QCR
Queensland Cancer Register

QCR Notification Approved Form

Hospital Notifiers

Version: 1.0

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Queensland Cancer Register

Cancer Alliance Queensland

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Contents

1. Purpose

This Approved Form replaces the 'File Formats' section of the QCR Instruction Manual and should be used as the authoritative specification for all data extracts.

As required under the Public Health Act 2005, notifications of cancer must be submitted to the QCR using an Approved Form. The purpose of this Approved Form is to define the mandatory file structure and data formatting requirements for data extracts provided to our organisation by hospital notifiers. It establishes a consistent, technically compliant standard to ensure that incoming files can be reliably processed, validated, and integrated into our systems.

This document specifies the required fields, their formats, and any exceptions noted in the Source/Description column. The files will be supplied in ascii comma delimited format with double quotes as a text delimiter. Fields which are reported with double
quotes as text delimiters will have any embedded double quotes replaced by single quotes. Other punctuation, including commas, will not be stripped from the data. By adhering to this Approved Form, data providers help maintain data quality, reduce processing errors, and support efficient downstream workflows.

2. Scope

This Approved Form applies to all public hospitals and private hospitals (including day hospitals and hospices) responsible for submitting data extracts to our organisation. It governs every instance in which these facilities generate, format, and transmit extract files, regardless of the system or vendor used to produce the data. All participating

facilities must ensure that their submissions comply with the technical specifications and formatting standards defined in this document. Submissions must also meet the legislative obligations set out in the *Public Health Act 2008*; see sections 2.2–2.3 of the *QCR Notifier Guidelines for Hospitals* for detailed requirements.

3. Hospital electronic cancer notification file names

The following file names are mandatory when sending the notifications to the Register. Please note:

- the first five digits denote the facility number
- the range of the month will change as per which month is being sent
- if there are no notifications for the month, the HDR file must still be submitted
- file names must be in capitals
- the file extension must end in '.QCR'

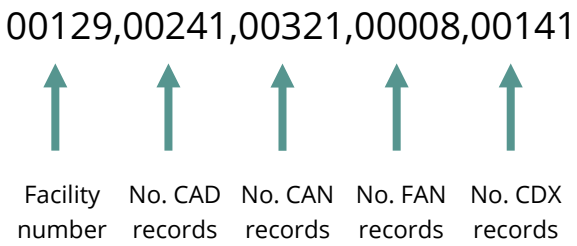
0012901OCT202531OCT2025CAD.QCR
0012901OCT202531OCT2025CAN.QCR
0012901OCT202531OCT2025CDX.QCR
0012901OCT202531OCT2025FAN.QCR

4. File structure and contents

4.1. Header Details (HDR) File

Data Item	Requested Format	Source/Description
Facility number	5 num Right adjusted and zero filled from left	The facility code for the set of files being submitted.
Number of CAD records	5 num Right adjusted and zero filled from left; zero if null	Total number of cancer admission records for that facility.
Number of CAN records	5 num Right adjusted and zero filled from left; zero if null	Total number of cancer primary site records for that facility.
Number of FAN records	5 num Right adjusted and zero filled from left; zero if null	Total number of former/alias name records for that facility.
Number of CDX records	5 num Right adjusted and zero filled from left; zero if null	Total number of reasons for clinical diagnosis records for that facility.

4.1.1. Example of data in the HDR file



4.2. Cancer Admission Details (CAD) File

Data Item	Requested Format	Source/Description
Patient Identifier (UR Number)	8 char Right adjusted and zero filled from left. Mandatory data item.	The unique number to identify the patient within the facility.
Admission Number	12 char Right adjusted and zero filled from left. Mandatory data item.	The admission number denotes a specific admission at the facility. Recording the admission number assists in identifying specific admissions as the patient can have one or more admissions within a certain time period and will have different cancer details for each admission. This is used to link each of the files for an admission when sending data to the Register.
Multiple Primary Site Count	2 num Right adjusted and zero filled from left. Mandatory data item.	The total number of primary sites for the cancer registration (i.e. for the patient) will be reported. Only a single CAD file will be reported for the cancer registration, even if there are multiple primary sites.
Medicare Number	11 num Blank if not available or if null. Desirable - if available.	The Medicare number of the patient. The field will not be zero or space filled. This comprises the 10 digit Medicare number and then the 1 digit reference number together.
Patient Surname	24 char	The current surname of the patient.

