QUEENSLAND CANCER REGISTRY

INSTRUCTION MANUAL

FOR NOTIFYING CANCER

HBCIS HOSPITALS

June 2009

Queensland Cancer Registry
Cancer Council Queensland
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Version 5.0

RELEASE HISTORY

Date	Release	Pages	Details
January 2006	Version No. v2	All	Kerrie Dennison
June 2006	Version No. v3	Page 5	Kerrie Dennison
February 2007	Version No. v4	Table of contents and page 21	Kerrie Dennison
April 2008	Version No. v5	Updated Lab facility & specimen no's.	Julie Moore
June 2009	Version No. v6.1	Updated CCQ & contact details. Updated CAN file – Morph field to 7 char from 9.	Marilla Fraser

CONTENTS

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NOTE. Items above marked with an * are specific requirements of the cancer registration screen.

Superseded Details:Amendments to previous versions:
Version 3 May 2006, is now obsolete
Version 2.1 Sept 2004 – the list of ICD-10 prompted site codes required have been included and the ranges included at the back of the document. (Appendix E). There have also been minor amendments to the text.
Qld Cancer Registry Instruction Manual V1 Jan 2002, is now obsolete.

1. INTRODUCTION

1.1 Establishment of the Cancer Registry

The Queensland Cancer Registry (QCR) operates under the *Public Health Act 2005,* to receive information on cancer in Queensland. The Cancer Registry is a population-based registry and maintains a Register of all cases of cancer diagnosed in Queensland since the beginning of 1982. It was established in response to the need for Statewide information on cancer expressed by community and state organisations such as the Queensland Institute of Medical Research and the Queensland Cancer Fund. Cancer is a notifiable disease in all States and Territories and is the only major disease category from which an almost complete coverage of incidence data is available. It is also the only major cause of death in Australia that is continuing to increase. Through the National Cancer Statistics Clearing House – a collaborative enterprise of the Australian Association of Cancer Registries and the Australian Institute of Health and Welfare, Queensland data is used in the compilation of Australia-wide figures and can be compared with cancer statistics from other States.

1.2 Aims of the Registry

The main aim of the Registry is to collect data to describe the nature and extent of cancer in Queensland. This can be combined with related data to assist in the control and prevention of cancer. To this end, Queensland Cancer Registry data is available for use:

- in research projects on the causes, treatment and prevention of cancer,
- in the planning and assessment of cancer treatment and prevention services,
- in monitoring survival times of cancer patients, and
- for the education of health professionals and members of the general public.

1.3 Notification and Sources of Data

Notification of cancer is a statutory requirement for all public and private hospitals, nursing homes and pathology services. Notifications are received for all persons with cancer separated from public and private hospitals and nursing homes. Queensland pathology laboratories provide copies of pathology reports for cancer specimens. Data on all persons who die of cancer or cancer patients who die of other diseases are abstracted from the mortality files of the Registrar of Births, Deaths and Marriages and linked to hospital and pathology data.

The Registry has obtained the approval of the Registrar General of Births, Deaths and Marriages to provide hospitals with details of patient deaths where the patient has been treated at that hospital and died elsewhere. This report will be provided annually to assist with patient survival follow-up and record culling.

1.4 The Act and Regulations

The *Public Health Act 2005,* Division 3 – Notifications about cancer 234 and 235 that the 'person in charge of a hospital' is responsible for furnishing returns on patients known to be suffering from cancer to the chief executive of Queensland Health, or under the direction of the chief executive to the Queensland Cancer Fund ('the contractor'), within one month.

The legislation may be viewed on the following website:

http://www.legislation.qld.gov.au/LEGISLTN/ACTS/2005/05AC048.pdf

1.5 Confidentiality of Data

All unit record information collected by the Queensland Cancer Registry is treated as strictly confidential. All information collected is used for statistical or research purposes only.

1.6 Enquiries

If you would like more information about the Queensland Cancer Registry or you wish to obtain any publications you may contact the:

Registrar
Queensland Cancer Registry
Queensland Cancer Fund
553 Gregory Terrace
Fortitude Valley Q 4006

Locked Bag No 1450
Spring Hill Q 4004

PH (07) 3258 2333
FAX (07) 3258 2345
Email kerrie_dennison@health.qld.gov.au

Further information about cancer may also be obtained from the following web sites:

www.health.gov.au/hic	(Queensland Health site, QCR data)
www.qldcancer.com.au	(Queensland Cancer Fund site, general cancer information)
www.aihw.gov.au/cancer/index.html	(AIHW site, national data)

2 ELECTRONIC NOTIFICATION

2.1 Background

Since early 2002, the Queensland Cancer Registry has been receiving cancer registrations from all Public Hospitals in Queensland electronically on a monthly basis.

The improvement in the quality and timely availability of cancer data from these sources has been substantial. In addition, each facility is able to submit queries for further information in this way.

3 BUSINESS RULES

3.1 What Hospitals Should Notify?

All public hospitals in Queensland with the HBCIS system are required to report cancer details to the Queensland Cancer Registry.

3.2 What Cancers Should Be Notified?

All cancers as defined in Part 2 Division 1, Section 229 of the *Public Health Act* 2005 are to be notified. The Act defines cancer as:

> ". . . a neoplasm of human tissue-
>
> a) in which cell multiplication is uncontrolled and progressive; and
> b) that, if unchecked, may invade adjacent tissues or extend beyond its site of origin; and
> c) that has the propensity to recur, either locally or remotely in the body
> d) skin cancer and non-invasive carcinoma, other than skin cancer and non-invasive carcinoma of a type prescribed under a regulation".

Therefore, all invasive cancers are to be reported (excluding Basal Cell Carcinomas and Squamous Cell Carcinomas of the skin where the ICD-10-AM site code range is C44.0 to C44.9 and morphology is M805 to M811). Merkel cell tumours of the skin and Kaposi's Sarcoma are also to be reported.

Please report any cancer with uncertain behaviour.

Please notify **all** in-situ conditions as well. The Registry collects for example, in-situ cancers of the cervix (CIN III - cervical intra-epithelial neoplasm), vagina (VAIN III - vaginal intra-epithelial neoplasm), vulva (VIN III - vulval intra-epithelial neoplasm), prostate (PIN - prostatic intra-epithelial neoplasm) bladder, breast and in-situ melanomas.

Benign central nervous system and brain tumours are also of interest to the Registry and must be reported.

Non-malignant conditions, such as CIN I or II, VAIN I or II, VIN I or II, solar keratosis or keratoacanthoma, are outside the scope of the collection.

3.3 When A Notification Should Be Completed

A notification should be completed and filed **within 30 days** for each of the following events:

(i) at discharge or transfer of a patient being **first** diagnosed with cancer, or when a **new site** is diagnosed, or the same site but a **different histological type** of cancer is diagnosed.

(ii) a patient's **first** date of attendance in each calendar year for chemotherapy or radiotherapy. (Note that as per the Queensland Health admission policy patients should be admitted for chemotherapy.)

(iii) at the **death** of a patient suffering from or with a **history** of cancer, where the patient died within the hospital.

(iv) at discharge or transfer from the **first** admission for each calendar year for all other patients suffering from or with a history of cancer. This includes patients who may be being treated for their cancer at that admission or where the cancer is incidental to that admission. It is a requirement to follow current coding standards and to only code history of cancer in the ICD-10-AM diagnosis codes where it is relevant to the admission. It is desirable for the cancer registry to still receive a notification through separately 'filing' a cancer registration notification.

A **separate notification** is required for each primary site.

Only notifications that have been filed will be forwarded as part of the extract. A print option is available for sites to use for retaining a record in their own charts. This is not a mandatory requirement of the Cancer Registry. The print option also serves as a back-up if at any time the electronic notification process fails. The Registry will notify hospitals if this is a required.

3.4 Amendments

Amendments can only be reported to the Registry if the registration is refiled. If the record is refiled within a reporting period, only the most recent registration will be forwarded to the QCR.

3.5 Deletions

Deletions cannot be provided electronically. If a notification has been filed it will be reported through to the Registry. A manual notification is required if the record is to be deleted from the QCR. This can be done by printing the notification prior to deleting or photocopying the relevant notification and crossing it with DELETED. If possible, a reason should be added, eg duplicate patient, not cancer, etc.

3.6 Further Information Required

After processing a cancer notification the Registry may identify a need for further information. A response to the request for further information is required within 30 days and should be addressed as follows:

CONFIDENTIAL
The Queensland Cancer Registry
Locked Bag No 1450
Spring Hill Q 4004

It is recommended that hospitals maintain a record of the completion and dispatch of the responses to the requests for further information.

3.7 Check For Outstanding Notifications

An Outstanding Cancer Registration Report should be run at the end of each month to ensure that all patients with a cancer code in their ICD-10-AM coding have a Cancer Registration. The layout of the report has been changed to include new fields and change the sequence of existing fields.

There is a new field '01 Date Selection', this field will allow the selection of a date range by 'discharge date' or 'coded date'.

Three new sort options have been added to field '04 Sort Sequence', these are User ID, Discharge Unit and Location.

Field '05 Method", changes to method '2 using the Primary Site of Cancer Codes Ref. File'. It will report four (4) types of patient episodes. It will report episodes with a History of Cancer, episodes where the primary site AND morphology combination are not registered, and episodes for the first presentation in a calendar year for a patient with an existing Cancer Registration. A new parameter has been added to exclude those neoplasms that are not required to be reported. Eg. Skin SCC/BCC, or benign cancers (except brain).

The report should be run for the period January (of the current year) to the current reporting month. The period checked will therefore be cumulative for a calendar year.

A manual check is required to identify those patients who have previously been registered and require reporting.

3.8 When A Notification Should Be Sent

Notifications should be sent on a monthly basis.

An extract should be run on the 10th day of each month (this will happen automatically). The extract should include all notifications filed in the previous month.

If run manually, there must be no gaps in date ranges for the extract periods. Nor should there be dates duplicated within extract periods. If data is to be resupplied for a period this should be negotiated with the Cancer Registry. It may require records to be refiled.

Each set of cancer registration extract files will contain a header (HDR) details file. The HDR file will provide counts of the total number of records for that facility (including nil returns).

3.9 Use of the Cancer Registry Flag

The CCR Number is no longer available on the Inpatient ICD Coding Screen. There is a flag (CCR2001) in the top right hand corner of this screen this displays the last year a patient cancer registration has been notified. You can get to the Cancer Registration Screen by simply entering CCR in the command line. This can be done regardless of whether there is a cancer code in the ICD coding. This simplifies the access to the Cancer Registration Screen for patients with a history of cancer.

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 registered (excludes combinations not to be reported eg 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 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 3.3) then you must check all cancer details (including for multiple primary sites) prior to filing the record.

4 FACILITY DETAILS

4.1 Facility Number

The facility number is a numerical code that uniquely identifies each health care facility. This manual covers the facilities listed in Appendix A, recognised public hospitals. All these hospitals are able to admit patients, although not all wish to do so.

It should be noted that there are some facilities which, although they share the same management, and in some cases the same site, are treated as separate facilities, have separate facility numbers and are to submit data to QCR separately. For example:
Mater Mothers' Private and Mater Mothers' Public.

Patients moving between these hospitals are counted as separate admissions and separations and are therefore reported by both facilities.

Nursing home residents should be reported under the facility number of the nursing home. Nursing home residents moving from a nursing home bed to an acute bed at another facility should be admitted as an acute patient from the date that they occupy the acute bed and reported as such.

This is not to be confused with a person's status as a nursing home type patient in an acute bed.

HBCIS hospitals allocate their facility number automatically when the data is extracted for the QCR. The facility will be identified using the discharge ward code for the linked admission episode. The ward code will be mapped to a campus code in the Ward Codes Reference File. The campus code will be mapped to a facility code in the Campus Codes Reference File.

5 PATIENT DETAILS

5.1 U R Number (Patient Number) *

A unique number allocated to each patient by the hospital. Allocation might be done manually or automatically by the computer. The number is used for each admission to identify the patient within the facility.

Upon entry of a valid patient number the following patient details will be displayed and should be checked for accuracy:

- The patient's surname, given names and date of birth.
- The patient's current suburb and postcode of usual residence.
- A deceased flag (D) displays if a date of death is recorded for the patient.

5.2 Patient Surname/Family Name

Upon entry of a valid patient number the patient surname/family name details will be displayed and should be checked for accuracy. It is derived from the surname field (02) on the Patient Registration Screen.

5.3 Given Names

5.3.1 First name
Upon entry of a valid patient number the patient's first name details will be displayed and should be checked for accuracy. It is derived from the given names field (03) on the Patient Registration Screen.

5.3.2 Second name
Upon entry of a valid patient number the patient's second, name details will be displayed and should be checked for accuracy. It is derived from the given names field (03) on the Patient Registration Screen.

Record the second given name or initials of the patient if available but not previously recorded.

5.4 Former Names/Alias
Derived from the number of alias names entered on the Patient Alias screen. Record any previous surname or other names that the patient or resident is now or has previously been known as. Record the complete name (first name, second name and surname).

5.5 Sex
Upon entry of a valid patient number the patient sex details will be displayed and should be checked for accuracy. It is derived from the sex field (05) on the Patient Registration Screen.

To avoid problems with edits, transsexuals undergoing a sex change operation should have their sex at the time of the hospital admission recorded.

Note that indeterminate will generally only be used for neonatal patients where the sex has not been determined.

