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Australian Digital Health Agency



Miscellaneous Detailed Clinical Models
Detailed Clinical Model Specification
Version 1.5

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1.0	23 Aug 2011	Initial public release. The document is created in accordance with archetypes from NEHTA Clinical Knowledge Manager ¹ .
1.1	30 Nov 2011	This version of the specification is published primarily to remove the Record Review Detailed Clinical Model and include the Requested Service Detailed Clinical Model.
1.2	22 Dec 2011	This version of the specification is published to support the Structured Content Specifications published (at the end of 2011) that use the versions of the DCMs included in this specification. Changes to the DCMs, included in this specification, are primarily to support the Consolidated View in the PCEHR.
1.3	4 Sep 2013	This version of the specification is published to include the Summary of Medication Entries and General Observation DCMs in support of the PCEHR Prescription and Dispense View Structured Content Specification and Consumer Entered Achievements Structured Content Specification respectively.
1.4	18 Dec 2015	This version of the specification is published to support the Structured Content Specifications published (in the first half of 2015) that use the versions of the DCMs included in this specification. Changes to the DCMs, included in this specification, are primarily to support Shared Health Summary and Event Summary in the PCEHR R5. Medical History Item DCM has been excluded from this specification. Document Use Authorisation DCM has been included. New major version of Requested Service DCM is included.
1.5	5 Aug 2016	Requested service DCM has been excluded from this specification. The remaining DCMs are unaltered, except for rebranding for the Australian Digital Health Agency.

Related Documents

Name	Version/Release Date
Participation Data Specification	Version 3.2, Issued 20 July 2011

¹ <http://dcm.nehta.org.au/ckm>

Included Detailed Clinical Models

This specification contains the following detailed clinical models:

- Clinical Synopsis, version 4.3
- Recommendations (Instruction), version 2.2
- Exclusion Statement, version 1.2
- Referral Detail, version 1.2
- Summary of Medication Entries, version 1.1
- General Observation, version 1.1
- Document Use Authorisation (Instruction), version 1.0

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1 Introduction

1.1 Purpose and Scope

This detailed clinical model (DCM) specification forms part of a suite of data specifications that the Australian Digital Health Agency (the Agency) is developing for the Australian health informatics community. The suite comprises specifications for a range of health topics (represented as data groups), which are considered to be the most critical to support the work programme given to the Agency and to realise the benefits derived from Level 4 (semantic) interoperability¹ in the Australian healthcare setting.

We value your questions and comments about this document. Please direct your questions or feedback to help@digitalhealth.gov.au.

1.2 Intended Audience

This document is intended to be read by jurisdictional information and communication technology (ICT) managers, clinicians involved in clinical information system specifications, software architects and developers, and implementers of clinical information systems in various healthcare settings.

This is a technical document; the audience should be familiar with the language of health data specification and also have some familiarity with health information standards and specifications. Definitions and examples are provided to clarify relevant terminology, usage, and intent.

1.3 Background

One area of priority for us is the identification of digital health data to be communicated and its structure. We are addressing this through data specifications, which detail the data elements (logically grouped) and their associated value domains.

Data specifications need to be independent of messaging formats. They are concerned with providing an information framework in which to achieve semantic interoperability.

Data specifications have been developed based on priorities identified by jurisdictions and clinicians, incorporating clinical examples of use to enhance utility and adoption. These specifications are intended to:

- suit the Australian model for a shared electronic health record;
- define collections of related information, e.g. event summaries, data groups, data elements;
- be human readable (with information enhanced by the hierarchical structure);
- provide a set of clinical terminologies specific to the requirements of the Australian healthcare system; and
- allow for expansion and extension as electronic systems mature.

While the My Health Record system is referred to in these documents, implementation within the system is not dealt with here.

1.4 Terminology

Our National Clinical Terminology Service (NCTS) is defining a national approach to clinical terminology. Consistent and accurate articulation and interpretation of clinical terms is critical to the process of safe exchange.

¹Level 4 interoperability is described in [The Value Of Health Care Information Exchange And Interoperability \[WALJ2005a\]](#).

We recommend the SNOMED CT as the preferred clinical terminology for Australia and this has been endorsed by the Australian, state and territory governments. SNOMED CT is considered to be the most comprehensive multilingual health terminology in the world. It is owned, maintained and distributed by the International Health Terminology Standards Development Organisation (IHTSDO).

Our NCTS is the Australian National Release Centre for SNOMED CT and is also responsible for managing, developing and distributing national clinical terminologies, such as SNOMED CT Australian Release (SNOMED CT-AU), the Australian Medicines Terminology (AMT), and related tools and services.

SNOMED CT-AU provides local variations and customisation of terms relevant to the Australian healthcare community. It includes the international resources, along with all Australian-developed terminology for implementation in Australian clinical information technology systems. The AMT provides a consistent approach to the identification and naming of medicines, and supports medicines management and activity across the Australian healthcare domain. The AMT is now included within SNOMED CT-AU, with even closer integration planned for the future.

Reference sets listed as value domains within this document have been developed taking into account data element and data group definitions, as well as how they align with and complement the SNOMED CT concept model.

SNOMED CT-AU has been available for software developers to use in their Australian products since 1 July 2006. It is updated monthly and is freely available under a dual licensing arrangement – namely the SNOMED CT Affiliate License and Australian National Terminology License.

For further information regarding terminology and the development of reference sets, please visit <http://www.healthterminologies.gov.au>. Email help@digitalhealth.gov.au with questions or feedback.

2 Clinical Synopsis Detailed Clinical Model

This chapter describes version 4.3 of the *Clinical Synopsis* Detailed Clinical Model.