Data Item	Requested Format	Source/Description
	Mandatory data item.	The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Patient First name	15 char If Unknown type 'Unknown' Mandatory data item.	The current given names of the patient or resident. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Patient Second name	15 char	Second names or initials where known. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Address of Usual Residence	50 char Mandatory data item. If Unknown type "Unknown"	Number and street of usual residential address of patient. Note: this is NOT a Post Office box or Mail Service Number. Identify street name where possible. The field will not be zero or space filled. Double quotes will be used as a text delimiter. Use Street Directory abbreviations (see QCR notifier Guidelines – Public and Private Hospitals, Appendix B – Address street type abbreviations)
Location (suburb/ town) of Usual Residence	40 char Mandatory data item.	Name of suburb, town or locality of usual residence. Note: this item is mandatory even if patient has a Property Name or mail service number.

Data Item	Requested Format	Source/Description
		The field will not be zero or space filled. Double quotes will be used as a text delimiter. Must be in CAPITALS.
Postcode of Usual Residence	4 num Mandatory data item.	Australian postcode corresponding to Address of usual residence. Supplementary codes: 0989 = not stated/unknown 9301 = Papua New Guinea 9302 = New Zealand 9399 = Overseas - other (not PNG or NZ) 9799 = at sea 9899 = Australian External Territories 9989 = no fixed address The field will not be zero or space filled.
Date of Birth	9 date DDMMMYYYY Mandatory data item.	Full date of birth of patient. If year is unknown, estimate the year. If the DOB is unknown, specify 15-JUN-1900. In addition, specify in the comments in the CAN file that the DOB is estimated.
Occupation (before retirement) Description	50 char Left adjusted, blank if null. Desirable – if known.	Means principal lifetime occupation. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

Data Item	Requested Format	Source/Description
Sex	1 char Mandatory data item.	The sex of the person. Only use the following: M= Male F= Female I= Indeterminate / Intersex
Country of Birth Code	4 num Right adjusted and zero filled from left. Mandatory data item.	The country in which the person is born. 4 digit codes found in Appendix E of the Queensland Hospital Admitted Patient Data Collection (QHAPDC) Manual
Marital Status	2 char Mandatory data item.	The patient's current marital status. Only use the following: NM= never married M= married F= De facto W= widowed D= divorced A= separated N= not stated/unknown The field will not be zero or space filled.
Indigenous Status	2 num Mandatory data item	Whether a person identifies as being of Aboriginal and/or Torres Strait Islander origin.