5.6 Date of Birth
Upon entry of a valid patient number the patient's date of birth details will be displayed and should be checked for accuracy. It is derived from the date of birth field (04) on the Patient Registration Screen.

Record the date of birth of patient using the full date (i.e. ddmmyyyy) and leading zeros where necessary.

- If the day of birth is unknown, use **.
- If the month of birth is unknown, use **.
- If the year of birth is unknown, estimate the year from the age of the patient.
- If the age of the patient is unknown and it is not possible to estimate an age and hence a year of birth (e.g. for unconscious patients, use the year 1900.

Although provision is made for recording an unknown date of birth (using **/**/1900), every effort should be made during the course of the admission to determine and record the patient's actual date of birth.

5.7 Address of Usual Residence

5.7.1 Number and street of usual residence
Derived from the address fields (15 and 16) on the Patient Registration Screen. Address details should be checked for accuracy.

If necessary record the building number and street name of the usual residential address of the patient. The usual residence is where the patient lives. For example, it is not the address where the patient might be staying temporarily before or after the period of hospitalisation.

Post Office box numbers or Mail Service Numbers should not be recorded. Use a building number and street name whenever possible. Even country properties have access roads that have names.

You may use standard abbreviations, for example:

- Alley - AL
- Approach – APP
- Arcade - ARC
- Avenue – AV
- Bend - BND
- Boulevard – BVD
- Break/Brook – BR
- Broadway – BWY
- Brow – BRW
- Bypass – BPS
- Centre – CTR
- Chase – CH
- Circle – CIR
- Circuit – CCT
- Circus - CRC
- Close – CL
- Concourse – CNC
- Copse – CPS
- Corner – CNR
- Corso - CSO
- Court – CT
- Courtyard – CYD
- Cove - COV
- Crescent – CR
- Crest – CST
- Cross – CS
- Crossing – CSG
- Dale – DLE
- Downs – DN
- Drive – DR
- Edge – EDG
- Elbow – ELB
- Entrance – ENT
- Esplanade – ESP
- Expressway – EXP
- Freeway – FWY
- Retreat – RT
- Ridge – RDG
- Rise - RI
- Road – RD
- Roadway – RDY
- Route – RTE
- Frontage – FR
- Garden/s – GDN
- Gate/s – GTE
- Glade – GLD
- Glen – GLN
- Grange – GRA
- Green – GRN
- Grove - GR
- Heights - HTS
- Highway – HWY
- Junction – JNC
- Lane – LA
- Link – LK
- Loop – LP
- Mall – ML
- Meander – MDR
- Mews – MW
- Motorway – MWY
- Nook – NK
- Outlook - OUT
- Parade – PDE
- Park – PK
- Parkway – PKY
- Pass – PS
- Pathway – PWY
- Place – PL
- Plaza – PLZ
- Pocket – PKT
- Port/Point – PT
- Promenade – PRM
- Quadrant – QD
- Quay – QY
- Ramble – RA
- Reach – RCH
- Reserve – RES
- Rest – RST
- Track – TR
- Trail – TRI
- Underpass – UPS
- Vale – VA
- View – VW
- Vista – VST

• Square – SQ • Street – ST • Tarn – TN • Terrace – TCE • Tollway – TWY	• Walk – WK • Walkway – WKY • Way – WY • Wynd - WYN

5.7.2 Suburb/Town of usual residence

Derived from the suburb field (17) on the Patient Registration Screen. Address details should be checked for accuracy.

If necessary, record the location of the usual residence of the patient as the suburb or town in which the patient usually lives. Do not record the location of temporary accommodation, or a (farm) property name in this field.

Interstate and overseas patients

If the patient lives interstate, the actual suburb or town of usual residence should be recorded.

If the patient is from overseas, also record the country in which he/she normally resides.

Patients diagnosed outside Queensland, while not reported by the Registry, are recorded on the Register. This assists with identifying duplicate registrations, notifying interstate cases, and assists matching for subsequent treatment notifications.

5.7.3 Postcode of usual residence

Derived from the postcode field (18) on the Patient Registration Screen. Postcode details should be checked for accuracy.

Record the postcode of the usual residential address of the patient.

If the patient is not an Australian resident or has no fixed address, use one of the 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

5.8 Medicare Number

Derived from the Medicare number field (35) on screen 2 of the Patient Admission Screen. Medicare number details should be checked for accuracy.

If the patient is eligible for medicare, record the Medicare number from the patient's Medicare card.

If the person does not have an Australian Medicare Number or if it is not available, leave this blank.

5.9 Marital Status

Derived from the marital status field (07) on the Patient Registration Screen. Marital status details should be checked for accuracy.

Record the current marital status of the patient.

Separated means those people who are legally separated or socially separated, not persons who are temporarily living apart (e.g. construction workers living in hotels or camps).

5.10 Country of Birth

Derived from the country field (06) on the Patient Registration Screen. Country of birth details should be checked for accuracy.

Record the country of birth of the patient using the appropriate numerical codes (as found on the HBCIS reference file).

- If the patient was born in Australia, use code 1101;
- If the patient was born in New Zealand, use code 1201.

5.11 Indigenous Status

Derived from the indigenous status field (11) on the Patient Registration Screen. Indigenous status details should be checked for accuracy.

The improvement of the health of Indigenous Australians has been identified as one of the priorities in the Queensland Health Corporate Plan (1998 – 2003) Key Performance Objectives. The accurate identification of Aboriginal and Torres Strait Islander patients in Queensland Health data collections is crucial to measuring their health status and the effectiveness of intervention programs.

All persons admitted to hospital should be asked "Are you of Aboriginal or Torres Strait Islander origin?". Persons who reply "Yes" to this question should be asked to specify which origin they are of, either Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander. This question must be asked of all admitted patients. Where the patient is unable to provide this information, for example, when a baby or child is admitted to hospital, the parent or guardian should be asked whether the child is of Aboriginal or Torres Strait Islander origin.

Data providers should be aware that:

(1) Patients born outside Australia are unlikely to be of Australian indigenous status; and
(2) A person's Indigenous status can not be determined by observation.

For data accuracy, the patient, their carer, or next of kin must be asked the question directly.

5.12 Occupation

Derived from the occupation field (21) on the Patient Registration Screen. Occupation details should be checked for accuracy.

Record the patient's occupation. Ideally the Registry would like principal lifetime occupation. Only use pensioner/ housewife/retired if lifetime occupation is unable to be ascertained.

6 ADMISSION DETAILS

6.1 Admission Number (Episode Number) *

This is allocated automatically by HBCIS and it is known as the episode number. The cancer registration must be linked to a specific admission number. Only admission numbers that are valid for the patient number may be entered. The episode number must be discharged.

Upon entry of a valid admission number the following details will be displayed and should be checked for accuracy:

- The admission date.
- The discharge date (if available*).
- The treating doctor initials (if available) or given names (if initials are not available) and surname for the doctor code current at the time of discharge (or system date if undischarged*).
- The code and description for the principal diagnosis code, as assigned on the Inpatient ICD Coding screen.

It will only be possible for converted registrations to be linked to the undischarged episode. An edit on screen filing will prevent such a cancer registration from being re-filed.

6.2 Admission Date

Upon entry of an episode number that is valid for the patient number the patient's admission date details will be displayed and should be checked for accuracy. It is derived from the admission date field (62) on screen 3 of the Patient Admission Screen for the linked admission episode.

Record the full date (that is, ddmmyyyy) of admission to hospital. Use leading zeros where necessary.

6.3 Separation Date

Upon entry of an episode number that is valid for the patient number the patient's separation date details will be displayed and should be checked for accuracy. It is derived from the discharge date field (02) on the Patient Discharge Screen for the linked admission episode.

At separation, record the full date (that is, ddmmyyyy), using leading zeros where necessary. This is the date that the patient was discharged, transferred or died.

6.4 Mode of Separation (Discharge Status)

Derived from the discharge code field (04) on the Patient Discharge Screen for the linked admission episode.

The mode of separation (discharge status) indicates the place to which a patient is referred immediately following formal separation from hospital or indicates whether this is a statistical separation due to a change in the type of episode of care.

If the patient died in hospital (Code 05), please record the appropriate details for whether an autopsy was held and cause of death details.

6.5 Transferring to Facility

Derived from the destination field (06) on the Patient Discharge Screen for the linked admission episode.

Record the facility number (extended source code) for the hospital, nursing home or correctional facility to which the patient is referred as an admitted patient.

6.6 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. The doctor's initials (03), doctor's given names (05) and surname (04) from the Doctor Codes Reference File will be reported.

To assist in improving the quality of this data, all fields should be completed.

Record the hospital code to describe the individual doctor chiefly responsible for treating the patient e.g. the Senior Treating Medical Officer, Specialist or Consultant in charge of the care. This is not the registrar or resident medical officer.

6.7 Cause of Death *

If the linked admission episode is flagged as "death" (ie the patient died in the hospital) the description for the principal diagnosis code, as entered in the Inpatient ICD coding screen, is automatically displayed in this field. Check and update the text details as required.

This should be stated as per the World Health Organisation (W.H.O.) definition as:

(a) "the disease or injury which initiated the train of morbid events leading directly to death, or"

(b) " the circumstances of the accident or violence which produced the fatal injury"

Ref: International Classification of Disease - 9 (Vol. 1, p. 700)

Please only complete the cause of death if the patient dies in the hospital.

A single entry for cause of death is stored for each cancer registration, even if there are multiple primary site items.

Cause of death details will no longer be able to be recorded for patients who die after discharge from the hospital.

6.8 Autopsy Held *

Record whether an autopsy or coroners inquiry is to be/has been undertaken with a Y or N.

Please only complete the autopsy held item if the patient dies in the hospital.

A single entry for autopsy flag is stored for each cancer registration, even if there are multiple primary site items.

6.9 Diagnosis at Separation

This is derived from the first diagnosis code assigned in the ICD code field (02) on the Inpatient ICD Coding screen for the linked admission episode.

7 CANCER DETAILS

7.1 Multiple Primary Site *

This is a two digit multivalued item field, allowing entry of multiple primary sites of cancer for any single patient.

The following fields are maintained independently for each primary site and must be checked prior to filing a cancer registration as all primary sites are notified on each filing.

- Primary Site of Cancer
- Morphology
- Date of First Diagnosis
- Date of First Diagnosis Flag
- Suburb/Locality at First Diagnosis
- Postcode at First Diagnosis
- Laterality
- Basis of Diagnosis
- Reasons for Clinical Diagnosis
- Comments

7.2 Primary Site of Cancer *

A primary site is defined as the site at which a neoplasm originated. Thus, a cancer CASE includes each primary site in a cancer patient, and a patient with two primary sites is considered as being two different cases of cancer. A patient with one primary site and one or more secondary sites is one case of cancer only.

See Section 3.2 for the cancers in the scope of the collection.

Where possible be specific when coding the primary site, for example, if known, code site as "upper lobe of lung" or "upper-inner quadrant of breast".

If the initial diagnosis is a secondary tumour, report the primary tumour site if possible. This may be indicated by the morphology or clinical notes. If it is not possible to identify the primary tumour, then code the cancer as an unknown primary site.

Details such as whether the cancer has metastasised (and to which site) should be included in the comments field.
Also include details in the comments field if a more precise description exists for the cancer than can be coded in ICD-10-AM. This may include more precise topography for melanomas, connective and soft tissue sites, meninges and brain, insitu cancers, etc. The Registry codes in ICD-O and has to convert or recode the ICD-10-AM codes. Any information that can assist this process would be useful.

7.3 Morphology *

See Section 3.2 for the cancers in the scope of the collection.

The behaviour code (5^{th} digit) should relate to the primary cancer. While the Registry does not collect information on secondary sites, details such as whether the cancer has metastasised (and to which site) should be included in the comments field.

Also include details in the comments field if a more precise description exists for the type of cancer than can be coded in ICD-10-AM. This may include more precise details for lymphomas and leukaemias, etc. The Registry codes in ICD-O and records details down to the descriptor level. ICD-10-AM codes have to be converted or recoded to ICD-O. Any information that can assist this process would be useful.

7.4 Date of First Diagnosis *

Try to accurately identify the full date of original diagnosis for this cancer where possible. Where unknown, please provide best estimate and enter Y in the Estimated field. If you are unable to provide an estimate, enter 15 JUN 1900 and enter Y in the Estimated field.

7.5 Date of First Diagnosis Flag *

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.

7.6 Suburb/Locality at First Diagnosis *

Name of suburb or town of usual residence at the time of first diagnosis of this cancer. Although the field will reference the Suburb Codes Reference File, an invalid suburb may be entered. The system will accept the data as free text. This is to allow for the fact that the diagnosis may well have been some years ago and the Reference file contains only current suburbs. Extra care is therefore required for patients diagnosed prior to the current admission.

The entry of AA will be valid in the suburb field and will cause the system to automatically refresh the patient's current suburb and postcode, as displayed at the top of the screen. Use this default only when the patient is diagnosed in this admission. Do not update this field with current address details unless that is where the person lived at the time of diagnosis.

If precise details of the suburb are not known but the State is, then include 'Not stated/unknown' as the suburb descriptor and the relevant default State supplementary postcode. This enables us to identify cases diagnosed outside Queensland.

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
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

7.7 Postcode at First Diagnosis *

Australian postcode corresponding to address of usual residence at the time of first diagnosis of cancer. 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.

Do not update this field with current address details unless that is where the person lived at the time of diagnosis.