2.1 Purpose

A clinician-entered clinical synopsis contains summary information or comments about the clinical management of the subject of care, and the prognosis of problems or diagnoses identified during the healthcare encounter. It may also include health-related information pertinent to the subject of care, and a clinical interpretation of relevant investigations and observations performed on the subject of care (including pathology and diagnostic imaging).

A clinical synopsis entered by the subject of care or their carer contains information such as reporting on one or more health events, summaries of health issues and assessments of health problems. Health events include blood pressure measurements, descriptions of instances of adverse reactions to food and reflections on mood.

2.2 Use

When used by a healthcare provider, clinical synopsis is used to describe additional information, including clinical interpretation of the condition or tests, the subject of care's understanding of the healthcare event, and other relevant clinical details not captured by other structured or unstructured information components pertinent to that healthcare event.

When used by the subject of care or a nominated representative (including carer), clinical synopsis is used to provide information such as descriptions of health events, summaries of health issues, and assessments of health problems as perceived by the subject of care or a nominated representative.

2.3 Misuse

Using when more specialised data components are available.

2.4 UML Class Diagrams

The following figure represents the data hierarchy using a UML 2.0 class diagram. The diagram displays data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes; data groups are displayed as classes; their label names are represented as association role names. Association role names are only displayed if they differ from the associated class name. When a data element has a choice of data types, the data type of the attribute that represents it is an abstract interface class generalised from the individual data types. The diagram shows the data hierarchy excluding the details of participation. The default multiplicity is 1..1.

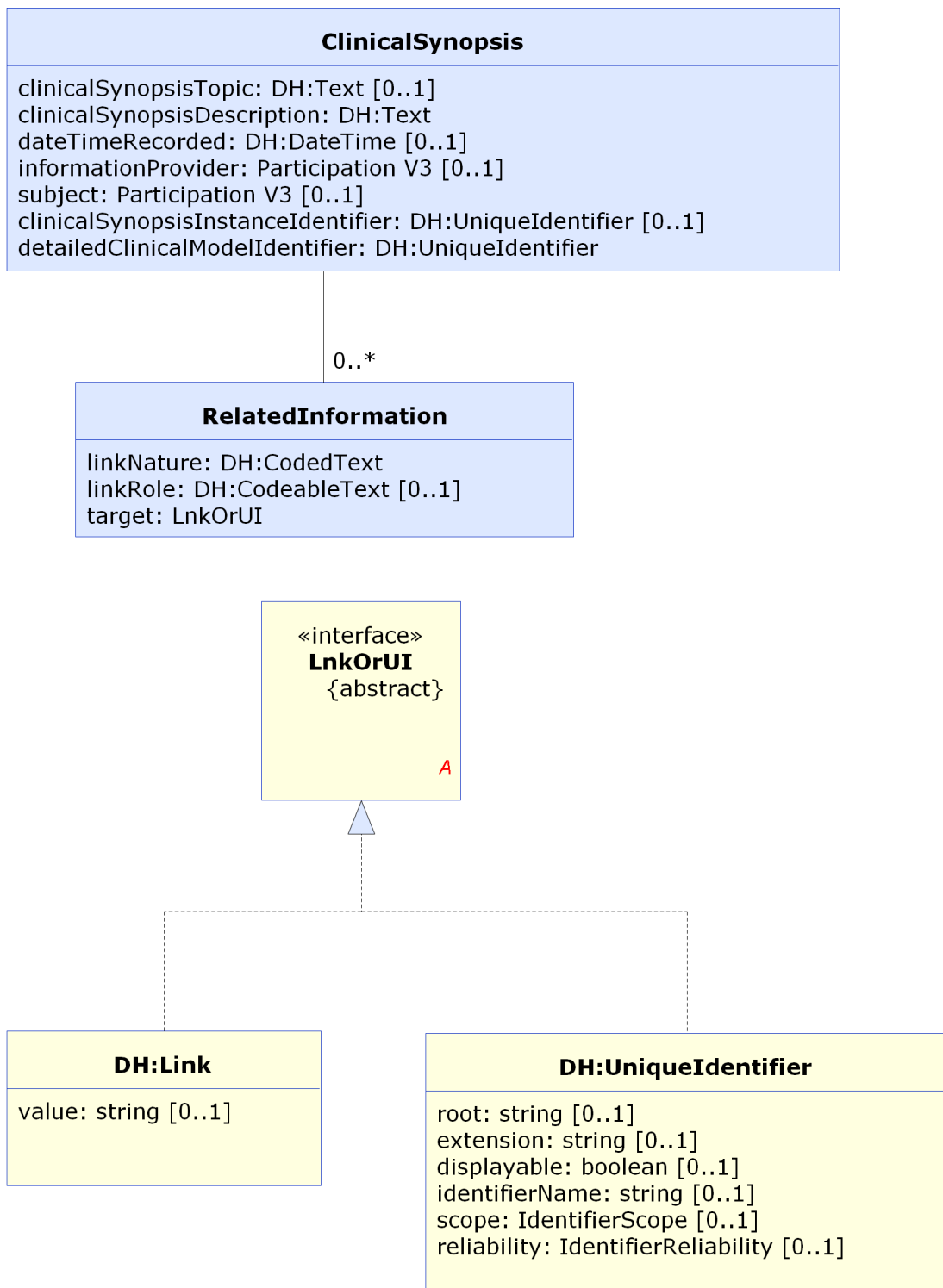


Figure 2.1. Clinical Synopsis

2.5 CLINICAL SYNOPSIS

Identification

Label	CLINICAL SYNOPSIS
Metadata Type	Data Group
Identifier	DG-15513
OID	1.2.36.1.2001.1001.101.102.15513

Definition

Definition	Summary information or comments about the clinical management of the patient, and the prognosis of diagnoses or problems identified during the healthcare encounter. It may also include health-related information pertinent to the patient, and a clinical interpretation of relevant investigations and observations performed on the patient (including pathology and diagnostic imaging).
Definition Source	Australian Digital Health Agency
Synonymous Names	Clinical Comment Clinical Note Clinical Summary Clinical Management Summary
Scope	Narrative information is captured or entered here by a healthcare provider from the focus of a healthcare provider, carer, subject of care or others unrelated to the subject of care.
Scope Source	Australian Digital Health Agency
Notes	Used by the healthcare provider to describe additional information, such as interpretation and the subject of care's understanding of the healthcare event, which is not captured by other structured or unstructured information components pertinent to that healthcare event.