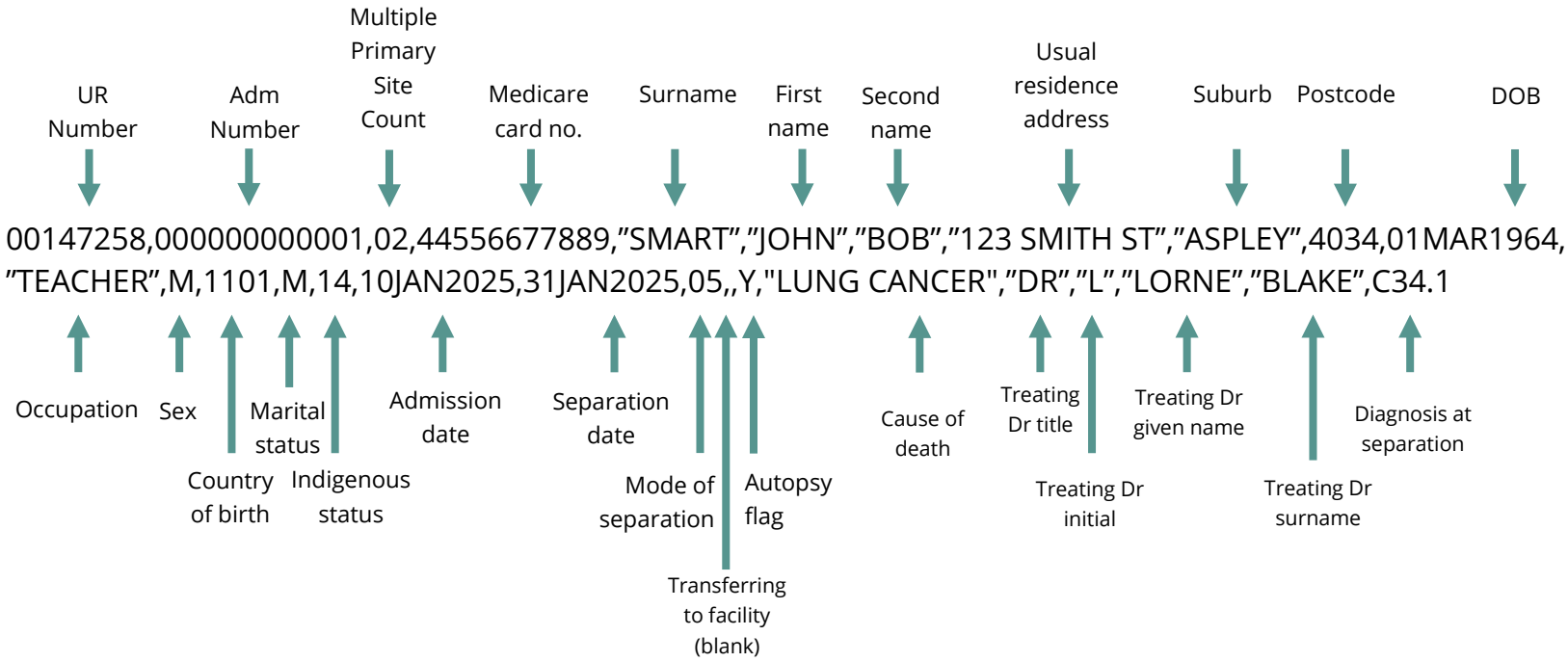
Data Item	Requested Format	Source/Description
		11=Indigenous-Aboriginal but not Torres Strait Islander origin. 12=Indigenous-Torres Strait Islander but not Aboriginal origin. 13=Indigenous-Aboriginal and Torres Strait Islander origin. 14=Not indigenous-not Aboriginal or Torres Strait Islander origin. 19=Not Stated The field will not be zero or space filled.
Admission Date	9 date DDMMMYYYY Mandatory data item.	This is the date on which an admitted patient commences an episode of care. Enter the full date of admission. DDMMMYYYY.
Separation Date	9 date DDMMMYYYY Mandatory data item.	This is the date that the patient was discharged, transferred or died. DDMMMYYYY.
Mode of Separation	2 char Mandatory data item.	Code which indicates the place to which a patient is referred immediately following separation from hospital. 01=Home/usual residence 04=Other health care establishment 05=Died in hospital 06=Care Type change 07=Discharge at own risk 09=Non return from leave

Data Item	Requested Format	Source/Description
		12=Correctional facility 13=Organ procurement 14=Boarder 15=Residential aged care service 16=Transferred to another hospital 17=Medi-Hotel 19=Other 21= Residential aged care service, which is not the usual place of residence 22= Residential aged care service, which is the usual place of residence 31= Residential mental health care facility 99=Unknown The field will not be zero or space filled.
Transferring to Facility	5 char Mandatory - If Transferred (Mode 16)	If the patient was transferred please complete facility number of the receiving facility. The field will not be zero or space filled.
Autopsy Flag	1 char Blank if null. Mandatory – If Died (Separation mode 05)	Record whether an autopsy or coroners inquiry is to be/has been undertaken with a Y or N.
Cause of Death	50 char Left adjusted, blank if null.	Please only complete the cause of death if the patient dies in the hospital .

Data Item	Requested Format	Source/Description
	Mandatory – If Died (Mode 05)	The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Treating Doctor Title	4 char Left adjusted. Mandatory data item.	Refers to the Tile of the Senior Treating Medical Officer, Specialist or Consultant in charge of the care of the patient during this admission. This is not the registrar or resident medical officer. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Treating Doctor Initials	9 char Left adjusted. Mandatory data item.	Refers to the Initials of the Senior Treating Medical Officer, Specialist or Consultant in charge of the care of the patient during this admission. This is not the registrar or resident medical officer. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Treating Doctor Given Names	55 char Left adjusted. Mandatory data item.	Refers to the Given Names of the Senior Treating Medical Officer, Specialist or Consultant in charge of the care of the patient during this admission.