If precise details of the postcode are not known but the State is, then use the relevant default State supplementary postcode. This enables us to identify cases diagnosed outside Queensland.
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
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

7.8 Laterality of Cancer *

Where possible, for cancers of paired organs, such as Breast (C50), Lung (C34), Kidney (C64), Ovary (56), Eyes (C69), Arms (C76.4, C44.6, C49.1, C47.1, C40.0, C77.3), Legs (C76.5, C44.7, C49.2, C47.2, C40.2, C77.4), Ears (C44.2, C49.0, C30.1), Testicles (C62) indicate the side affected by the tumour.

The valid inputs are:

L	Left
R	Right
B	Bilateral
U	Unknown
N	Not applicable

Bilateral cancers are extremely rare. Includes organs that are bilateral as a single primary (e.g. bilateral retinoblastoma (M9510/3, C69.2), (M9511/3, C69.2), (M9512/3, C69.2), (C69.6, C48.0), bilateral Wilms tumours (C64.9, M8960/3)).

Unknown: It is unknown whether, for a paired organ, the origin of the cancer was on the left or right side of the body.

Not applicable is the default value. This should be recorded for all non-paired organ sites.

7.9 Basis of Diagnosis *

Refers to the most valid basis of diagnosis AT THIS ADMISSION. The following notes may assist.

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.

1. **Unknown**

Usually refers to a tumour which was diagnosed and treated elsewhere and the current hospital has no information regarding that treatment. This code would only apply if the current admission is unrelated to the cancer (ie a history of cancer only admission). Please provide details explaining unknown codes in the comments field. Any indication of where the person was diagnosed would avoid further follow-up.

2. **Clinical only**
When a tumour has been diagnosed by clinical examination (eg palpation) only at this admission or where the tumour has been diagnosed at a previous admission or different hospital and the diagnosis is supported only by clinical evidence at this admission.

3. **Clinical investigations**
When a tumour is diagnosed at this admission without invasive surgical procedures but may include diagnostic radioscopy and endoscopy.

4. **Exploratory surgery**
When a tumour is diagnosed at this admission by exploratory surgery without biopsy and histology. Include here an incidental autopsy finding of cancer without biopsy and histology.

5. **Specific biochemical or immunological testing**
Tumour diagnosed using particular laboratory techniques only, eg. Prostate specific antigen (PSA) for prostate.

6. **Cytology or haematology**
Tumour diagnosed using particular laboratory techniques only, eg. Fine needle aspiration without biopsy.

7. **Histology of metastasis**
When a histology is performed on a tissue sample of secondary tumour. Please identify the primary tumour if possible.

8. **Histology of primary**
When histology is performed on a tissue sample of primary tumour.

9. **Autopsy and histology**
When histology is performed on a tissue sample taken during an autopsy.

7.10 Reasons for Clinical Diagnosis *

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. This item has been designed to reduce the number of queries back to hospitals. Multiple reasons may be completed. 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	Doctor's Notes/Referral (Provide doctor details)
03	Previous Pathology (Provide laboratory details)
04	Radiological Investigation (Specify investigation details)
05	Other Non-invasive Investigation (Specify investigation details)
06	Invasive Investigation (Specify investigation details)
07	Non Cancer Admission (Specify details)
09	Other (Specify details)

Patients with a clinical admission for chemotherapy should be recorded with a code 09 and chemotherapy specified.

7.11 Details for Clinical Diagnosis *
This free text field allows the user to provide the relevant details as outlined above in Reasons for Clinical Diagnosis.

7.12 Comments *

This free text field allows the user to provide any other relevant details regarding the cancer that may assist the registry staff or reduce queries for the hospital.

This may include a more precise description of the cancer than is able to be coded in ICD-10-AM. Also include any indication as to whether the cancer has metastasised and to which site.

Where possible, specify grading or differentiation - that is:

1	Grade I	(Well) differentiated
2	Grade II	Moderately (well) differentiated
3	Grade III	Poorly differentiated
4	Grade IV	Undifferentiated, anaplastic

7.13 Laboratory Facility Number *

This field becomes 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

7.14 Laboratory Specimen Number *

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.

7.15 Registration Filed By *

The user details are kept when the registration is filed.

7.16 Filed by Date *

The date that the registration was completed. Before registrations are filed, please check to see all relevant details are filled in correctly.

Appendix A –Public HBCIS Hospitals Required to Report Cancer to QCR

CODE	FACILITY NAME Affiliation
00131	ALPHA HOSPITAL
00151	ARAMAC HOSPITAL
00211	ATHERTON HOSPITAL
00111	AUGATHELLA HOSPITAL
00230	AURUKUN PRIMARY HEALTH CARE CENTRE
00191	AYR HOSPITAL
00212	BABINDA HOSPITAL
00213	BAMAGA HOSPITAL
00132	BARALABA HOSPITAL

00152 BARCALDINE HOSPITAL
00041 BEAUDESERT HOSPITAL
00061 BIGGENDEN HOSPITAL
00133 BILOELA HOSPITAL
00153 BLACKALL HOSPITAL
00134 BLACKWATER HOSPITAL
00902 BLUFF OUTPATIENTS CLINIC Outpost of Blackwater Hospital
00903 BOLLON OUTPATIENTS CLINIC Outpost of St George Hospital
00042 BOONAH HOSPITAL
00154 BOULIA PRIMARY HEALTH CENTRE
00192 BOWEN HOSPITAL
00062 BUNDABERG BASE HOSPITAL
00241 BURKETOWN HEALTH CENTRE
00030 CABOOLTURE HOSPITAL
00214 CAIRNS BASE HOSPITAL
00043 CALOUNDRA HOSPITAL
00242 CAMOOWEAL HEALTH CENTRE
00905 CAPELLA OUTPATIENTS CLINIC Outpost of Emerald Hospital
00112 CHARLEVILLE HOSPITAL
00193 CHARTERS TOWERS HOSPITAL
00063 CHERBOURG HOSPITAL
00064 CHILDERS HOSPITAL
00215 CHILLAGOE HOSPITAL
00091 CHINCHILLA HOSPITAL
00171 CLERMONT HOSPITAL
0243 CLONCURRY HOSPITAL
00255 COEN PRIMARY HEALTH CARE CENTRE
00194 COLLINSVILLE HOSPITAL
00216 COOKTOWN HOSPITAL
00907 CRACOW OUTPATIENTS CLINIC Outpost of Theodore Hospital
00217 CROYDON HOSPITAL
00113 CUNNAMULLA HOSPITAL
00251 DAJARRA OUTPATIENTS CENTRE Outpost of Mt Isa Hospital
00092 DALBY HOSPITAL
00908 DIMBULAH HOSPITAL Outpost of Mareeba Hospital
00909 DINGO OUTPATIENTS CLINIC Outpost of Blackwater Hospital
00114 DIRRANBANDI HOSPITAL
00252 DOOMADGEE HOSPITAL
00910 DUARINGA OUTPATIENTS CLINIC Outpost of Rockhampton Hospital
00025 DUNWICH OUTPATIENTS CENTRE Outpost of Redland Hospital
00176 DYSART HOSPITAL
00065 EIDSVOLD HOSPITAL
00135 EMERALD HOSPITAL
00044 ESK HOSPITAL
00218 FORSAYTH HOSPITAL
00045 GATTON HOSPITAL
00066 GAYNDAH HOSPITAL
00940 GEMFIELDS OUTPATIENTS CLINIC Outpost of Emerald Hospital
00219 GEORGETOWN COMMUNITY HOSPITAL
00067 GIN GIN HOSPITAL
00136 GLADSTONE HOSPITAL
00912 GLENMORGAN OUTPATIENTS CLINIC Outpost of Surat Hospital
00050 GOLD COAST HOSPITAL
00093 GOONDIWINDI HOSPITAL

00220	GORDONVALE HOSPITAL
00068	GYMPIE HOSPITAL
00221	HERBERTON HOSPITAL
00069	HERVEY BAY HOSPITAL
00195	HOME HILL HOSPITAL
00231	HOPEVALE MEDICAL CENTRE Outpost of Cooktown Hospital
00244	HUGHENDEN HOSPITAL
00196	INGHAM HOSPITAL
00094	INGLEWOOD HOSPITAL
00115	INJUNE HOSPITAL
00222	INNISFAIL HOSPITAL
00015	IPSWICH HOSPITAL
00160	ISISFORD PRIMARY HEALTH CENTRE Outpost of Blackall Hospital
00939	ISLAND MEDICAL CENTRE Outpost of Thursday Island Hospital. Comprises outposts of Badu, Boigu,Coconut, Darnley, Dauan, Kubin, Mabuiag, Moa (St. Paul's Village), Murray,Saibai, Stephen, Warreber, Yam and Yorke Islands in the Torres Strait.
00095	JANDOWAE HOSPITAL
00914	JERICHO BUSH NURSES ASSOCIATION Outpost of Alpha Hospital
00197	JOYCE PALMER HEALTH SERVICE (WAS PALM ISLAND HOSPITAL)
00245	JULIA CREEK HOSPITAL
00155	JUNDAH PRIMARY HEALTH CENTRE Outpost of Longreach Hospital
00250	KARUMBA HEALTH CENTRE Outpost of Normanton Hospital
00026	KEPERRA HOSPITAL
00046	KILCOY HOSPITAL
00070	KINGAROY HOSPITAL
00199	KIRWAN HOSPITAL FOR WOMEN
00253	KOWANYAMA COMMUNITY HOSPITAL
00047	LAIDLEY HOSPITAL
00915	LAURA OUTPATIENTS CLINIC Outpost of Cairns Hospital
00233	LOCKHART RIVER PRIMARY HEALTH CARE CENTRE
00029	LOGAN HOSPITAL
00156	LONGREACH HOSPITAL
00172	MACKAY BASE HOSPITAL
00916	MAGNETIC ISLAND HEALTH SERVICE CENTRE Outpost of Townsville Hospital
00928	MALAKOOLA PRIMARY HEALTH CARE CENTRE Outpost of Weipa Hospital
00917	MALANDA OUTPATIENTS CLINIC Outpost of Atherton Hospital
00048	MALENY HOSPITAL
00965	MAPOON HEALTH CENTRE
00223	MAREEBA HOSPITAL
00918	MARLBOROUGH OUTPATIENTS CLINIC Outpost of Rockhampton Hospital
00071	MARYBOROUGH HOSPITAL
00001	MATER MISERICORDIAE PUBLIC ADULT HOSPITAL
00002	MATER MISERICORDIAE PUBLIC CHILDREN'S HOSPITAL
00003	MATER MISERICORDIAE PUBLIC MOTHER'S HOSPITAL
00919	MEANDARRA OUTPATIENTS CLINIC Outpost of Tara Hospital
00097	MILES HOSPITAL
00920	MILLAA MILLAA OUTPATIENTS CLINIC Outpost of Atherton Hospital
00098	MILLMERRAN HOSPITAL
00116	MITCHELL HOSPITAL
00072	MONTO HOSPITAL
00935	MOONIE OUTPATIENTS CLINIC Outpost of Tara Hospital

00173	MORANBAH HOSPITAL
00249	MORNINGTON ISLAND HOSPITAL
00224	MOSSMAN HOSPITAL
00225	MOUNT GARNET OUTPATIENTS CLINIC Outpost of Atherton Hospital
00246	MOUNT ISA BASE HOSPITAL
00139	MOUNT MORGAN HOSPITAL
00073	MOUNT PERRY HEALTH CENTRE
00140	MOURA HOSPITAL
00074	MUNDUBBERA HOSPITAL
00117	MUNGINDI HOSPITAL
00075	MURGON HOSPITAL
00157	MUTTABURRA PRIMARY HEALTH CENTRE Outpost of Longreach Hospital
00049	NAMBOUR GENERAL HOSPITAL
00076	NANANGO HOSPITAL
00247	NORMANTON HOSPITAL
00099	OAKEY HOSPITAL
00922	OGMORE OUTPATIENTS CLINIC Outpost of Rockhampton Hospital
00254	PORMPURAAW PRIMARY HEALTH CENTRE
00004	PRINCE CHARLES (THE) HOSPITAL
00011	PRINCESS ALEXANDRA HOSPITAL
00174	PROSERPINE HOSPITAL
00022	QUEEN ELIZABETH II JUBILEE HOSPITAL
00118	QUILPIE HOSPITAL
00924	RAVENSHOE OUTPATIENTS CLINIC Outpost of Atherton Hospital
00016	REDCLIFFE HOSPITAL
00028	REDLAND HOSPITAL
00248	RICHMOND HOSPITAL
00017	RIVERTON CENTRE (CLAYFIELD)
00141	ROCKHAMPTON BASE HOSPITAL
00119	ROMA HOSPITAL
00005	ROYAL BRISBANE HOSPITAL (INCL ROSEMOUNT)
00007	ROYAL CHILDREN'S HOSPITAL
00009	ROYAL WOMEN'S HOSPITAL
00959	SANDGATE MEDICAL & DENTAL CLINIC Outpost of Royal Brisbane Hospital/Keperra Hospital
00175	SARINA HOSPITAL
00960	SESIA HEALTH CENTRE Outpost of Bamaga Hospital
00142	SPRINGSURE HOSPITAL
00120	ST GEORGE HOSPITAL
00926	ST LAWRENCE OUTPATIENTS CLINIC Outpost of Rockhampton Hospital
00100	STANTHORPE HOSPITAL
00121	SURAT HOSPITAL
00158	TAMBO PRIMARY HEALTH CENTRE Outpost of Blackall Hospital
00101	TARA HOSPITAL
00102	TAROOM HOSPITAL
00103	TEXAS HOSPITAL
00122	THARGOMINDAH HOSPITAL Outpost of Cunnamulla Hospital
00143	THEODORE HOSPITAL
00226	THURSDAY ISLAND PRIMARY HEALTH CENTRE
00104	TOOWOOMBA HOSPITAL
00198	TOWNSVILLE HOSPITAL
00200	THE TOWNSVILLE HOSPITAL
00227	TULLY HOSPITAL
00962	UMAGICO HEALTH CENTRE Outpost of Bamaga Hospital

00123 WALLUMBILLA HOSPITAL Outpost of Roma Hospital
00106 WANDOAN HOSPITAL Outpost of Miles Hospital
00105 WARWICK HOSPITAL
00228 WEIPA HOSPITAL
00162 WINDORAH CLINIC Outpost of Longreach Hospital
00159 WINTON HOSPITAL
00077 WONDAI HOSPITAL
00145 WOORABINDA HOSPITAL
00232 WUJAL WUJAL COMMUNITY HOSPITAL
00024 WYNNUM HOSPITAL
00161 YARAKA CLINIC Outpost of Blackall Hospital
00229 YARRABAH HOSPITAL
00144 YEPPOON HOSPITAL

Public Psychiatric Hospitals

CODE	**FACILITY NAME Affiliation**
00701	BAILLIE HENDERSON HOSPITAL
00715	KIRWAN REHABILITATION UNIT
00750	WOLSTON PARK HOSPITAL COMPLEX

Appendix B – File Formats

All fields are to be provided in the extract in the format specified in the Requested Format column, unless otherwise stated in the Source/Description column. The files will be supplied in ascii comma delimited format with double quotes as a text delimiter. Field 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.

