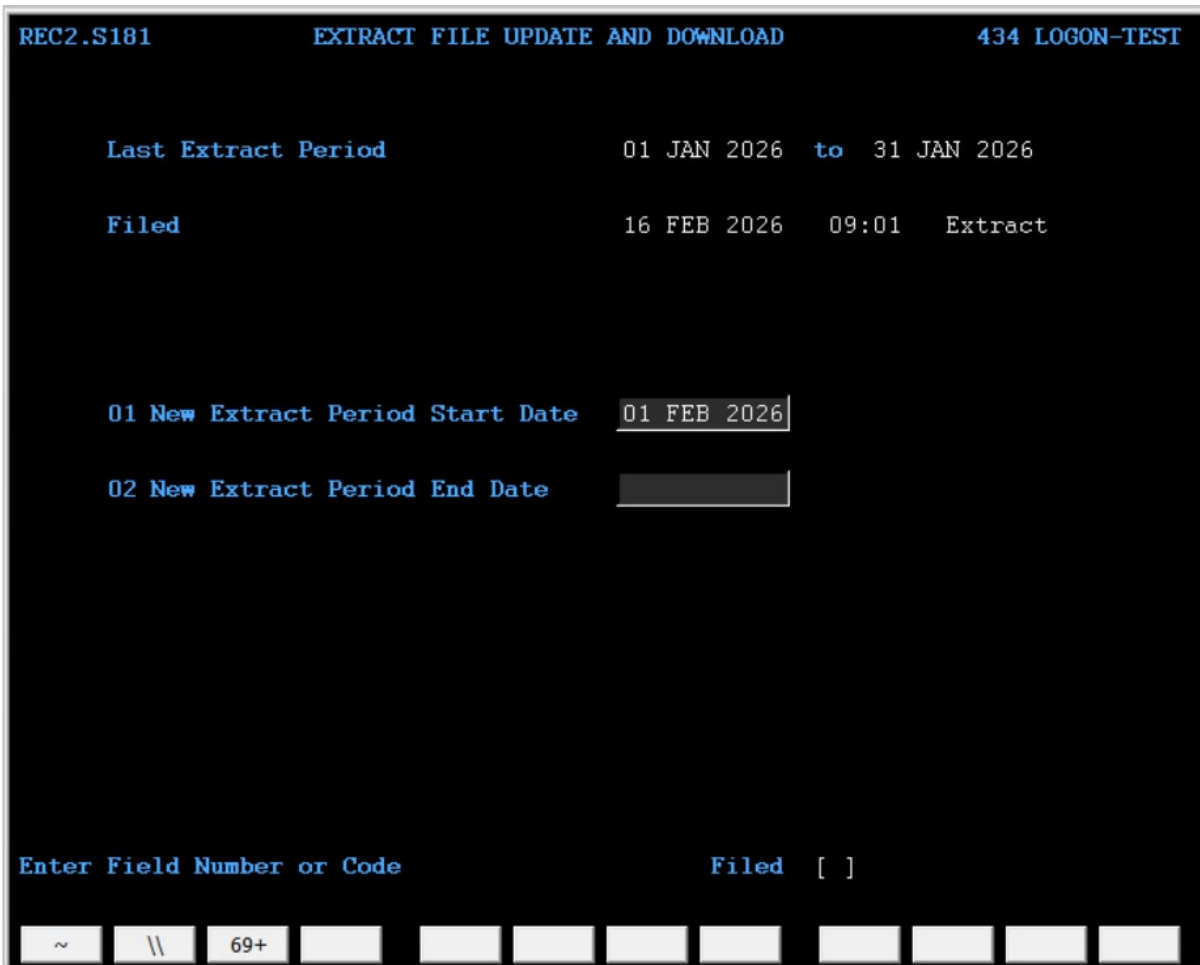
      3. Cancer Reports Menu

      4. System Management Menu

      5. Extract File Update and Download

Enter selection or 'OFF' to logoff █

~  \|  69+  END  OFF  █  █  █  █  █  █  █  █
```



- Enter the dates for period which you wish to extract – **Note:** Only extract on a monthly basis.
- If you re-run an extract that has previously been run, the system will give you a warning message – Date entered not after previous extract period end. Continue Y/N?
- Click Y to continue if you have been requested to re-extract by the Cancer Registry.

Version control

Version no.	Date	Created/modified by	Modifications made
1.0	May 2026	Phoebe Woodrow	Document created – adapted from 'Cancer Registration Manual HBCIS' 2010 v4.0