Data Item	Requested Format	Source/Description
		This is not the registrar or resident medical officer. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Treating Doctor Surname	29 char Left adjusted. Mandatory data item.	Refers to the Surname of the Senior Treating Medical Officer, Specialist or Consultant in charge of the care of the patient during this admission. This is not the registrar or resident medical officer. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Diagnosis at Separation	9 char Left adjusted. Mandatory data item.	The principal diagnosis ICD 10-AM code for this admission. The field will not be zero or space filled.

4.2.1. Example of data in a CAD file



4.3. Cancer Details (CAN) File

Data Item	Requested Format	Source/Description
Patient Identifier (UR number)	8 char Right adjusted and zero filled from left. Mandatory data item.	A unique number to identify the patient within the facility.
Admission Number	12 char Right adjusted and zero filled from left. Mandatory data item.	The admission number denotes a specific admission at the facility. Recording the admission number assists in identifying specific admissions as the patient can have one or more admissions within a certain time period and will have different cancer details for each admission. This is used to link each of the files for an admission when sending data to the Register.
Multiple Primary Site Number	2 num Right adjusted and zero filled from left. Mandatory data item.	Each primary site for the cancer registration for that admission (for the patient) will be reported in a separate CAN record. Therefore, the patient, for that admission, may have one or many CAN records.
Primary Site of Cancer Code	9 char Left adjusted Mandatory data item.	Indicates the site where the neoplasm originated. Punctuation will not be stripped from the code. The field will not be zero or space filled. See Appendix E of the QCR Notifier Guidelines for Hospitals

Data Item	Requested Format	Source/Description
Primary Site of Cancer Description	40 char Left adjusted. Mandatory data item.	Where possible, be specific when describing the primary site, for example, if known, state site as "upper or lower lobe of lung" or "upper-inner quadrant of breast". The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Morphology Code	7 char Mandatory data item.	4-digit Morphology code from ICD 10 AM and 5th digit indicting the behaviour of the tumour, for example invasive or insitu etc. Punctuation will not be stripped from the code. The field will not be zero or space filled.
Date of First Diagnosis	9 date DDMMMYYYY Mandatory data item.	Try to accurately identify the full date of original diagnosis for this cancer where possible. If the date is unknown, the users will be required to enter 15 JUN 1900 in this field.
Date of First Diagnosis Flag	1 char Mandatory data item.	Where the full date of original diagnosis is unknown enter Y in the Estimated field. If the date of diagnosis is known enter an N. This is the default value.
Location (suburb/ town) of usual residence at diagnosis	40 char Mandatory data item.	Name of suburb or town of usual residence at the time of first diagnosis of this cancer. The field will not be zero or space filled. Double quotes will be used as a text delimiter. Must be in CAPITALS.

Data Item	Requested Format	Source/Description
Postcode of Usual Residence at Diagnosis	4 num Mandatory data item.	Australian postcode corresponding to Address of usual residence at the time of first diagnosis of cancer. Supplementary codes: 0989 = not stated/unknown 9301 = Papua New Guinea 9302 = New Zealand 9399 = Overseas - other (not PNG or NZ) 9799 = at sea 9899 = Australian External Territories 9989 = no fixed address The field will not be zero or space filled.