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 reported.
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.

Cancer Admission Details (CAD) File

Data Item	Requested Format	Source/Description
Patient Identifier	8 char Right adjusted and zero filled from left	Derived from the patient number field (01) on the Cancer Registration screen.
Admission Number	12 char Right adjusted and zero filled from left	Derived from the admission number field (02) on the Cancer Registration screen. Maximum length in HOMER is 4 digits and therefore, will be zero filled to 12 digits. The admission number that is currently linked to the cancer registration at the time of creating the extract file will be reported.
Multiple Primary Site Count	2 num Right adjusted and zero filled from left	Derived from the primary site field (05) on the Cancer Registration screen. The total number of primary sites for the cancer registration (ie. 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	Derived from the Medicare number field (35) on screen 2 of the Patient Admission screen. The field will not be zero or space filled.
Patient Surname	24 char	Derived from the surname field (02) on the Patient Registration screen. Maximum length in HOMER is 23 characters. The field will not be zero or space filled. . Double quotes will be used as a text delimiter.
Patient First name	15 char Blank if null	Derived from the given names field (03) on the Patient Registration screen. If more than one given name is entered on the Patient Registration screen, then only the first name will be used to populate the patient first name field in the CAD record. The second and subsequent given names entered on the Patient Registration screen will be used to populate the patient second name field in the CAD record. The patient's first name will be assumed to start at character 1 and finish where the first space is entered. The second and subsequent names will be assumed to start after the first space. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Patient Second name	15 char Blank if null	Derived from the given names field (03) on the Patient Registration screen. Refer to patient first name field (above) for further details. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Address of Usual Residence	50 char Blank if null	Derived from the address fields (15 and 16) on the Patient Registration screen. Only the address with the highest priority address type code (eg. 0 or 1) will be reported. The data

Data Item	Requested Format	Source/Description
		from the two 25 character address fields will be merged into the one 50 character field in the extract. . Unnecessary spaces after the data value in both fields will be stripped. The field will not be zero or space filled. Double quotes will be used as a text delimiter. The address will be reported as entered in these fields for the highest priority address type (eg. with text "PO Box 123" or "Windsor House, 18 Lea St" etc.)
Location (suburb/ town) of Usual Residence	40 char	Derived from the suburb field (17) on the Patient Registration screen. Maximum length in HOMER is 25 characters. The field will not be zero or space filled. Double quotes will be used as a text delimiter
Postcode of Usual Residence	4 num	Derived from the postcode field (18) on the Patient Registration screen. There will be no translation of this data before inclusion in the extract file. Therefore, supplementary codes (eg. 9399 = overseas – other or 9989 = no fixed address) will only be reported if entered as such on the Patient Registration screen. The field will not be zero or space filled.
Date of Birth	9 date ddmmmctyy	Derived from the date of birth field (04) on the Patient Registration screen. If the patient's DOB is estimated (ie. entered with asterisks), then it will be reported in the extract file as displayed on the Patient Registration screen, with ** for the day and/or *** for the month. (The year can not be entered as asterisks in HOMER.)
Occupation (before retirement) Description	50 char Left adjusted, blank if null	Derived from the occupation field (21) on the Patient Registration screen. Maximum length in HOMER is 26 characters. The field will not be zero or space filled. Double quotes will be used as a text delimiter. There will be no translation of this data before inclusion in the extract file.
Sex	1 char	Derived from the sex field (05) on the Patient Registration screen. There will be no translation of this data before inclusion in the extract file.
Country of Birth Code	4 num Right adjusted and zero filled from left	Derived from the country field (06) on the Patient Registration screen. There will be no translation of this data before inclusion in the extract file.
Marital Status	2 char	Derived from the marital status field (07) on the Patient Registration screen. There will be no translation of this data before inclusion in the extract file. The field will not be zero or

Data Item	Requested Format	Source/Description
		space filled.
Indigenous Status	2 num	Derived from the indigenous status field (11) on the Patient Registration screen. There will be no translation of this data before inclusion in the extract file. The field will not be zero or space filled.
Admission Date	9 date ddmmmctyy	Derived from the admission date field (62) on screen 3 of the Patient Admission screen, for the linked admission episode.
Separation Date	9 date ddmmmctyy	Derived from the discharge date field (02) on the Patient Discharge screen, for the linked admission episode.
Mode of Separation	4 char	Derived from the discharge code field (04) on the Patient Discharge screen, for the linked admission episode. There will be no translation of this data before inclusion in the extract file. The field will not be zero or space filled.
Transferring to Facility	5 char	Derived from the destination field (06) on the Patient Discharge screen, for the linked admission episode, if available. There will be no translation of this data before inclusion in the extract file. The field will not be zero or space filled.
Autopsy Flag	1 char Blank if null	Derived from the autopsy held field (03) on the new Cancer Registration screen, if available.
Cause of Death	50 char Left adjusted, blank if null	Derived from the cause of death field (04) on the new Cancer Registration screen, if available. 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, blank if null	Derived from the code entered in the treating doctor field (75) on screen 3 of the Patient Admission screen, for the linked admission episode. The doctor's title as defined in field 02 in the Doctor Codes Reference File (if available) is reported. 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, blank if null	Derived from the code entered in the treating doctor field (75) on screen 3 of the Patient Admission screen, for the linked admission episode. The doctor's initials as defined in field 03 in the Doctor Codes Reference File (if available) are reported. 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, blank if	Derived from the code entered in the treating doctor field (75) on screen 3 of the Patient

Data Item	Requested Format	Source/Description
	null	Admission screen, for the linked admission episode. The doctor's given names as defined in field 05 in the Doctor Codes Reference File (if available) are reported. 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	Derived from the code entered in the treating doctor field (75) on screen 3 of the Patient Admission screen, for the linked admission episode. The doctor's surname as defined in field 04 in the Doctor Codes Reference File (if available) is reported. 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	Derived from the first diagnosis code, as assigned in the ICD code field (02) on the Inpatient ICD Coding screen for the linked episode. If a prefix is assigned to the code (eg. "P") this will be stripped prior to reporting, however, the first alpha character of the actual code will not be stripped. Punctuation will not be stripped from the code. The field will not be zero or space filled.

Cancer Details (CAN) File

Data Item	Requested Format	Source/Description
Patient Identifier	8 char Right adjusted and zero filled from left	Derived from the patient number field (01) on the Cancer Registration screen
Admission Number	12 char Right adjusted and zero filled from left	Derived from the admission number field (02) on the Cancer Registration screen. Maximum length in HOMER is 4 digits and therefore, will be zero filled to 12 digits. The admission number that is currently linked to the cancer registration at the time of creating the extract file will be reported.
Multiple Primary Site Number	2 num Right adjusted and zero filled from left	Derived from the primary site field (05) on the Cancer Registration screen. Each primary site for the cancer registration (ie. for the patient) will be reported in a separate CAN record. Therefore, the patient may have one or many CAN records.
Primary Site of Cancer Code	9 char Left adjusted	Derived from the primary site code field (06) for that primary site item, on the new Cancer Registration screen. Punctuation will not be stripped from the code. The field will not be zero or space filled.
Primary Site of Cancer Description	40 char Left adjusted	Derived from the code entered in the primary site code field (06) on the new Cancer Registration screen. The description as defined in field 02 in the Primary Site of Cancer Codes Reference File is reported. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Morphology Code	7 char	Derived from the morphology field (07) on the new Cancer Registration screen. Punctuation will not be stripped from the code. The field will not be zero or space filled.
Date of First Diagnosis	9 date ddmmmctyy	Derived from the date of first diagnosis field (09) on the new Cancer Registration screen. If the date is unknown, the users will be required to enter 15 JUN 1900 in this field. There will be no conversion of this data before inclusion in the extract file.
Date of First Diagnosis Flag	1 char Blank if null	Derived from the estimated field (10) on the new Cancer Registration screen.
Location (suburb/ town) of usual residence at diagnosis	40 char	Derived from the suburb at 1st diagnosis field (11) on the new Cancer Registration screen. Maximum length in HOMER is 25 characters. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

Data Item	Requested Format	Source/Description
Postcode of Usual Residence at Diagnosis	4 num	Derived from the postcode field (12) on the new Cancer Registration screen There will be no translation of this data before inclusion in the extract file. Therefore, supplementary codes (eg. 9399 = overseas – other or 9989 = no fixed address) will only be reported if entered as such on the Cancer Registration screen. The field will not be zero or space filled.
Laterality of Cancer	1 char	Derived from the laterality field (08) on the new Cancer Registration screen. There will be no translation of this data before inclusion in the extract file.
Basis of Diagnosis	2 num	Derived from the basis of diagnosis field (13) on the new Cancer Registration screen. There will be no translation of this data before inclusion in the extract file. The field will not be zero or space filled.
Comments	50 char Left adjusted, blank if null	Derived from the comments field (19) on the new Cancer Registration screen. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Laboratory Facility No.	2 char	Derived from the comments field (17) on the new Cancer Registration screen. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Laboratory Specimen No.	50 char	Derived from the comments field (18) on the new Cancer Registration screen. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

Former/Alias Names (FAN) File

Data Item	Requested Format	Source/Description
Patient Identifier	8 char Right adjusted and zero filled from left	Derived from the patient number field (01) on the Cancer Registration screen.
Admission Number	12 char Right adjusted and zero filled from left	Derived from the admission number field (02) on the Cancer Registration screen. Maximum length in HOMER is 4 digits and therefore, will be zero filled to 12 digits. The admission number that is currently linked to the cancer registration at the time of creating the extract file will be reported.
Former/Alias Name Identifier	2 num Right adjusted and zero filled from left	Derived from the number of alias names entered on the Patient Alias screen. 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 in HOMER 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 at the time of creating the extract will be reported, regardless of the admission episode number reported. As above, the admission episode number that is reported will be the episode that is linked to the cancer registration at the time of creating the extract.
Patient Surname	24 char Left adjusted	Derived from the alias surname field (02) for that alias item, on the Patient Alias screen. Maximum length in HOMER is 23 characters. The field will not be zero or space filled. Double quotes will be used as a text delimiter.
Patient First Name	15 char Left adjusted	Derived from the alias given names field (03) for that alias item, on the Patient Alias screen. If more than one given name is entered for that alias item, then only the first name will be used to populate the patient first name field in the FAN record. The second and subsequent given names entered for that alias item will be used to populate the patient second name field in the FAN record. The patient's first name will be assumed to start at character 1 and finish where the first space is entered. The second and subsequent names will be assumed to start after the first space. 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 Second Name	15 char Left adjusted	Derived from the alias given names field (03) for that alias item, on the Patient Alias screen. Refer to patient first name field (above) for further details. The field will not be zero or space filled. Double quotes will be used as a text delimiter.

Reason for Clinical Diagnosis (CDX) File

Data Item	Requested Format	Source/Description
Patient Identifier	8 char Right adjusted and zero filled from left	Derived from the patient number field (01) on the Cancer Registration screen.
Admission Number	12 char Right adjusted and zero filled from left	Derived from the admission number field (02) on the Cancer Registration screen. Maximum length in HOMER is 4 digits and therefore, will be zero filled to 12 digits. The admission number that is currently linked to the cancer registration at the time of creating the extract file will be reported.
Multiple Primary Site Number	2 num Right adjusted and zero filled from left	Derived from the primary site field (05) on the Cancer Registration screen, for the reason for clinical diagnosis being reported. 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	Derived from the code field (15) for the reason for clinical diagnosis item being reported. There will be no translation of this data before inclusion in the extract file. The field will not be zero or space filled.
Reasons for clinical diagnosis text	50 char Blank if reasons for clinical diagnosis code = 01	Derived from the details field (16) for the reason for clinical diagnosis item being reported, if available. Functionality in the new Cancer Registration screen will force the entry of the details when relevant for the reason for clinical diagnosis code/s. Therefore, the extract will not include any functionality to include or exclude details based upon the code. 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.