Usage


Misuse	Do not use in place of other individual data items.
---------------	---











Data Hierarchy



Note

Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. Typically, such identifiers will be generated internally by systems and not displayed to users since they rarely have clinical significance.

	CLINICAL SYNOPSIS	
T	Clinical Synopsis Topic	0..1
T	Clinical Synopsis Description	1..1

	DateTime Recorded		0..1
	INFORMATION PROVIDER		0..1
	SUBJECT		0..1
	Clinical Synopsis Instance Identifier		0..1
	RELATED INFORMATION		0..*
		Link Nature	1..1
		Link Role	0..1
	 	Target	1..1
	Detailed Clinical Model Identifier		1..1

2.6 Clinical Synopsis Topic

Identification

Label	Clinical Synopsis Topic
Metadata Type	Data Element
Identifier	DE-16673
OID	1.2.36.1.2001.1001.101.103.16673

Definition


Definition	The title or topic of the clinical synopsis.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	Topic of the clinical description about the subject of care and the healthcare event or encounter. The topic enables the organisation of the healthcare provider's description or the subject of care's interpretation of the health event or encounter.
Context Source	Australian Digital Health Agency
Notes	Possible uses include being a title to identify the synopsis in a list of synopses, being a summary to provide a short precis of the synopsis, and being a topic to classify the content of the synopsis.
Data Type	Text

Usage

Examples	<ol style="list-style-type: none"> 1) My Diabetes: 2) Diagnosis: 3) My Blood Pressure:
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	CLINICAL SYNOPSIS	0..1

2.7 Clinical Synopsis Description

Identification

Label	Clinical Synopsis Description
Metadata Type	Data Element
Identifier	DE-15582
OID	1.2.36.1.2001.1001.101.103.15582

Definition


Definition	Short description, overview or summary of a clinical event and its reasons.
Definition Source	Australian Digital Health Agency
Synonymous Names	Clinical Summary Description
Context	Provides concise narrative about the subject of care and the healthcare event or encounter. It may include the healthcare provider's interpretation (meta-observation) and the subject of care's understanding of the healthcare event that complements other structured or unstructured information captured or communicated about the health event or encounter.
Context Source	Australian Digital Health Agency
Notes	The description may include a summary of the issues or problems, management strategies, outcomes or progress, and possible prognosis.
Data Type	Text

Usage

Examples	<ol style="list-style-type: none"> 1) Admitted for elective bronchoscopy for assessment of left lingular and bibasal pneumonia. No focal endobronchial pathology identified. No evidence of malignancy and no pathogens isolated on bronchial brushings and washings. 2) 3/52 ago involved in a rear end motor vehicle accident, mid-velocity impact; complaining of neck pain, dizziness, nausea and difficulties concentrating. Disturbed sleep. No spinal cord signs.
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	CLINICAL SYNOPSIS	1..1

2.8 DateTime Recorded

Identification

Label	DateTime Recorded
Metadata Type	Data Element
Identifier	DE-15511
OID	1.2.36.1.2001.1001.101.103.15511

Definition


Definition	The date, or date and time, when the clinical synopsis recording was made.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	DateTime

Usage

Examples	Please see DateTime in Appendix B, Specification Guide for Use for examples and usage information on specifying a date or time (or both).
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	CLINICAL SYNOPSIS	0..1

2.9 INFORMATION PROVIDER

Identification

Label	INFORMATION PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296
External Identifier	AS4846-2006

Definition


Definition	Details pertinent to the identification of a healthcare provider individual who is reporting the clinical synopsis information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This does not have to be a person and, in particular, does not have to be a healthcare provider. Types of sources include:</p> <ul style="list-style-type: none"> • the subject of care; • a subject of care agent, e.g. parent, guardian; • the clinician; and • a device or software.

Usage

Conditions of Use	<p>This SHALL NOT be used unless the provider of the information is not the <i>Composer/Author</i> of the enclosing Structured Document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to "Information Provider". • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or as a DEVICE.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	CLINICAL SYNOPSIS	0..1

2.10 SUBJECT

Identification

Label	SUBJECT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	The individual about whom the clinical synopsis was written.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Generally only used when the recorder needs to make it explicit. Otherwise, the subject of the enclosing Structured Document is assumed.
Scope Source	Australian Digital Health Agency

Usage

Conditions of Use	<p>This SHALL NOT be used unless the subject of the information is not the <i>Subject of Care</i> of the enclosing Structured Document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> Participation Type SHALL have an implementation-specific value equivalent to "Subject". PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	CLINICAL SYNOPSIS	0..1

2.11 Clinical Synopsis Instance Identifier

Identification

Label	Clinical Synopsis Instance Identifier
Metadata Type	Data Element
Identifier	DE-16706
OID	1.2.36.1.2001.1001.101.103.16706

Definition


Definition	A globally unique identifier for each instance of a <i>Clinical Synopsis</i> evaluation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	CLINICAL SYNOPSIS	0..1