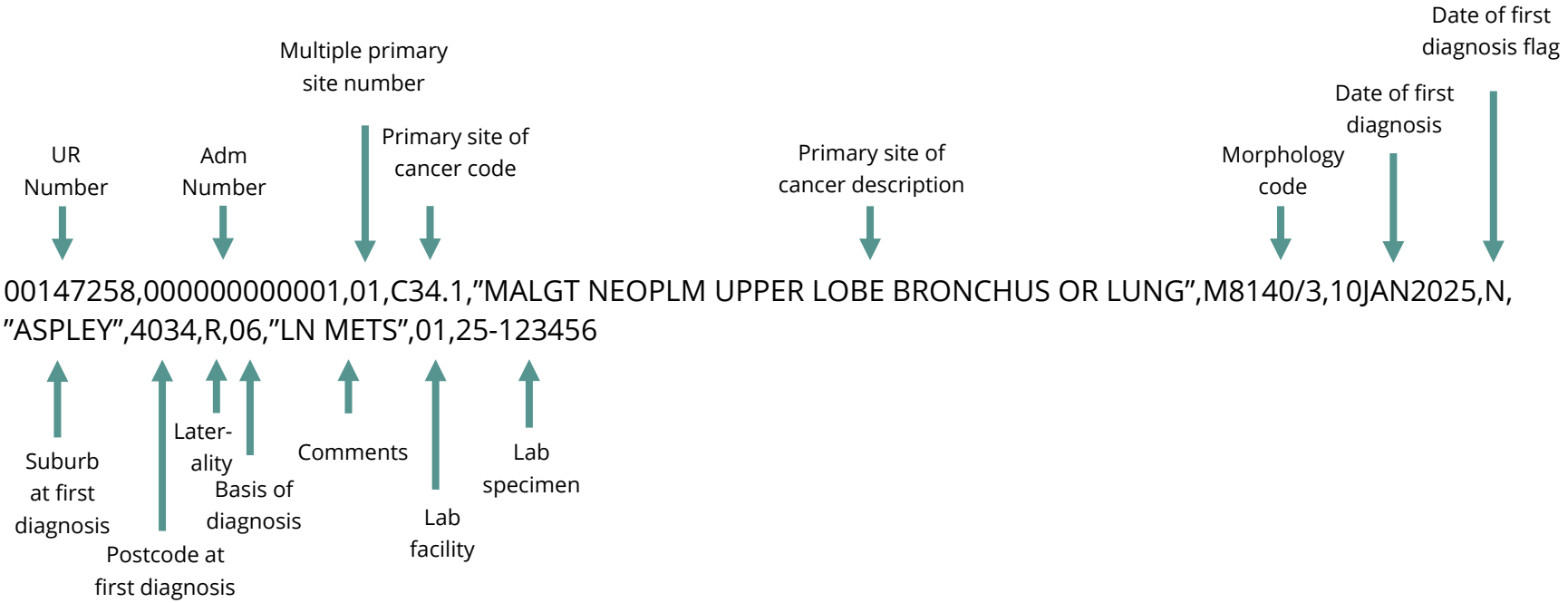
Data Item	Requested Format	Source/Description
Laterality of Cancer	1 char Mandatory data item.	Where possible, for cancers of paired organs (ovary, breast, kidney, lung, eyes, arms, legs, ears and testicles), indicate which the side is affected by the tumour. R= Right L= Left B= Bilateral N= Not applicable U= Unknown For all non-paired organ sites, not applicable is the default. Unknown is used for paired organs only.

Data Item	Requested Format	Source/Description
Basis of Diagnosis	2 num Mandatory data item.	Refers to the basis of diagnosis AT THIS ADMISSION. Note that the basis of diagnosis is hierarchical from 1 (least definitive) to 9 (most definitive). If more than one diagnostic technique is employed during this admission, select the higher number. 01=Unknown 02=Clinical Only 03=Clinical Investigations 04=Exploratory Surgery 05=Specific Biochemical and immunological testing 06=Cytology 07=Histology of Metastasis 08=Histology of Primary Site 09=Autopsy and histology The field will not be zero or space filled. (If 02 or 03 is entered, a reason for clinical diagnosis will be displayed in the CDX file)

Data Item	Requested Format	Source/Description
Comments	250 char Left adjusted, blank if null. Desirable – if applicable.	This free text field allows the user to provide any other relevant details regarding the cancer that may assist the Register staff or reduce queries for the hospital. The field will not be zero or space filled. Double quotes will be used as a text de-limiter. If there is a Previous Pathology field or a Radiological Investigations field, this would be ideal in the comments data item, otherwise we will not know of any other tests performed if the basis of diagnosis is not clinical.
Laboratory facility number	2 char Mandatory - when the codes of 06, 07, 08 or 09, is entered into field 13 (Basis of Diagnosis).	The laboratory facility number field displays the laboratory where the specimen was sent to. It is linked to a reference file. The codes are as follows: 01 Auslab 02 S & N 03 QML 04 Private Laboratory 05 Other
Laboratory Specimen No.	50 char	The lab specimen number will record the specimen lab number (e.g. report number) and any other comments required (e.g. if 'Other' lab is recorded, then the user can record the actual lab name along with the Laboratory specimen number). This is a non-mandatory free text field, and only becomes enabled when the codes of 06, 07 08 or 09 is entered into field 13.