Appendix C – Public HBCIS Hospital Notification Form Example

QUEENSLAND CANCER REGISTRY – HBCIS FORM
CANCER REGISTRATION REGULATIONS, PUBLIC Health Act 2005

1	Name of Hosp/Inst	12345 iSOFT General Hosp
2	Medicare Number	XXXXXXXXXX
3	UR Number	0000000001
4	Surname	X
5	Given Name(s)	X
6	Date of Birth	XX XXX XXXX
7	Estimated?	N
8	Former Names/Alias	XXXXXXXX XXXXX
9	No. and Street	X/XX XXXXXXXXX TCE
10		XXXXXXXX HOUSE
11	Suburb/Locality	XXXXXX
12	Postcode	4010
13	Occupation	XXXXXXXXXXX
14	Sex	F FEMALE
15	Country of Birth	1100 AUSTRALIA NOS
16	Marital Status	NM NEVER MARRIED
17	Indigenous Status	14 NOT INDIGENOUS
18	Date of Admission	XX XXX 2001
19	Date of Separation	XX XXX 2001
20	Separation Mode	01 HOME/USUAL RESIDENCE
21	Transfer Destination	
22	Diag at Separation	B05.9 MEASLES WITHOUT COMPLICATION
23	Treating Doctor	DR XXXXXXXXX
24	Autopsy Held?	
25	Cause of Death	
26	Multiple Primary Sites	Y
27	Primary Site 1	C18.4 MALIGNANT NEOPLASM OF TRANSVERSE COLON
28	Morphology	M8140/3 ADENOCARCINOMA NOS
29	Date of 1st Diagnosis	XX XXX 1996
30	Estimated?	N
31	Suburb at 1st Diag	XXXXXX
32	Postcode at 1st Diag	4010
33	Laterality	N Not Applicable
34	Basis of Diagnosis	03 CLINICAL INVESTIGATION
35	Reasons for Clin Diag	02 DOCTOR'S NOTES/REFERRAL
36	Details	ADENOCARCINOMA DOCUMENTED IN REFERRAL LTR FROM GP
35	Reasons for Clin Diag	01 PALLIATIVE CARE ADMISSION
36	Details	
35	Reasons for Clin Diag	04 RADIOLOGICAL INVESTIGATION
36	Details	ULTRASOUND OF ABDOMEN NOTED LARGE NEOPLASM
37	Comments	NO FURTHER DETAILS AVAILABLE

QUEENSLAND CANCER REGISTRY – HBCIS FORM
CANCER REGISTRATION REGULATIONS, Public Health Act 2005

1	Name of Hosp/Inst	12345 iSOFT General Hosp
2	Medicare Number	XXXXXXXXXXXX
3	UR Number	0000000001
4	Surname	XXXXXXXX
5	Given Name(s)	XXXXXX
6	Date of Birth	XX XXX XXXX
7	Estimated?	N
27	Primary Site 2	C45.0 MESOTHELIOMA OF PLEURA
28	Morphology	M9050/3 MESOTHELIOMA, MALIGNANT
29	Date of 1st Diagnosis	XX XXX 1990
30	Estimated?	N
31	Suburb at 1st Diag	XXXXXXXXXXX
32	Postcode at 1st Diag	4012
33	Laterality	L LEFT
34	Basis of Diagnosis	06 CYTOLOGY OR HAEMATOLOGY
35	Reasons for Clin Diag	
36	Details	
37	Lab. Facility No.	[2] 30XXXXXXXXXXXXXXXXX
38	Lab. Specimen No.	[50XXXXXXXXXXXXXXXXXXXXX
39	Comments	
40	Registration Filed By	JSJ XXXXXX
41	Date	XX XXX 2001

APPENDIX D – HBCIS TRAINING MANUAL

APPENDIX E - LIST OF ICD-10-AM SITE CODES REQUIRED BY THE QCR

All Hospitals are required to notify QCR for the following:

- All invasive cancers
- All cancers with an uncertain behaviour
- All in-situ conditions
- Benign central nervous system and brain tumours

- Do not need Basal Cell Carcinomas and Squamous Cell Carcinomas of the Skin.

A prompt appears if any of the following required ICD10-AM v4 Site Codes are entered on the screen. These Site codes follow the cancers required to be sent to the registry eg. invasive, in-situ etc. as above.

ICD-AM-10 version 4 Site Codes

Site	*Description*
C00.0	MALIGNANT NEOPLASM OF EXTERNAL UPPER LIP
C00.1	
C00.2	MALIGNANT NEOPLASM EXTERNAL LIP NOS
C00.3	MALGT NEOPLASM UPPER LIP INNER ASPECT
C00.4	MALGT NEOPLASM LOWER LIP INNER ASPECT
C00.5	MALGT NEOPLASM LIP NOS INNER ASPECT
C00.6	MALIGNANT NEOPLASM OF COMMISSURE OF LIP
C00.8	OVERLAPPING MALIGNANT LESION OF LIP
C00.9	MALIGNANT NEOPLASM OF LIP UNSPECIFIED
C01	MALIGNANT NEOPLASM OF BASE OF TONGUE
C02.0	MALGT NEOPLASM DORSAL SURFACE OF TONGUE
C02.1	MALIGNANT NEOPLASM OF BORDER OF TONGUE
C02.2	MALGT NEOPLASM VENTRAL SURFACE TONGUE
C02.3	MALGT NEOPLASM ANT TONGUE PART UNSPEC
C02.4	MALIGNANT NEOPLASM OF LINGUAL TONSIL
C02.8	MALGT NEOPLASM OVERLAPPING LESION TONGUE
C02.9	MALIGNANT NEOPLASM TONGUE UNSPECIFIED
C03.0	MALIGNANT NEOPLASM OF UPPER GUM
C03.1	MALIGNANT NEOPLASM OF LOWER GUM
C03.9	MALIGNANT NEOPLASM OF GUM UNSPECIFIED
C04.0	MALIGNANT NEOPLASM ANT FLOOR OF MOUTH
C04.1	MALIGNANT NEOPLASM LAT FLOOR OF MOUTH
C04.8	OVERLAPPING MALGT LESION FLOOR OF MOUTH
C04.9	MALGT NEOPLASM OF FLOOR OF MOUTH NOS
C05.0	MALIGNANT NEOPLASM OF HARD PALATE
C05.1	MALIGNANT NEOPLASM OF SOFT PALATE
C05.2	MALIGNANT NEOPLASM OF UVULA
C05.8	OVERLAPPING MALIGNANT LESION OF PALATE
C05.9	MALIGNANT NEOPLASM OF PALATE UNSPECIFIED
C06.0	MALIGNANT NEOPLASM OF CHEEK MUCOSA

C06.1	MALIGNANT NEOPLASM OF VESTIBULE OF MOUTH
C06.2	MALIGNANT NEOPLASM OF RETROMOLAR AREA
C06.8	OVERLAP MALGT LESION OTH/UNSPEC MOUTH
C06.9	MALIGNANT NEOPLASM OF MOUTH UNSPECIFIED
C07	MALIGNANT NEOPLASM OF PAROTID GLAND
C08.0	MALIGNANT NEOPLASM SUBMANDIBULAR GLAND
C08.1	MALIGNANT NEOPLASM OF SUBLINGUAL GLAND
C08.8	OVERLAPPING MALGT LESION MAJOR SAL GLD
C08.9	MALGT LESION MAJOR SALIVARY GLAND NOS
C09.0	MALIGNANT NEOPLASM OF TONSILLAR FOSSA
C09.1	MALGT NEOPLASM TONSILLAR PILLAR
C09.8	OVERLAPPING MALIGNANT LESION OF TONSIL
C09.9	MALIGNANT NEOPLASM TONSIL UNSPECIFIED
C10.0	MALIGNANT NEOPLASM OF VALLECULA
C10.1	MALGT NEOPLASM ANT SURFACE EPIGLOTTIS
C10.2	MALIGNANT NEOPLASM LAT WALL OROPHARYNX
C10.3	MALIGNANT NEOPLASM POST WALL OROPHARYNX
C10.4	MALIGNANT NEOPLASM OF BRANCHIAL CLEFT
C10.8	OVERLAPPING MALIGNANT LESION OROPHARYNX
C10.9	MALIGNANT LESION OROPHARYNX UNSPECIFIED
C11.0	MALGT NEOPLASM SUPERIOR WALL NASOPHRYNX
C11.1	MALIGNANT NEOPLASM POST WALL NASOPHARYNX
C11.2	MALIGNANT NEOPLASM LAT WALL NASOPHARYNX
C11.3	MALIGNANT NEOPLASM ANT WALL NASOPHARYNX
C11.8	OVERLAPPING MALGT NEOPLASM NASOPHARYNX
C11.9	MALIGNANT NEOPLASM NASOPHARYNX NOS
C12	MALIGNANT NEOPLASM OF PYRIFORM SINUS
C13.0	MALIGNANT NEOPLASM OF POSTCRICOID REGION
C13.1	MALGT NEOPLM HYPOPHRNGL ARYEPIGLTC FOLD
C13.2	MALIGNANT NEOPLASM POST WALL HYPOPHARYNX
C13.8	OVERLAPPING MALIGNANT LESION HYPOPHARYNX
C13.9	MALIGNANT LESION HYPOPHARYNX UNSPECIFIED
C14.0	MALIGNANT NEOPLASM PHARYNX UNSPECIFIED
C14.2	MALIGNANT NEOPLASM OF WALDEYER'S RING
C14.8	OVERLAP MALGT NEOPLM LIP ORAL CV PHRYNX
C15.0	MALIGNANT NEOPLASM CERVICAL OESOPHAGUS
C15.1	MALIGNANT NEOPLASM THORACIC OESOPHAGUS
C15.2	MALIGNANT NEOPLASM ABDOMINAL OESOPHAGUS
C15.3	MALGT NEOPLASM UPPER THIRD OESOPHAGUS
C15.4	MALGT NEOPLASM MIDDLE THIRD OESOPHAGUS
C15.5	MALGT NEOPLASM LOWER THIRD OESOPHAGUS
C15.8	OVERLAPPING MALIGNANT LESION OESOPHAGUS
C15.9	MALIGNANT LESION OESOPHAGUS UNSPECIFIED
C16.0	MALIGNANT NEOPLASM OF CARDIA
C16.1	MALIGNANT NEOPLASM OF FUNDUS OF STOMACH
C16.2	MALIGNANT NEOPLASM OF BODY OF STOMACH
C16.3	MALIGNANT NEOPLASM OF PYLORIC ANTRUM
C16.4	MALIGNANT NEOPLASM OF PYLORUS
C16.5	MALGT NEOPLASM LESSER CURVE STOMACH NOS
C16.6	MALGT NEOPLASM GREATER CURVE STOMACH NOS
C16.8	OVERLAPPING MALIGNANT LESION OF STOMACH
C16.9	MALIGNANT NEOPLASM STOMACH UNSPECIFIED
C17.0	MALIGNANT NEOPLASM OF DUODENUM

C17.1	MALIGNANT NEOPLASM OF JEJUNUM
C17.2	MALIGNANT NEOPLASM OF ILEUM
C17.3	MALIGNANT NEOPLASM MECKEL'S DIVERTICULUM
C17.8	OVERLAP MALGT LESION SMALL INTESTINE
C17.9	MALIGNANT LESION SMALL INTESTINE NOS
C18.0	MALIGNANT NEOPLASM OF CAECUM
C18.1	MALIGNANT NEOPLASM OF APPENDIX
C18.2	MALIGNANT NEOPLASM OF ASCENDING COLON
C18.3	MALIGNANT NEOPLASM OF HEPATIC FLEXURE
C18.4	MALIGNANT NEOPLASM OF TRANSVERSE COLON
C18.5	MALIGNANT NEOPLASM OF SPLENIC FLEXURE
C18.6	MALIGNANT NEOPLASM OF DESCENDING COLON
C18.7	MALIGNANT NEOPLASM OF SIGMOID COLON
C18.8	OVERLAPPING MALIGNANT LESION OF COLON
C18.9	MALGT NEOPLASM COLON UNSPECIFIED PART
C19	MALIGNANT NEOPLASM RECTOSIGMOID JUNCTION
C20	MALIGNANT NEOPLASM OF RECTUM
C21.0	MALIGNANT NEOPLASM OF ANUS UNSPECIFIED
C21.1	MALIGNANT NEOPLASM OF ANAL CANAL
C21.2	MALIGNANT NEOPLASM OF CLOACOGENIC ZONE
C21.8	OVERLAP MALGT LSN RECTUM ANUS ANAL CNL
C22.0	LIVER CELL CARCINOMA
C22.1	INTRAHEPATIC BILE DUCT CARCINOMA
C22.2	HEPATOBLASTOMA
C22.3	ANGIOSARCOMA OF LIVER
C22.4	OTHER SARCOMAS OF LIVER
C22.7	OTHER SPECIFIED CARCINOMAS OF LIVER
C22.9	MALIGNANT NEOPLASM OF LIVER UNSPECIFIED
C23	MALIGNANT NEOPLASM OF GALLBLADDER
C24.0	MALIGNANT NEOPLM EXTRAHEPATIC BILE DUCT
C24.1	MALIGNANT NEOPLASM OF AMPULLA OF VATER
C24.8	OVERLAPPING MALGT LESION BILIARY TRACT
C24.9	MALIGNANT LESION BILIARY TRACT NOS
C25.0	MALIGNANT NEOPLASM OF HEAD OF PANCREAS
C25.1	MALIGNANT NEOPLASM OF BODY OF PANCREAS
C25.2	MALIGNANT NEOPLASM OF TAIL OF PANCREAS
C25.3	MALIGNANT NEOPLASM OF PANCREATIC DUCT
C25.4	MALIGNANT NEOPLASM OF ENDOCRINE PANCREAS
C25.7	MALIGNANT NEOPLASM OTHER PARTS PANCREAS
C25.8	OVERLAPPING MALIGNANT LESION OF PANCREAS
C25.9	MALIGNANT NEOPLASM PANCREAS PART UNSPEC
C26.0	MALGT NEOPLASM INTEST TRACT PART UNSPEC
C26.1	MALIGNANT NEOPLASM OF SPLEEN
C26.8	OVERLAP MALGT LESION DIGESTIVE SYSTEM
C26.9	MALGT NEOPLM ILL-DEF SITE DIGEST SYSTEM
C30.0	MALIGNANT NEOPLASM OF NASAL CAVITY
C30.1	MALIGNANT NEOPLASM OF MIDDLE EAR
C31.0	MALIGNANT NEOPLASM OF MAXILLARY SINUS
C31.1	MALIGNANT NEOPLASM OF ETHMOIDAL SINUS
C31.2	MALIGNANT NEOPLASM OF FRONTAL SINUS
C31.3	MALIGNANT NEOPLASM OF SPHENOIDAL SINUS
C31.8	OVERLAP MALGT LESION ACCESSORY SINUSES
C31.9	MALIGNANT NEOPLASM ACCESSORY SINUS NOS