2.12 RELATED INFORMATION

Identification


Label	RELATED INFORMATION
Metadata Type	Data Group
Identifier	DG-16692
OID	1.2.36.1.2001.1001.101.102.16692

Definition




Definition	Information held elsewhere that is relevant to this instance of <i>Exclusion Statement</i> .
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Items of related information include, but are not limited to, documents, parts of documents, images and web pages.</p> <p>“Elsewhere” includes elsewhere in the same document.</p> <p>1:1 and 1:N relationships between instances of DCMs can be expressed by using one, or more than one, respectively, links. Chains of links can be used to see problem threads or other logical groupings of items. 1:1 and 1:N relationships between instances of DCMs can be expressed by using one, or more than one, respectively, links. Chains of links can be used to see problem threads or other logical groupings of items.</p> <p>Links are only to be used between instances of DCMs or documents, i.e. between objects representing complete domain concepts. This is because relationships between sub-elements of whole concepts are not necessarily meaningful and may be confusing.</p> <p>When the item of related information is a complete document (including images) or a web page (or part thereof) an appropriate specialisation of the <i>Related Information</i> data group should be used.</p> <p>The document or other data component instance containing the <i>Related Information</i> data group is called the <i>source</i>. The related information is called the <i>target</i>.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	CLINICAL SYNOPSIS	0..*

Children

Data Type	Name	Occurrences
	Link Nature	1..1
	Link Role	0..1
	Target	1..1

2.13 Link Nature

Identification

Label	Link Nature
Metadata Type	Data Element
Identifier	DE-16698
OID	1.2.36.1.2001.1001.101.103.16698

Definition


Definition	The general semantic category of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs or document. This attribute is intended to be a coarse-grained category that can be used to enable interoperability between sender and receiver.
Data Type	CodedText
Value Domain	Link Nature Values

Usage

Examples	<ol style="list-style-type: none"> 1) is related to 2) is confirmed by or authorised by 3) is related to the same problem or health issue
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

2.14 Link Nature Values

Identification

Label	Link Nature Values
Metadata Type	Value Domain
Identifier	VD-16698
OID	1.2.36.1.2001.1001.101.104.16698
External Identifier	LINK_NATURE

Definition

Definition	Set of values for the general semantic category of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency


Value Domain

Source	ISO 13606-3:2009	
Permissible Values	The permissible values are those specified in Termlist LINK_NATURE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] . They are listed here.	
	LINK-A0, is related to	A generic category for any Link, the details of which will be given by the value of Link Role.
	LINK-B0, is confirmed by or authorised by	The target link contains [an instance of a DCM or document] that acts as the legal or clinical basis for the activity documented in the source [DCM instance], or is a declaration of intent to provide (or not to provide) requested care. This Link is to be used to connect two [DCM instances or DCM and document], as opposed to the inclusion of a corroborating or authorising participant as an identified party within a single [DCM instance or document].
	LINK-C0, is related to the same problem or health issue	The target [instance of a DCM or document] documents health or health care that pertains to the same clinical situation as the source [DCM instance]. One of the two might be defining a problem for which the other is a manifestation, or the relationship might for example be cause and effect, stages in an evolving clinical history, a different interpretation of an observation, a clinical indication or contraindication.
	LINK-D0, is related to the same care plan, act or episode	The source and the target [instances of DCM or documents] are each documenting parts of the same care plan, act or episode. One of the two might be defining the same care plan, act or episode, or both might be related milestones.

	LINK-E0, is a related documentation	The target [instance of a DCM or document] is an alternative documentary form of the source [DCM instance], such as re-expression of the same clinical information or additional supplementary explanatory information.
--	-------------------------------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Nature	1..1

2.15 Link Role

Identification

Label	Link Role
Metadata Type	Data Element
Identifier	DE-16699
OID	1.2.36.1.2001.1001.101.103.16699

Definition


Definition	The detailed semantic description of the relationship between this instance of this DCM (i.e. the source), and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs. This attribute provides for a specific description of the actual role played by the target in relation to the source.</p> <p>This attribute may be populated from any suitable terminology, and therefore might support human readership better than interoperable automated processing.</p>
Data Type	CodeableText
Value Domain	Link Role Values

Usage

Examples	<ol style="list-style-type: none"> 1) unspecified link 2) suggests 3) endorses 4) evidence for 5) outcome 6) is documented by 7) excerpts
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	0..1

2.16 Link Role Values

Identification

Label	Link Role Values
Metadata Type	Value Domain
Identifier	VD-16699
OID	1.2.36.1.2001.1001.101.104.16699
External Identifier	LINK_ROLE

Definition

Definition	Set of values for the detailed semantic description of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Context	These values are used within the context of the value of the <i>Link Nature</i> data element. They provide greater specificity and may be selected more for human readership than for interoperable automated processing.
Context Source	Australian Digital Health Agency

Value Domain

Source	ISO 13606-3:2009										
Permissible Values	<p>Values SHOULD be from Termlist LINK_ROLE in ISO 13606-3:2009 [ISO2009a].</p> <p>Values MAY be from any suitable terminology.</p> <p>Some values from Termlist LINK_ROLE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] are:</p> <table border="1"> <tr> <td>LINK-A1, unspecified link</td> <td>The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.</td> </tr> <tr> <td>LINK-A2, suggests</td> <td>The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.</td> </tr> <tr> <td>LINK-B1, endorses</td> <td>The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.</td> </tr> <tr> <td>LINK-C3, evidence for</td> <td>The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.</td> </tr> <tr> <td>LINK-D1, outcome</td> <td>The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.</td> </tr> </table>	LINK-A1, unspecified link	The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.	LINK-A2, suggests	The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.	LINK-B1, endorses	The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.	LINK-C3, evidence for	The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.	LINK-D1, outcome	The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.
LINK-A1, unspecified link	The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.										
LINK-A2, suggests	The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.										
LINK-B1, endorses	The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.										
LINK-C3, evidence for	The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.										
LINK-D1, outcome	The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.										