4.3.1. Example of data in a CAN file

For patient UR 147258, the admission dated 10 January 2025 includes a histologically confirmed malignant lung neoplasm, represented by 'multiple primary site number' **01** (first row). The second row shows an additional registration linked to the same admission, capturing the patient's prior history of malignant colon neoplasm, although the date and location of the original diagnosis cannot be determined. This condition is recorded with 'multiple primary site number' **02**.



00147258,000000000001,02,C18.9,"MALIGNANT NEOPLASM OF COLON, UNSPECIFI",M8000/3,15JUN1900,Y,"NOT STATED/UNKNOWN",0989,U,02,"HISTORY",,

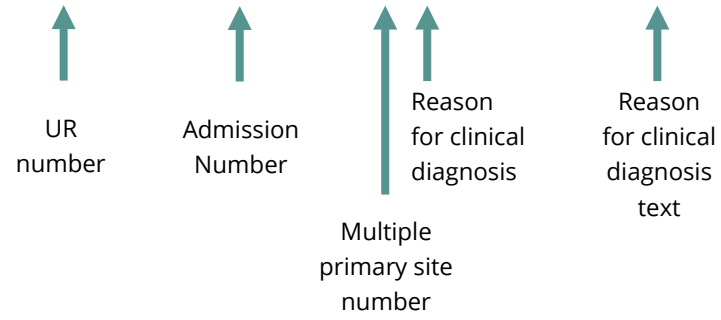
4.4. Reason for Clinical Diagnosis (CDX) File

Data Item	Requested Format	Source/Description
Patient Identifier (UR number)	8 char Right adjusted and zero filled from left Mandatory data item.	A unique number to identify the patient within the facility.
Admission Number	12 char Right adjusted and zero filled from left. Mandatory data item.	The admission number denotes a specific admission at the facility. Recording the admission number assists in identifying specific admissions as the patient can have one or more admissions within a certain time period and will have different cancer details for each admission. This is used to link each of the files for an admission when sending data to the Register.
Multiple Primary Site Number	2 num Right adjusted and zero filled from left. Mandatory data item.	Each reason for clinical diagnosis for each primary site for the cancer registration will be reported in a separate CDX record. Therefore, the patient may have none, one or many CDX records and the patient may have none, one or many CDX records for a given primary site.
Reasons for clinical diagnosis code	2 num Right adjusted and zero filled from left. Mandatory data item.	Refers to reasons why a patient may be admitted to hospital where a clinical only or clinical investigations basis of diagnosis is given as the most valid basis of diagnosis. Some codes for the Reasons for Clinical Diagnosis require further detail to be supplied in the Details field. The codes are as follows: 01=Palliative care admission 02=Doctors notes/Referral 03=Pathology 04=Radiological investigations

Data Item	Requested Format	Source/Description
		05=Other non-invasive investigations 06=Invasive investigation 07=Non cancer admission 09=Other The field will not be zero or space filled. You cannot have more than one of the above codes for the same primary site. i.e. for patient UR number 123456; primary site number 01, the code 03 cannot be used more than once. You need to use another code if there is another reason, therefore use 03 and 09.
Reasons for clinical diagnosis text	250 char Blank if reasons for clinical diagnosis code = 01. Desirable – if applicable.	Some codes for the Reasons for Clinical Diagnosis require further detail to be supplied in this field. The extract will simply include the details if available for that reason for clinical diagnosis item or leave the field in the CDX record blank if the details field is blank for that reason for clinical diagnosis item. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

4.4.1. Example of data in CDX file

00147258,000000000001,02,02,”MEDICAL RECORD NOTES”