C32.0	MALIGNANT NEOPLASM OF GLOTTIS
C32.1	MALIGNANT NEOPLASM OF SUPRAGLOTTIS
C32.2	MALIGNANT NEOPLASM OF SUBGLOTTIS
C32.3	MALIGNANT NEOPLASM LARYNGEAL CARTILAGE
C32.8	OVERLAPPING MALIGNANT LESION OF LARYNX
C32.9	MALIGNANT NEOPLASM LARYNX UNSPECIFIED
C33	MALIGNANT NEOPLASM OF TRACHEA
C34.0	MALIGNANT NEOPLASM OF MAIN BRONCHUS
C34.1	MALGT NEOPLM UPPER LOBE BRONCHUS OR LUNG
C34.2	MALGT NEOPLASM MID LOBE BRONCHUS OR LUNG
C34.3	MALGT NEOPLM LOWER LOBE BRONCHUS OR LUNG
C34.8	OVERLAP MALGT LESION BRONCHUS OR LUNG
C34.9	MALIGNANT NEOPLASM BRONCHUS OR LUNG NOS
C37	MALIGNANT NEOPLASM OF THYMUS
C38.0	MALIGNANT NEOPLASM OF HEART
C38.1	MALIGNANT NEOPLASM ANTERIOR MEDIASTINUM
C38.2	MALIGNANT NEOPLASM POSTERIOR MEDIASTINUM
C38.3	MALGT NEOPLASM MEDIASTINUM, PART UNSPEC
C38.4	MALIGNANT NEOPLASM OF PLEURA
C38.8	OVERLAP MALGT LSN HEART MEDIAST & PLEURA
C39.0	MALGT NEOPLM UPPER RESP TRACT PRT UNSPEC
C39.8	OVERLAP MALGT LSN RESP & INTRATHOR ORG
C39.9	MALGT NEOPLM ILL-DEF SITES RESP SYSTEM
C40.0	MALGT NEOPLM SCAPULA LONG BONES UPP LMB
C40.1	MALGT NEOPLASM SHORT BONES UPPER LIMB
C40.2	MALIGNANT NEOPLASM LONG BONES LOWER LIMB
C40.3	MALGT NEOPLASM SHORT BONES LOWER LIMB
C40.8	OVERLAP MALGT LSN BONE ARTLR CART LIMB
C40.9	MALGT NEOPLM BONE & ARTLR CART LIMB NOS
C41.0	MALIGNANT NEOPLASM OF CRANIOFACIAL BONES
C41.0	MALIGNANT NEOPLASM MAXILLOFACIAL BONES
C41.1	MALIGNANT NEOPLASM OF MANDIBLE
C41.2	MALIGNANT NEOPLASM OF VERTEBRAL COLUMN
C41.3	MALIGNANT NEOPLASM RIBS STERNUM CLAVICLE
C41.4	MALGT NEOPLM PELVIC BONES SACRUM COCCYX
C41.8	OVERLAP MALIGNANT LESION BONE ARTLR CART
C41.9	MALGT NEOPLASM BONE & ARTLR CART NOS
C43.0	MALIGNANT MELANOMA OF LIP
C43.1	MALGT MELANOMA EYELID INCLUDING CANTHUS
C43.2	MALGT MELANOMA EAR & EXT AURICULAR CANAL
C43.3	MALGT MELANOMA OTHER & UNSPEC PARTS FACE
C43.4	MALIGNANT MELANOMA OF SCALP AND NECK
C43.5	MALIGNANT MELANOMA OF TRUNK
C43.6	MALGT MELANOMA UPPER LIMB INCL SHOULDER
C43.7	MALIGNANT MELANOMA LOWER LIMB INCL HIP
C43.8	OVERLAPPING MALIGNANT MELANOMA OF SKIN
C43.9	MALIGNANT MELANOMA OF SKIN UNSPECIFIED
C44.0	MALIGNANT NEOPLASM OF SKIN OF LIP
C44.1	MALGT NEOPLASM SKIN EYELID INCL CANTHUS
C44.2	MALGT NEOPLM SKIN EAR & EXT AURIC CANAL
C44.3	MALGT NEOPLM SKIN OTH/UNSPEC PARTS FACE
C44.4	MALIGNANT NEOPLASM SKIN OF SCALP & NECK
C44.5	MALIGNANT NEOPLASM OF SKIN OF TRUNK

C44.6	MALGT NEOPLM SKIN UPP LMB INCL SHOULDER
C44.7	MALGT NEOPLASM SKIN LOWER LIMB INCL HIP
C44.8	OVERLAPPING MALIGNANT LESION OF SKIN
C44.9	MALIGNANT NEOPLASM OF SKIN UNSPECIFIED
C45.0	MESOTHELIOMA OF PLEURA
C45.1	MESOTHELIOMA OF PERITONEUM
C45.2	MESOTHELIOMA OF PERICARDIUM
C45.7	MESOTHELIOMA OF OTHER SITES
C45.9	MESOTHELIOMA UNSPECIFIED
C46.0	KAPOSI'S SARCOMA OF SKIN
C46.1	KAPOSI'S SARCOMA OF SOFT TISSUE
C46.2	KAPOSI'S SARCOMA OF PALATE
C46.3	KAPOSI'S SARCOMA OF LYMPH NODES
C46.7	KAPOSI'S SARCOMA OF OTHER SITES
C46.8	KAPOSI'S SARCOMA OF MULTIPLE ORGANS
C46.9	KAPOSI'S SARCOMA UNSPECIFIED
C47.0	MALGT NEOPLM PERPH NERVE HEAD FACE NECK
C47.1	MALGT NEOPLM PERPH NRV UPP LMB SHOULDER
C47.2	MALGT NEOPLM PERPH NRV LOW LIMB INCL HIP
C47.3	MALGT NEOPLASM PERIPHERAL NERVES THORAX
C47.4	MALGT NEOPLM PERIPHERAL NERVES ABDOMEN
C47.5	MALGT NEOPLASM PERIPHERAL NERVES PELVIS
C47.6	MALGT NEOPLASM PERPH NERVES OF TRUNK NOS
C47.8	OVERLAP MALGT LSN PERPH NRV/AUT NRVS SYS
C47.9	MALGT NEOPLM PERPH NRV/AUT NRVS SYS NOS
C48.0	MALIGNANT NEOPLASM OF RETROPERITONEUM
C48.1	MALGT NEOPLM SPEC PARTS OF PERITONEUM
C48.2	MALIGNANT NEOPLASM PERITONEUM NOS
C48.8	OVERLAP MALGT LSN RETPERITONM PERITONEUM
C49.0	MALGT NEOPLM CON/SFT TIS HEAD FACE NECK
C49.1	MALGT NEOPLM CON/SFT TIS UPP LMB SHOLD
C49.2	MALGT NEOPLM CON/SFT TIS LOWER LIMB HIP
C49.3	MALGT NEOPLASM CON & SOFT TISSUE THORAX
C49.4	MALGT NEOPLASM CON & SOFT TISSUE ABDOMEN
C49.5	MALGT NEOPLASM CON & SOFT TISSUE PELVIS
C49.6	MALGT NEOPLM CON/SOFT TIS TRUNK NOS
C49.8	OVERLAP MALGT LESION CON & SOFT TISSUE
C49.9	MALGT NEOPLASM CON & SOFT TISSUE NOS
C50.0	MALIGNANT NEOPLASM OF NIPPLE AND AREOLA
C50.1	MALGT NEOPLASM CENTRAL PORTION BREAST
C50.2	MALGT NEOPLASM UPP INNR QUADRANT BREAST
C50.3	MALGT NEOPLASM LOW INNR QUADRANT BREAST
C50.4	MALGT NEOPLASM UPP OUTR QUADRANT BREAST
C50.5	MALGT NEOPLASM LOW OUTER QUADRANT BREAST
C50.6	MALIGNANT NEOPLASM AXILLARY TAIL BREAST
C50.8	OVERLAPPING MALIGNANT LESION OF BREAST
C50.9	MALIGNANT NEOPLASM BREAST PART UNSPEC
C51.0	MALIGNANT NEOPLASM OF LABIUM MAJUS
C51.1	MALIGNANT NEOPLASM OF LABIUM MINUS
C51.2	MALIGNANT NEOPLASM OF CLITORIS
C51.8	OVERLAPPING MALIGNANT LESION OF VULVA
C51.9	MALIGNANT NEOPLASM OF VULVA UNSPECIFIED
C52	MALIGNANT NEOPLASM OF VAGINA

C53.0	MALIGNANT NEOPLASM OF ENDOCERVIX
C53.1	MALIGNANT NEOPLASM OF EXOCERVIX
C53.8	OVERLAP MALIGNANT LESION CERVIX UTERI
C53.9	MALIGNANT NEOPLASM CERVIX UTERI NOS
C54.0	MALIGNANT NEOPLASM OF ISTHMUS UTERI
C54.1	MALIGNANT NEOPLASM OF ENDOMETRIUM
C54.2	MALIGNANT NEOPLASM OF MYOMETRIUM
C54.3	MALIGNANT NEOPLASM OF FUNDUS UTERI
C54.8	OVERLAP MALIGNANT LESION CORPUS UTERI
C54.9	MALIGNANT NEOPLASM CORPUS UTERI NOS
C55	MALIGNANT NEOPLASM UTERUS PART UNSPEC
C56	MALIGNANT NEOPLASM OF OVARY
C57.0	MALIGNANT NEOPLASM OF FALLOPIAN TUBE
C57.1	MALIGNANT NEOPLASM OF BROAD LIGAMENT
C57.2	MALIGNANT NEOPLASM OF ROUND LIGAMENT
C57.3	MALIGNANT NEOPLASM OF PARAMETRIUM
C57.4	MALIGNANT NEOPLASM UTERINE ADNEXA NOS
C57.7	MALGT NEOPLM OTHER SPEC FEMLE GEN ORG
C57.8	OVERLAP MALGT LSN FEMALE GENITAL ORGANS
C57.9	MALGT NEOPLASM FEMALE GENITAL ORGAN NOS
C58	MALIGNANT NEOPLASM OF PLACENTA
C60.0	MALIGNANT NEOPLASM OF PREPUCE
C60.1	MALIGNANT NEOPLASM OF GLANS PENIS
C60.2	MALIGNANT NEOPLASM OF BODY OF PENIS
C60.8	OVERLAPPING MALIGNANT LESION OF PENIS
C60.9	MALIGNANT NEOPLASM OF PENIS UNSPECIFIED
C61	MALIGNANT NEOPLASM OF PROSTATE
C62.0	MALIGNANT NEOPLASM OF UNDESCENDED TESTIS
C62.1	MALIGNANT NEOPLASM OF DESCENDED TESTIS
C62.9	MALIGNANT NEOPLASM OF TESTIS UNSPECIFIED
C63.0	MALIGNANT NEOPLASM OF EPIDIDYMIS
C63.1	MALIGNANT NEOPLASM OF SPERMATIC CORD
C63.2	MALIGNANT NEOPLASM OF SCROTUM
C63.7	OTHER SPECIFIED MALE GENITAL ORGANS
C63.8	OVERLAP MALGT LESION MALE GENITAL ORGANS
C63.9	MALGT NEOPLASM MALE GENITAL ORGAN NOS
C64	MALGT NEOPLASM KIDNEY EX RENAL PELVIS
C65	MALIGNANT NEOPLASM OF RENAL PELVIS
C66	MALIGNANT NEOPLASM OF URETER
C67.0	MALIGNANT NEOPLASM OF TRIGONE OF BLADDER
C67.1	MALIGNANT NEOPLASM OF DOME OF BLADDER
C67.2	MALIGNANT NEOPLASM LATERAL WALL BLADDER
C67.3	MALIGNANT NEOPLASM ANTERIOR WALL BLADDER
C67.4	MALGT NEOPLASM OF POSTERIOR WALL BLADDER
C67.5	MALIGNANT NEOPLASM OF BLADDER NECK
C67.6	MALIGNANT NEOPLASM OF URETERIC ORIFICE
C67.7	MALIGNANT NEOPLASM OF URACHUS
C67.8	OVERLAPPING MALIGNANT LESION OF BLADDER
C67.9	MALIGNANT NEOPLASM OF BLADDER NOS
C68.0	MALIGNANT NEOPLASM OF URETHRA
C68.1	MALIGNANT NEOPLASM OF PARAURETHRAL GLAND
C68.8	OVERLAP MALIGNANT LESION URINARY ORGANS
C68.9	MALIGNANT NEOPLASM URINARY ORGAN NOS