LINK-E1, documented by	A clinical situation documented in the source component is more formally documented in the target component.
LINK-E4, excerpts	The source component is an extract (copy) of part or all of the information contained within the target component.

Usage

Conditions of Use	Each of the link terms in LINK_ROLE from ISO 13606-3:2009 is a subcategory of a corresponding term in <i>Link Nature Values</i> , where that correspondence is indicated by the first letter after the code string “LINK-”. For example the term LINK-A1 is a subcategory of term LINK-A0. If a term in this list is used for the <i>Link Role</i> data element, the appropriate corresponding value SHALL be used from <i>Link Nature Values</i> .
Conditions of Use Source	ISO 13606-3:2009

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Role	1..1

2.17 Target

Identification

Label	Target
Metadata Type	Data Element
Identifier	DE-16700
OID	1.2.36.1.2001.1001.101.103.16700

Definition


Definition	The “linked to” or identified information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Link UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Link , and UniquelIdentifier .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

2.18 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.15513

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	CLINICAL SYNOPSIS	1..1

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3 Recommendation Detailed Clinical Model

This chapter describes version 2.2 of the *Recommendations (Instruction)* Detailed Clinical Model.

3.1 Purpose

To capture a recommendation, such as from a referee or specialist to a recipient healthcare provider, regarding the management of the patient.

3.2 Use

Use in a letter from a specialist to the referring healthcare provider.

3.3 UML Class Diagrams

The following figure represents the data hierarchy using a UML 2.0 class diagram. The diagram displays data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes; data groups are displayed as classes; their label names are represented as association role names. Association role names are only displayed if they differ from the associated class name. When a data element has a choice of data types, the data type of the attribute that represents it is an abstract interface class generalised from the individual data types. The diagram shows the data hierarchy excluding the details of participation. The default multiplicity is 1..1.

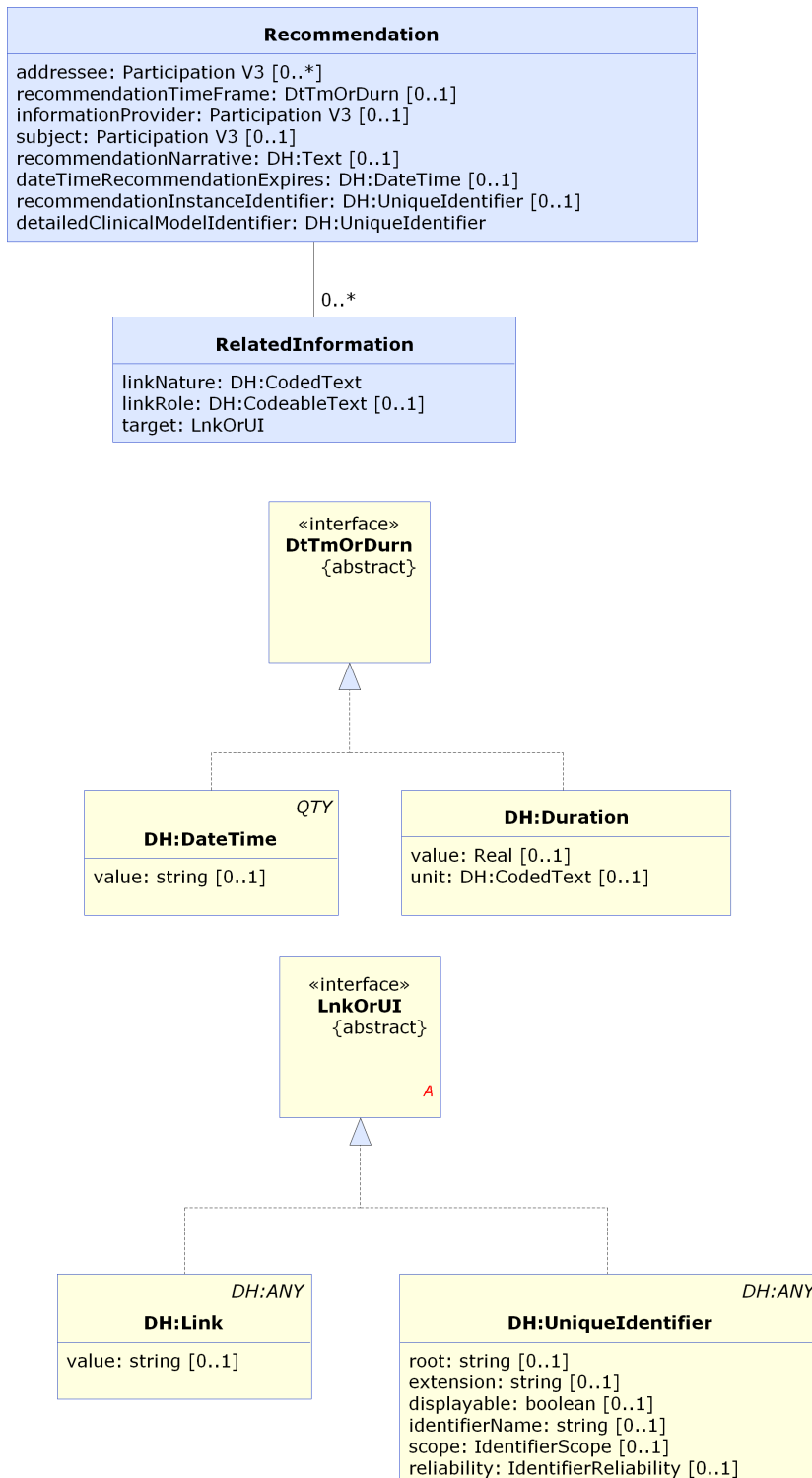


Figure 3.1. Recommendations

3.4 RECOMMENDATION

Identification

Label	RECOMMENDATION
Metadata Type	Data Group
Identifier	DG-20116
OID	1.2.36.1.2001.1001.101.102.20116

Definition












Definition	Recommendation by a clinician to a recipient healthcare provider regarding the management of the patient.
Definition Source	Australian Digital Health Agency
Synonymous Names	




Data Hierarchy



Note

Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. Typically, such identifiers will be generated internally by systems and not displayed to users since they rarely have clinical significance.