4.5. Former/Alias Names (FAN) File

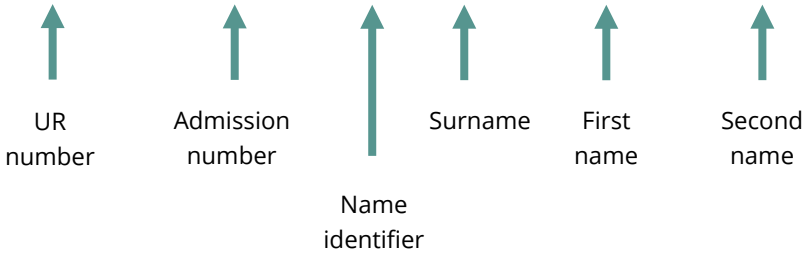
Data Item	Requested Format	Source/Description
Patient Identifier (UR number)	8 char Right adjusted and zero filled from left. Mandatory data item.	A unique number to identify the patient within the facility.
Admission Number	12 char Right adjusted and zero filled from left. Mandatory data item.	The admission number denotes a specific admission at the facility. Recording the admission number assists in identifying specific admissions as the patient can have one or more admissions within a certain time period and will have different cancer details for each admission. This is used to link each of the files for an admission when sending data to the Register.
Former/Alias Name Identifier	2 num Right adjusted and zero filled from left. Mandatory data item.	Each alias entered for the patient will be reported in a separate FAN record. Therefore, the patient may have none, one or many FAN records. The alias details are linked to an individual patient but are not linked to an individual admission for that patient. Therefore, when the alias details are reported in the FAN record/s, each alias that exists for that patient will be reported, regardless of the admission number reported. If a patient has an alias and therefore a FAN record, the name identifier cannot be '00'.
Patient Surname	24 char Left adjusted. Mandatory data item.	Any previous surname that the patient or resident is now or has previously been known as. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

Data Item	Requested Format	Source/Description
Patient First Name	15 char Left adjusted. Mandatory data item.	Any previous first name that the patient or resident is now or has previously been known as. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Patient Second Name	15 char Left adjusted. Desirable – if applicable.	Any previous second name that the patient or resident is now or has previously been known as. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

4.5.1. Example of data in FAN file

00147258,000000000001,01,”SMART”,”JOHNATHAN”

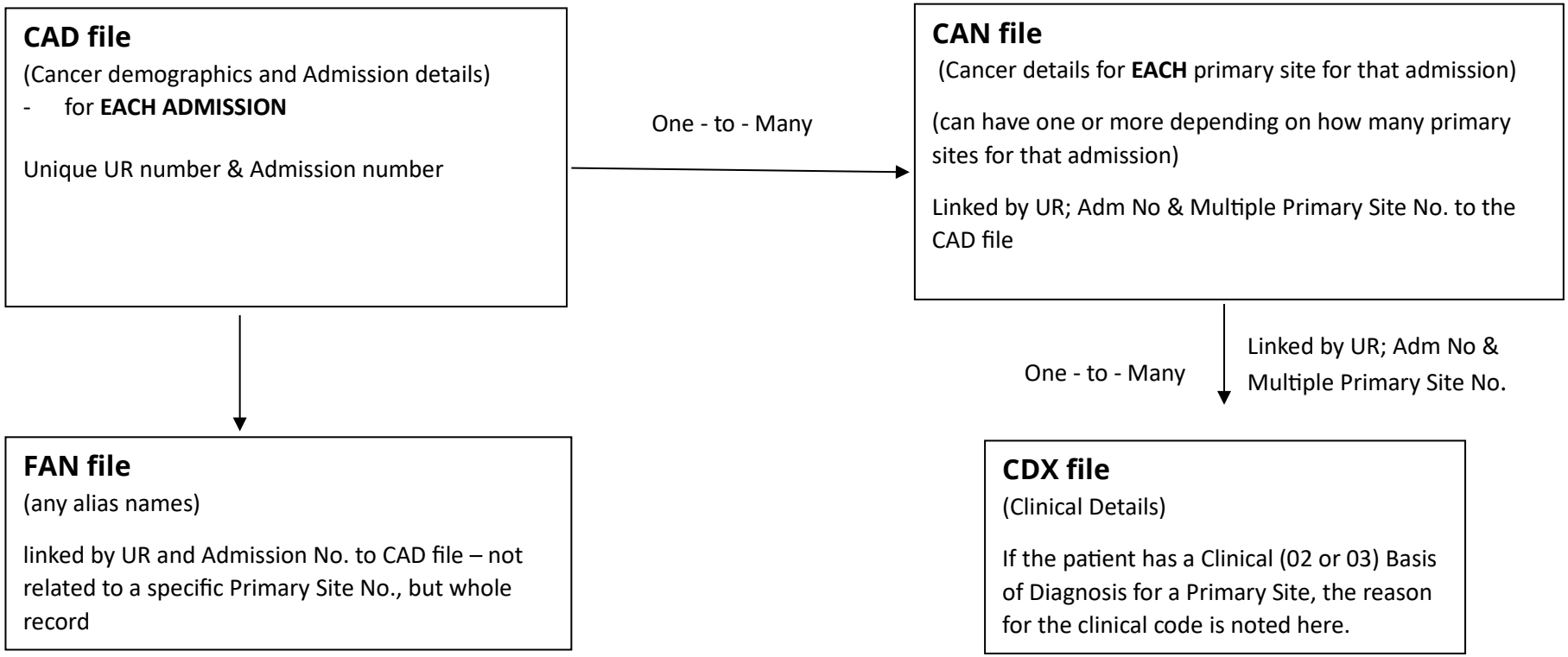
00147258,000000000001,02,”SMART”,”JOHNNY”,”ROBERT”