C69.0	MALIGNANT NEOPLASM OF CONJUNCTIVA
C69.1	MALIGNANT NEOPLASM OF CORNEA
C69.2	MALIGNANT NEOPLASM OF RETINA
C69.3	MALIGNANT NEOPLASM OF CHOROID
C69.4	MALIGNANT NEOPLASM OF CILIARY BODY
C69.5	MALIGNANT NEOPLASM LACRIMAL GLAND & DUCT
C69.6	MALIGNANT NEOPLASM OF ORBIT
C69.8	OVERLAP MALIGNANT LESION EYE & ADNEXA
C69.9	MALIGNANT NEOPLASM OF EYE UNSPECIFIED
C70.0	CEREBRAL MENINGES
C70.1	SPINAL MENINGES
C70.9	MENINGES UNSPECIFIED
C71.0	MALGT NEOPLM CEREBRUM EX LOBES & VENTRL
C71.1	MALIGNANT NEOPLASM OF FRONTAL LOBE
C71.2	MALIGNANT NEOPLASM OF TEMPORAL LOBE
C71.3	MALIGNANT NEOPLASM OF PARIETAL LOBE
C71.4	MALIGNANT NEOPLASM OF OCCIPITAL LOBE
C71.5	MALIGNANT NEOPLASM OF CEREBRAL VENTRICLE
C71.6	MALIGNANT NEOPLASM OF CEREBELLUM
C71.7	MALIGNANT NEOPLASM OF BRAIN STEM
C71.8	OVERLAPPING MALIGNANT LESION OF BRAIN
C71.9	MALIGNANT NEOPLASM OF BRAIN UNSPECIFIED
C72.0	MALIGNANT NEOPLASM OF SPINAL CORD
C72.1	MALIGNANT NEOPLASM OF CAUDA EQUINA
C72.2	MALIGNANT NEOPLASM OF OLFACTORY NERVE
C72.3	MALIGNANT NEOPLASM OF OPTIC NERVE
C72.4	MALIGNANT NEOPLASM OF ACOUSTIC NERVE
C72.5	MALGT NEOPLASM OTH/UNSPEC CRANIAL NERVES
C72.8	OVERLAP MALGT LESION BRAIN & OTHER CNS
C72.9	MALIGNANT NEOPLASM CNS UNSPECIFIED
C73	MALIGNANT NEOPLASM OF THYROID GLAND
C74.0	MALIGNANT NEOPLASM CORTEX ADRENAL GLAND
C74.1	MALIGNANT NEOPLASM MEDULLA ADRENAL GLAND
C74.9	MALIGNANT NEOPLASM ADRENAL GLAND NOS
C75.0	MALIGNANT NEOPLASM OF PARATHYROID GLAND
C75.1	MALIGNANT NEOPLASM OF PITUITARY GLAND
C75.2	MALIGNANT NEOPLASM CRANIOPHARYNGEAL DUCT
C75.3	MALIGNANT NEOPLASM OF PINEAL GLAND
C75.4	MALIGNANT NEOPLASM OF CAROTID BODY
C75.5	MALGT NEOPLM AORTIC BODY OTH PARAGANGLIA
C75.8	MALGT NEOPLASM PLURIGLANDULAR INV NOS
C75.9	MALIGNANT NEOPLASM ENDOCRINE GLAND NOS
C76.0	MALIGNANT NEOPLASM HEAD FACE & NECK
C76.1	MALIGNANT NEOPLASM OF THORAX
C76.2	MALIGNANT NEOPLASM OF ABDOMEN
C76.3	MALIGNANT NEOPLASM OF PELVIS
C76.4	MALIGNANT NEOPLASM OF UPPER LIMB
C76.5	MALIGNANT NEOPLASM OF LOWER LIMB
C76.7	MALIGNANT NEOPLASM OTHER ILL-DEF SITES
C76.8	OVERLAP MALGT LESION OTH & ILL-DEF SITES
C80	MALIGNANT NEOPLASM WO SITE SPECIFICATION
C81.0	HODGKINS DIS LYMPHOCYTIC PREDOMINANCE
C81.1	HODGKIN'S DISEASE NODULAR SCLEROSIS

C81.2	HODGKIN'S DISEASE MIXED CELLULARITY
C81.3	HODGKIN'S DISEASE LYMPHOCYTIC DEPLETION
C81.7	OTHER HODGKIN'S DISEASE
C81.9	HODGKIN'S DISEASE UNSPECIFIED
C82.0	SMALL CLEAVED CELL FOLLICULAR NHL
C82.1	MIXED SMALL CLEAVED LARGE CELL FOL NHL
C82.2	LARGE CELL FOLLICULAR NHL
C82.7	OTHER TYPES FOLLICULAR NHL
C82.9	FOLLICULAR NHL UNSPECIFIED
C83.0	SMALL CELL (DIFFUSE) NHL
C83.1	SMALL CLEAVED CELL (DIFFUSE) NHL
C83.2	MIXED SMALL & LARGE CELL (DIFFUSE) NHL
C83.3	LARGE CELL (DIFFUSE) NHL
C83.4	IMMUNOBLASTIC (DIFFUSE) NHL
C83.5	LYMPHOBLASTIC (DIFFUSE) NHL
C83.6	UNDIFFERENTIATED (DIFFUSE) NHL
C83.7	BURKITT'S TUMOUR
C83.8	OTHER TYPES DIFFUSE NHL
C83.9	DIFFUSE NHL UNSPECIFIED
C84.0	MYCOSIS FUNGOIDES
C84.1	S,ZARY'S DISEASE
C84.2	T-ZONE LYMPHOMA
C84.3	LYMPHOEPITHELIOID LYMPHOMA
C84.4	PERIPHERAL T-CELL LYMPHOMA
C84.5	OTHER AND UNSPECIFIED T-CELL LYMPHOMAS
C85.0	LYMPHOSARCOMA
C85.1	B-CELL LYMPHOMA UNSPECIFIED
C85.7	OTHER SPECIFIED TYPES OF NHL
C85.9	NHL UNSPECIFIED TYPE
C88.0	WALDENSTROMS MACROGLOBULINAEMIA WO REM
C88.0	WALDENSTROMS MACROGLOBULINAEMIA IN REM
C88.1	ALPHA HEAVY CHAIN DISEASE WO REMISSION
C88.1	ALPHA HEAVY CHAIN DISEASE IN REMISSION
C88.2	GAMMA HEAVY CHAIN DISEASE WO REMISSION
C88.2	GAMMA HEAVY CHAIN DISEASE IN REMISSION
C88.3	IMMUNOPROLIFERATIVE SM INTEST DIS WO REM
C88.3	IMMUNOPROLIFERATIVE SM INTEST DIS IN REM
C88.7	OTH MALGT IMMUNOPROLIFERATIVE DIS WO REM
C88.7	OTH MALGT IMMUNOPROLIFERATIVE DIS IN REM
C88.9	UNSPEC IMMUNOPROLIFERATIVE DIS WO REM
C88.9	UNSPEC IMMUNOPROLIFERATIVE DIS IN REM
C90.0	MULTIPLE MYELOMA WITHOUT REMISSION
C90.0	MULTIPLE MYELOMA IN REMISSION
C90.1	PLASMA CELL LEUKAEMIA WO REMISSION
C90.1	PLASMA CELL LEUKAEMIA IN REMISSION
C90.2	PLASMACYTOMA EXTRAMEDULLARY WO REMISSION
C90.2	PLASMACYTOMA EXTRAMEDULLARY IN REM
C91.0	ACUTE LYMPHOBLASTIC LEUKAEMIA WO REM
C91.0	ACUTE LYMPHOBLASTIC LEUKAEMIA IN REM
C91.1	CHRONIC LYMPHOCYTIC LEUKAEMIA WO REM
C91.1	CHRONIC LYMPHOCYTIC LEUKAEMIA IN REM
C91.2	SUBACUTE LYMPHOCYTIC LEUKAEMIA WO REM
C91.2	SUBACUTE LYMPHOCYTIC LEUKAEMIA IN REM

C91.3	PROLYMPHOCYTIC LEUKAEMIA WO REMISSION
C91.3	PROLYMPHOCYTIC LEUKAEMIA IN REMISSION
C91.4	HAIRY-CELL LEUKAEMIA WITHOUT REMISSION
C91.4	HAIRY-CELL LEUKAEMIA IN REMISSION
C91.5	ADULT T-CELL LEUKAEMIA WITHOUT REMISSION
C91.5	ADULT T-CELL LEUKAEMIA IN REMISSION
C91.7	OTHER LYMPHOID LEUKAEMIA WO REMISSION
C91.7	OTHER LYMPHOID LEUKAEMIA IN REMISSION
C91.9	LYMPHOID LEUKAEMIA UNSPEC WO REMISSION
C91.9	LYMPHOID LEUKAEMIA UNSPEC IN REMISSION
C92.0	ACUTE MYELOID LEUKAEMIA WO REMISSION
C92.0	ACUTE MYELOID LEUKAEMIA IN REMISSION
C92.1	CHRONIC MYELOID LEUKAEMIA WO REMISSION
C92.1	CHRONIC MYELOID LEUKAEMIA IN REMISSION
C92.2	SUBACUTE MYELOID LEUKAEMIA WO REMISSION
C92.2	SUBACUTE MYELOID LEUKAEMIA IN REMISSION
C92.3	MYELOID SARCOMA WITHOUT REMISSION
C92.3	MYELOID SARCOMA IN REMISSION
C92.4	ACUTE PROMYELOCYTIC LEUKAEMIA WO REM
C92.4	ACUTE PROMYELOCYTIC LEUKAEMIA IN REM
C92.5	ACUTE MYELOMONOCYTIC LEUKAEMIA WO REM
C92.5	ACUTE MYELOMONOCYTIC LEUKAEMIA IN REM
C92.7	OTHER MYELOID LEUKAEMIA WO REMISSION
C92.7	OTHER MYELOID LEUKAEMIA IN REMISSION
C92.9	MYELOID LEUKAEMIA UNSPEC WO REMISSION
C92.9	MYELOID LEUKAEMIA UNSPEC IN REMISSION
C93.0	ACUTE MONOCYTIC LEUKAEMIA WO REMISSION
C93.0	ACUTE MONOCYTIC LEUKAEMIA IN REMISSION
C93.1	CHRONIC MONOCYTIC LEUKAEMIA WO REMISSION
C93.1	CHRONIC MONOCYTIC LEUKAEMIA IN REMISSION
C93.2	SUBACUTE MONOCYTIC LEUKAEMIA WO REM
C93.2	SUBACUTE MONOCYTIC LEUKAEMIA IN REM
C93.7	OTHER MONOCYTIC LEUKAEMIA WO REMISSION
C93.7	OTHER MONOCYTIC LEUKAEMIA IN REMISSION
C93.9	MONOCYTIC LEUKAEMIA UNSPEC WO REMISSION
C93.9	MONOCYTIC LEUKAEMIA UNSPEC IN REMISSION
C94.0	AC ERYTHRAEMIA & ERYTHROLEUKAEMIA WO REM
C94.0	AC ERYTHRAEMIA & ERYTHROLEUKAEMIA IN REM
C94.1	CHRONIC ERYTHRAEMIA WITHOUT REMISSION
C94.1	CHRONIC ERYTHRAEMIA IN REMISSION
C94.2	ACUTE MEGAKARYOBLASTIC LEUKAEMIA WO REM
C94.2	ACUTE MEGAKARYOBLASTIC LEUKAEMIA IN REM
C94.3	MAST CELL LEUKAEMIA WITHOUT REMISSION
C94.3	MAST CELL LEUKAEMIA IN REMISSION
C94.4	ACUTE PANMYELOSIS WITHOUT REMISSION
C94.4	ACUTE PANMYELOSIS IN REMISSION
C94.5	ACUTE MYELOFIBROSIS WITHOUT REMISSION
C94.5	ACUTE MYELOFIBROSIS IN REMISSION
C94.7	OTHER SPECIFIED LEUKAEMIAS WO REMISSION
C94.7	OTHER SPECIFIED LEUKAEMIAS IN REMISSION
C95.0	ACUTE LEUKAEMIA UNSPEC CELL TYPE WO REM
C95.0	ACUTE LEUKAEMIA UNSPEC CELL TYPE IN REM
C95.1	CHR LEUKAEMIA UNSPEC CELL TYPE WO REM