 RECOMMENDATION			
		ADDRESSEE	0..*
	 	Time Frame (<i>Recommendation Time Frame</i>)	0..1
		INFORMATION PROVIDER	0..1
		SUBJECT	0..1
		Recommendation Narrative	0..1
		DateTime Recommendation Expires	0..1
		Recommendation Instance Identifier	0..1
		RELATED INFORMATION	0..*
	 <small>001011001</small>	Link Nature	1..1

			Link Role	0..1
			Target	1..1
			Detailed Clinical Model Identifier	1..1

3.5 ADDRESSEE

Identification

Label	ADDRESSEE
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	The intended recipient of the recommendation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This is a person and the types of addressees include:</p> <ul style="list-style-type: none"> • the clinician; and • a healthcare provider. <p>A recommendation is intended to be for a clinician, but, as the individual may be unknown, it can be addressed to an organisation.</p>

Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to "Recommendation Addressee". • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or an ORGANISATION.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RECOMMENDATION	0..*

3.6 Recommendation Time Frame

Identification

Label	Time Frame
Metadata Type	Data Element
Identifier	DE-16586
OID	1.2.36.1.2001.1001.101.103.16586

Definition


Definition	The time or time period for which the recommendation applies.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	DateTime Duration

Usage

Examples	Please see DateTime in Appendix B, Specification Guide for Use for examples and usage information on specifying a date or time (or both).
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RECOMMENDATION	0..1

3.7 INFORMATION PROVIDER

Identification

Label	INFORMATION PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	Details pertinent to the identification of the source of the information about the recommendation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This does not have to be a person and, in particular, does not have to be a healthcare provider. Types of sources include:</p> <ul style="list-style-type: none"> • the subject of care; • a subject of care agent, e.g. parent, guardian; • the clinician; and • a device or software.

Usage

Conditions of Use	<p>This SHALL NOT be used unless the provider of the information is not the <i>Composer/Author</i> of the enclosing Structured Document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to "Information Provider". • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or as a DEVICE.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RECOMMENDATION	0..1

3.8 SUBJECT

Identification

Label	SUBJECT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	The individual upon whom the recommendation is (to be) performed.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Generally only used when the recorder needs to make it explicit. Otherwise, the subject of the enclosing Structured Document is assumed.
Scope Source	Australian Digital Health Agency

Usage

Conditions of Use	<p>This SHALL NOT be used unless the subject of the information is not the <i>Subject of Care</i> of the enclosing Structured Document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> Participation Type SHALL have an implementation-specific value equivalent to "Subject". PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RECOMMENDATION	0..1

3.9 Recommendation Narrative

Identification

Label	Recommendation Narrative
Metadata Type	Data Element
Identifier	DE-16587
OID	1.2.36.1.2001.1001.101.103.16587

Definition


Definition	A textual narrative describing what the recommendation instruction is about.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This could include a recommendation regarding when the subject of care should see the specialist again/discharge from the specialist's care, changes initiation of treatment or recommended investigations.
Data Type	Text

Usage

Examples	<ol style="list-style-type: none"> 1) Monitor diabetic status, renal function and digoxin levels. 2) Review cardiac status.
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RECOMMENDATION	0..1

3.10 DateTime Recommendation Expires

Identification

Label	DateTime Recommendation Expires
Metadata Type	Data Element
Identifier	DE-16588
OID	1.2.36.1.2001.1001.101.103.16588

Definition


Definition	The date and, optionally, time after which the recommendation instruction is no longer effective or in force.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	DateTime

Usage

Examples	Please see DateTime in Appendix B, Specification Guide for Use for examples and usage information on specifying a date or time (or both).
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RECOMMENDATION	0..1

3.11 Recommendation Instance Identifier

Identification

Label	Recommendation Instance Identifier
Metadata Type	Data Element
Identifier	DE-16707
OID	1.2.36.1.2001.1001.101.103.16707

Definition


Definition	A globally unique identifier for each instance of a <i>Recommendation</i> instruction.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RECOMMENDATION	0..1

3.12 RELATED INFORMATION

Identification


Label	RELATED INFORMATION
Metadata Type	Data Group
Identifier	DG-16692
OID	1.2.36.1.2001.1001.101.102.16692

Definition


Definition	Information held elsewhere that is relevant to this instance of <i>Exclusion Statement</i> .
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Items of related information include, but are not limited to, documents, parts of documents, images and web pages.</p> <p>“Elsewhere” includes elsewhere in the same document.</p> <p>1:1 and 1:N relationships between instances of DCMs can be expressed by using one, or more than one, respectively, links. Chains of links can be used to see problem threads or other logical groupings of items.</p> <p>Links are only to be used between instances of DCMs or documents, i.e. between objects representing complete domain concepts. This is because relationships between sub-elements of whole concepts are not necessarily meaningful and may be confusing.</p> <p>When the item of related information is a complete document (including images) or a web page (or part thereof) an appropriate specialisation of the <i>Related Information</i> data group should be used.</p> <p>The document or other data component instance containing the <i>Related Information</i> data group is called the <i>source</i>. The related information is called the <i>target</i>.</p>



Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RECOMMENDATION	0..*

Children

Data Type	Name	Occurrences
	Link Nature	1..1

Data Type	Name	Occurrences
	Link Role	0..1
	Target	1..1

3.13 Link Nature

Identification

Label	Link Nature
Metadata Type	Data Element
Identifier	DE-16698
OID	1.2.36.1.2001.1001.101.103.16698

Definition


Definition	The general semantic category of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs or document. This attribute is intended to be a coarse-grained category that can be used to enable interoperability between sender and receiver.
Data Type	CodedText
Value Domain	Link Nature Values

Usage

Examples	<ol style="list-style-type: none"> 1) is related to 2) is confirmed by or authorised by 3) is related to the same problem or health issue
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

3.14 Link Nature Values

Identification

Label	Link Nature Values
Metadata Type	Value Domain
Identifier	VD-16698
OID	1.2.36.1.2001.1001.101.104.16698
External Identifier	LINK_NATURE

Definition

Definition	Set of values for the general semantic category of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency

Value Domain


Source	ISO 13606-3:2009	
Permissible Values	The permissible values are those specified in Termlist LINK_NATURE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] . They are listed here.	
	LINK-A0, is related to	A generic category for any Link, the details of which will be given by the value of Link Role.
	LINK-B0, is confirmed by or authorised by	The target link contains [an instance of a DCM or document] that acts as the legal or clinical basis for the activity documented in the source [DCM instance], or is a declaration of intent to provide (or not to provide) requested care. This Link is to be used to connect two [DCM instances or DCM and document], as opposed to the inclusion of a corroborating or authorising participant as an identified party within a single [DCM instance or document].
	LINK-C0, is related to the same problem or health issue	The target [instance of a DCM or document] documents health or health care that pertains to the same clinical situation as the source [DCM instance]. One of the two might be defining a problem for which the other is a manifestation, or the relationship might for example be cause and effect, stages in an evolving clinical history, a different interpretation of an observation, a clinical indication or contraindication.
	LINK-D0, is related to the same care plan, act or episode	The source and the target [instances of DCM or documents] are each documenting parts of the same care plan, act or episode. One of the two might be defining the same care plan, act or episode, or both might be related milestones.

LINK-E0, is a related documentation

The target [instance of a DCM or document] is an alternative documentary form of the source [DCM instance], such as re-expression of the same clinical information or additional supplementary explanatory information.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Nature	1..1

3.15 Link Role

Identification

Label	Link Role
Metadata Type	Data Element
Identifier	DE-16699
OID	1.2.36.1.2001.1001.101.103.16699

Definition


Definition	The detailed semantic description of the relationship between this instance of this DCM (i.e. the source), and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs. This attribute provides for a specific description of the actual role played by the target in relation to the source.</p> <p>This attribute may be populated from any suitable terminology, and therefore might support human readership better than interoperable automated processing.</p>
Data Type	CodeableText
Value Domain	Link Role Values

Usage

Examples	<ol style="list-style-type: none"> 1) unspecified link 2) suggests 3) endorses 4) evidence for 5) outcome 6) is documented by 7) excerpts
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	0..1

3.16 Link Role Values

Identification

Label	Link Role Values
Metadata Type	Value Domain
Identifier	VD-16699
OID	1.2.36.1.2001.1001.101.104.16699
External Identifier	LINK_ROLE

Definition

Definition	Set of values for the detailed semantic description of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Context	These values are used within the context of the value of the <i>Link Nature</i> data element. They provide greater specificity and may be selected more for human readership than for interoperable automated processing.
Context Source	Australian Digital Health Agency

Value Domain

Source	ISO 13606-3:2009										
Permissible Values	<p>Values SHOULD be from Termlist LINK_ROLE in ISO 13606-3:2009 [ISO2009a].</p> <p>Values MAY be from any suitable terminology.</p> <p>Some values from Termlist LINK_ROLE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] are:</p> <table border="1"> <tr> <td>LINK-A1, unspecified link</td> <td>The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.</td> </tr> <tr> <td>LINK-A2, suggests</td> <td>The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.</td> </tr> <tr> <td>LINK-B1, endorses</td> <td>The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.</td> </tr> <tr> <td>LINK-C3, evidence for</td> <td>The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.</td> </tr> <tr> <td>LINK-D1, outcome</td> <td>The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.</td> </tr> </table>	LINK-A1, unspecified link	The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.	LINK-A2, suggests	The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.	LINK-B1, endorses	The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.	LINK-C3, evidence for	The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.	LINK-D1, outcome	The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.
LINK-A1, unspecified link	The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.										
LINK-A2, suggests	The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.										
LINK-B1, endorses	The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.										
LINK-C3, evidence for	The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.										
LINK-D1, outcome	The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.										


LINK-E1, documented by	A clinical situation documented in the source component is more formally documented in the target component.
LINK-E4, excerpts	The source component is an extract (copy) of part or all of the information contained within the target component.

Usage

Conditions of Use	Each of the link terms in LINK_ROLE from ISO 13606-3:2009 is a subcategory of a corresponding term in <i>Link Nature Values</i> , where that correspondence is indicated by the first letter after the code string “LINK-”. For example the term LINK-A1 is a subcategory of term LINK-A0. If a term in this list is used for the <i>Link Role</i> data element, the appropriate corresponding value SHALL be used from <i>Link Nature Values</i> .
Conditions of Use Source	ISO 13606-3:2009

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Role	1..1

3.17 Target

Identification

Label	Target
Metadata Type	Data Element
Identifier	DE-16700
OID	1.2.36.1.2001.1001.101.103.16700

Definition


Definition	The “linked to” or identified information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Link UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Link , and UniquelIdentifier .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

3.18 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.20116

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RECOMMENDATION	1..1

4 Exclusion Statement Detailed Clinical Model

This chapter describes version 1.2 of the *Exclusion Statement* Detailed Clinical Model.