5. How the files are linked together

The CAD record relates to a specific admission, so if the patient is admitted twice in the extract period (can happen if the extract period is for a month) then there will be 2 CAD records for the patient, and subsequent CAN records from that admission.

There could also be more than one CDX file if the second CAD admission and subsequent CAN/s have a CDX (i.e. Clinical Details) as well as the first admission, as the CDX file is linked to the CAN file for that specific primary site number.



6. System considerations for private hospitals

To support consistency, data quality, and compliance with Queensland cancer notification requirements, the following section outlines key parameters and design considerations drawn from the HBCIS model used in public hospitals. While private facilities operate a range of patient administration systems, incorporating these elements into your cancer registration module will help ensure accurate case capture, streamlined reporting, and alignment with statewide cancer registry standards.

6.1. Non-notifiable skin cancers

This parameter identifies combinations of topography and morphology codes that are excluded from cancer registration. Specifically, it excludes the following skin neoplasms coded to; **C44.0 - C44.9**, **D04.0 – D04.9** and **D48.5**, when paired with morphology codes for basal cell or squamous cell carcinomas (**M8050/0 – M8110/9**)

These combinations represent non-notifiable skin cancers and should not trigger a cancer registration record.

6.2. History of cancer

This parameter supports the reporting of episodes where a personal history of malignant neoplasm has been coded and the episode represents the patient's first presentation within the calendar year. It includes codes in the range Z85.0–Z85.9.

As Z-codes are not accepted by the Queensland Cancer Registry, the system should prompt the user when a Z85 code is entered. The prompt should direct the user to complete the cancer registration using the corresponding ICD-10-AM C-code (malignant neoplasm) that reflects the patient's original cancer site.

6.3. Outstanding cancer registration report

This report identifies all patients with notifiable ICD cancer codes who have not been fully registered in the Cancer Reporting Module. Users can specify a date range and the report will list patients/admissions that meet any of the following criteria:

- Notifiable neoplasm code present in their ICD coding without a corresponding cancer registration
- History of cancer code present in their ICD coding without a cancer registration
- Deceased patients whose cancer registration is missing a Cause of Death entry
- Previously registered cancer cases where the cancer was recorded in a prior year but no updated registration has been completed

6.4. Amendments to registrations

When a registration is amended after its initial submission, the updated record should be included automatically in the next monthly extract, regardless of the original admission period. This approach treats each extract as a “current state” snapshot of all registrations that have been created or modified since the previous submission. By doing so, retrospective updates flow through naturally in the next cycle, removing the need for facilities to re-extract or re-submit historical months when past registrations are corrected.

7. Version control

Version no.	Date	Created/modified by	Modifications made
V1.0	01/05/2026	Phoebe Woodrow	An Approved Form has been created. This content was previously included in the *Queensland Cancer Register Instruction Manual for Notifying Cancer* under the section titled 'File Formats'. A decision has been made to separate this form into its own standalone document to ensure alignment with organisational requirements and legislative changes introduced in May 2025. Key updates/changes: • Updated examples of data within each file to ensure they are current and more relevant. • Expanded *Section 6: System Considerations for Private Hospitals* to outline key parameters and design considerations, drawing on the HBCIS model utilised in public hospitals. • No other changes have been made to the content of the file structures, with the exception of an increase in character limits for two fields: the 'Comments' field in the CAN file and the 'Reasons for clinical diagnosis text' field in the CDX file, both of which have increased from 50 to 250 characters.