C95.1	CHR LEUKAEMIA UNSPEC CELL TYPE IN REM
C95.2	SUBAC LEUKAEMIA UNSPEC CELL TYPE WO REM
C95.2	SUBAC LEUKAEMIA UNSPEC CELL TYPE IN REM
C95.7	OTH LEUKAEMIA OF UNSPEC CELL TYPE WO REM
C95.7	OTH LEUKAEMIA OF UNSPEC CELL TYPE IN REM
C95.9	LEUKAEMIA UNSPECIFIED WITHOUT REMISSION
C95.9	LEUKAEMIA UNSPECIFIED IN REMISSION
C96.0	LETTERER-SIWE DISEASE
C96.1	MALIGNANT HISTIOCYTOSIS
C96.2	MALIGNANT MAST CELL TUMOUR
C96.3	TRUE HISTIOCYTIC LYMPHOMA
C96.7	OTHER SPEC NEOPLM LYMPHOID, HAEMAT & TIS
C96.9	NEOPLASM LYMPHOID HAEMAT TISSUE NOS
D00.0	CA IN SITU LIP ORAL CAVITY PHARYNX
D00.1	CARCINOMA IN SITU OF OESOPHAGUS
D00.2	CARCINOMA IN SITU OF STOMACH
D01.0	CARCINOMA IN SITU OF COLON
D01.1	CA IN SITU RECTOSIGMOID JUNCTION
D01.2	CARCINOMA IN SITU OF RECTUM
D01.3	CARCINOMA IN SITU OF ANUS AND ANAL CANAL
D01.4	CA IN SITU OTH/UNSPEC PARTS INTESTINE
D01.5	CA IN SITU LIVER GALLBLADDER BILE DUCTS
D01.7	CA IN SITU OTHER SPEC DIGESTIVE ORGANS
D01.9	CA IN SITU DIGESTIVE ORGAN NOS
D02.0	CARCINOMA IN SITU OF LARYNX
D02.1	CARCINOMA IN SITU OF TRACHEA
D02.2	CARCINOMA IN SITU OF BRONCHUS AND LUNG
D02.3	CA IN SITU OTH PARTS RESPIRATORY SYSTEM
D02.4	CA IN SITU RESPIRATORY SYSTEM NOS
D03.0	MELANOMA IN SITU OF LIP
D03.1	MELANOMA IN SITU EYELID INCL CANTHUS
D03.2	MELANOMA IN SITU EAR & EXT AURIC CANAL
D03.3	MELANOMA IN SITU OTH/UNSPEC PARTS FACE
D03.4	MELANOMA IN SITU OF SCALP AND NECK
D03.5	MELANOMA IN SITU OF TRUNK
D03.6	MELANOMA IN SITU UPP LIMB INCL SHOULDER
D03.7	MELANOMA IN SITU LOWER LIMB INCL HIP
D03.8	MELANOMA IN SITU OF OTHER SITES
D03.9	MELANOMA IN SITU UNSPECIFIED
D04.0	CARCINOMA IN SITU OF SKIN OF LIP
D04.1	CA IN SITU SKIN EYELID INCL CANTHUS
D04.2	CA IN SITU SKIN EAR & EXT AURIC CANAL
D04.3	CA IN SITU SKIN OTH/UNSPEC PARTS FACE
D04.4	CARCINOMA IN SITU SKIN SCALP & NECK
D04.5	CARCINOMA IN SITU OF SKIN OF TRUNK
D04.6	CA IN SITU SKIN UPPER LIMB INCL SHOULDER
D04.7	CA IN SITU SKIN LOWER LIMB INCL HIP
D04.8	CARCINOMA IN SITU OF SKIN OF OTHER SITES
D04.9	CARCINOMA IN SITU OF SKIN UNSPECIFIED
D05.0	LOBULAR CARCINOMA IN SITU OF BREAST
D05.1	INTRADUCTAL CARCINOMA IN SITU OF BREAST
D05.7	OTHER CARCINOMA IN SITU OF BREAST
D05.9	CARCINOMA IN SITU OF BREAST UNSPECIFIED

D06.0	CARCINOMA IN SITU OF ENDOCERVIX
D06.1	CARCINOMA IN SITU OF EXOCERVIX
D06.7	CA IN SITU OTHER PARTS OF CERVIX
D06.9	CARCINOMA IN SITU OF CERVIX UNSPECIFIED
D07.0	CARCINOMA IN SITU OF ENDOMETRIUM
D07.1	CARCINOMA IN SITU OF VULVA
D07.2	CARCINOMA IN SITU OF VAGINA
D07.3	CA IN SITU OTH/UNSPEC FEMALE GEN ORG
D07.4	CARCINOMA IN SITU OF PENIS
D07.5	CARCINOMA IN SITU OF PROSTATE
D07.6	CA IN SITU OTH/UNSPEC MALE GENITAL ORG
D09.0	CARCINOMA IN SITU OF BLADDER
D09.1	CA IN SITU OTHER & UNSPEC URINARY ORGANS
D09.2	CARCINOMA IN SITU OF EYE
D09.3	CA IN SITU THYROID & OTH ENDOCRINE GLAND
D09.7	CA IN SITU OTHER SPECIFIED SITES
D09.9	CARCINOMA IN SITU UNSPECIFIED
D18.02	HAEMANGIOMA INTRACRANIAL STRUCTURES
D32.0	BENIGN NEOPLASM OF CEREBRAL MENINGES
D32.1	BENIGN NEOPLASM OF SPINAL MENINGES
D32.9	BENIGN NEOPLASM OF MENINGES UNSPECIFIED
D33.0	BENIGN NEOPLASM BRAIN SUPRATENTORIAL
D33.1	BENIGN NEOPLASM BRAIN INFRATENTORIAL
D33.2	BENIGN NEOPLASM OF BRAIN UNSPECIFIED
D33.3	BENIGN NEOPLASM OF CRANIAL NERVES
D33.4	BENIGN NEOPLASM OF SPINAL CORD
D33.7	BENIGN NEOPLASM OTHER SPEC PARTS OF CNS
D33.9	BENIGN NEOPLASM CNS UNSPECIFIED
D37.0	NEOPLM UNCRT/UNK BEH LIP ORAL CV PHARYNX
D37.1	NEOPLM UNCERTAIN OR UNKNOWN BEH STOMACH
D37.2	NEOPLM UNCRT/UNK BEH SMALL INTESTINE
D37.3	NEOPLM UNCERTAIN OR UNKNOWN BEH APPENDIX
D37.4	NEOPLASM UNCERTAIN OR UNKNOWN BEH COLON
D37.5	NEOPLASM UNCERTAIN OR UNKNOWN BEH RECTUM
D37.6	NEOPLM UNCRT/UNK BEH LVR GALLB BILE DUCT
D37.7	NEOPLM UNCRT/UNK BEH OTH DIGESTIVE ORGAN
D37.9	NEOPLASM UNCRT/UNK BEH DIGEST ORGAN NOS
D38.0	NEOPLASM UNCERTAIN OR UNKNOWN BEH LARYNX
D38.1	NEOPLM UNCRT/UNK BEH TRACHEA BRONC LUNG
D38.2	NEOPLASM UNCERTAIN OR UNKNOWN BEH PLEURA
D38.3	NEOPLM UNCRT OR UNKNOWN BEH MEDIASTINUM
D38.4	NEOPLASM UNCERTAIN OR UNKNOWN BEH THYMUS
D38.5	NEOPLASM UNCRT/UNK BEH OTHER RESP ORG
D38.6	NEOPLASM UNCRT/UNK BEH RESP ORG NOS
D39.0	NEOPLASM UNCERTAIN OR UNKNOWN BEH UTERUS
D39.1	NEOPLASM UNCERTAIN OR UNKNOWN BEH OVARY
D39.2	NEOPLM UNCERTAIN OR UNKNOWN BEH PLACENTA
D39.7	NEOPLASM UNCRT/UNK BEH OTH FEMLE GEN ORG
D39.9	NEOPLASM UNCRT/UNK BEH FEMLE GEN ORG NOS
D40.0	NEOPLASM UNCERTAIN OR UNK BEH PROSTATE
D40.1	NEOPLASM UNCERTAIN OR UNKNOWN BEH TESTIS
D40.7	NEOPLASM UNCRT/UNK BEH MALE GENITAL ORG
D40.9	NEOPLM UNCRT/UNK BEH MALE GEN ORG NOS

D41.0	NEOPLASM UNCERTAIN OR UNKNOWN BEH KIDNEY
D41.1	NEOPLASM UNCRT/UNK BEH RENAL PELVIS
D41.2	NEOPLASM UNCERTAIN OR UNKNOWN BEH URETER
D41.3	NEOPLM UNCERTAIN OR UNKNOWN BEH URETHRA
D41.4	NEOPLM UNCERTAIN OR UNKNOWN BEH BLADDER
D41.7	NEOPLASM UNCRT/UNK BEH OTH URINARY ORGAN
D41.9	NEOPLASM UNCRT/UNK BEH URIN ORGAN NOS
D42.0	NEOPLASM UNCRT/UNK BEH CEREBRAL MENINGES
D42.1	NEOPLM UNCRT/UNK BEH SPINAL MENINGES
D42.9	NEOPLASM UNCRT/UNK BEH MENINGES NOS
D43.0	NEOPLASM UNCRT/UNK BEH BRAIN SUPRATENTOR
D43.1	NEOPLASM UNCRT/UNK BEH BRAIN INFRATENTOR
D43.2	NEOPLASM UNCRT/UNK BEH BRAIN NOS
D43.3	NEOPLASM UNCRT/UNK BEH CRANIAL NERVES
D43.4	NEOPLASM UNCRT/UNK BEH SPINAL CORD
D43.7	NEOPLM UNCRT/UNK BEH OTHER PARTS CNS
D43.9	NEOPLM UNCERTAIN OR UNKNOWN BEH CNS NOS
D44.0	NEOPLASM UNCRT/UNK BEH THYROID GLAND
D44.1	NEOPLASM UNCRT/UNK BEH ADRENAL GLAND
D44.2	NEOPLASM UNCRT/UNK BEH PARATHYROID GLAND
D44.3	NEOPLM UNCRT/UNK BEH PITUITARY GLAND
D44.4	NEOPLM UNCRT/UNK BEH CRANOPHARNGL DCT
D44.5	NEOPLASM UNCRT/UNK BEH PINEAL GLAND
D44.6	NEOPLASM UNCRT/UNK BEH CAROTID BODY
D44.7	NEOPLM UNCRT/UNK BEH AORTIC BD OTH PARAG
D44.8	NEOPLASM UNCRT/UNK BEH PLURIGLNDR INV
D44.9	NEOPLASM UNCRT/UNK BEH ENDOCRINE GLD NOS
D45	POLYCYTHAEMIA VERA
D46.0	REFRACT ANAEMIA WO SIDEROBLASTS SO STATE
D46.1	REFRACTORY ANAEMIA WITH SIDEROBLASTS
D46.2	REFRACTORY ANAEMIA WITH EXCESS OF BLASTS
D46.3	RAEB WITH TRANSFORMATION
D46.4	REFRACTORY ANAEMIA UNSPECIFIED
D46.7	OTHER MYELODYSPLASTIC SYNDROMES
D46.9	MYELODYSPLASTIC SYNDROME UNSPECIFIED
D47.0	HISTIOCYTIC MAST CELL TUM UNCRT/UNK BEH
D47.1	CHRONIC MYELOPROLIFERATIVE DISEASE
D47.2	MONOCLONAL GAMMOPATHY
D47.3	ESSENTIAL THROMBOCYTHAEMIA
D47.7	OTH SPEC NEOPLM UNCRT/UNK BEH LYMPH HAEM
D47.9	NEOPLM UNCRT/UNK BEH LYMPH HAEM TIS NOS
D48.0	NEOPLM UNCRT/UNK BEH BONE ARTICULAR CART
D48.1	NEOPLM UNCRT/UNK BEH CONN OTH SFT TISSUE
D48.2	NEOPLASM UNCRT/UNK BEH PERPH & AUT NRVS
D48.3	NEOPLM UNCRT/UNK BEH RETROPERITONEUM
D48.4	NEOPLASM UNCERTAIN OR UNK BEH PERITONEUM
D48.5	NEOPLASM UNCERTAIN OR UNKNOWN BEH SKIN
D48.6	NEOPLASM UNCERTAIN OR UNKNOWN BEH BREAST
D48.7	NEOPLASM UNCRT/UNK BEH OTH SPEC SITES
D48.9	NEOPLASM UNCERTAIN OR UNKNOWN BEH NOS
D76.0	LANGERHANS' CELL HISTIOCYTOSIS NEC
Q85.0	NEUROFIBROMATOSIS (NONMALIGNANT)

(We do not require the following site codes and therefore these are not in the above list:
C77, C78 and C79 – secondary sites
D10-D31.9 – Benign, not Brain
D34 – D36.9 – Benign, not Brain)

These are the Ranges in the Site Codes (as above) we DO require:

Invasive

C00.0 – C76.8
C80.0 – C96.9
and exclude C44.0 to C44.9 AND M80500 to M81109 (Skin SCC's and BCC's)

Insitu and Benign Brain/CNS

D00.0 – D09.9
D32.0 – D33.9
but want D18.02 Benign Brain
and exclude D04.0 to D04.9 AND M80500 to M81109 (Skin SCC's and BCC's)

Uncertain

D37.0 to D48.9
and exclude D48.5 AND M80500 to M81109 (Skin SCC's and BCC's)

We also require:
Q85.0
D76.0