4.1 Purpose

To positively record the absence or exclusion of any clinical findings or evaluations within the health record.

4.2 Use

Use to record the positive exclusion or absence of clinical findings or evaluations within the health record. This Detailed Clinical Model (DCM) avoids the need to use terminology to express negation about any item within the health record.

Specialisations of this DCM will capture specific and more detailed information about common exclusions, such as problems or diagnoses. This DCM has been deliberately kept simple and open in order to capture simple statements about anything that may be usefully recorded as absent or excluded within the health record.

4.3 Misuse

Do not use to record the exclusion or absence of adverse reactions, problems, diagnoses or interventions (procedures) - use specific specialisations of this DCM in these situations.

4.4 UML Class Diagrams

The following figure represents the data hierarchy using a UML 2.0 class diagram. The diagram displays data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes; data groups are displayed as classes; their label names are represented as association role names. Association role names are only displayed if they differ from the associated class name. When a data element has a choice of data types, the data type of the attribute that represents it is an abstract interface class generalised from the individual data types. The diagram shows the data hierarchy excluding the details of participation. The default multiplicity is 1..1.

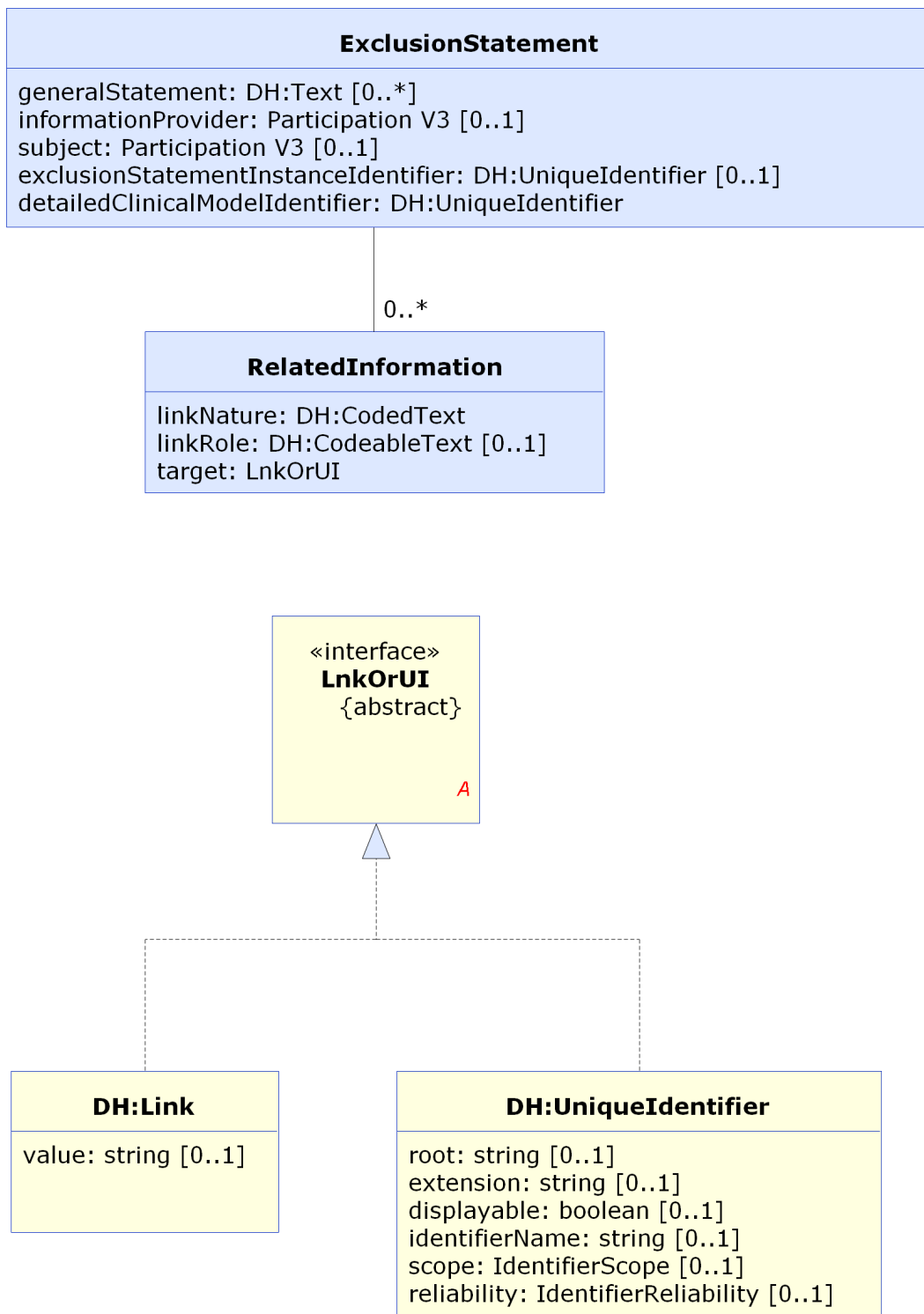


Figure 4.1. Exclusion Statement

4.5 EXCLUSION STATEMENT

Identification

Label	EXCLUSION STATEMENT
Metadata Type	Data Group
Identifier	DG-16134
OID	1.2.36.1.2001.1001.101.102.16134

Definition











Definition	Statements that need to be positively asserted about the absence or exclusion of data values.
Definition Source	openEHR Foundation
Synonymous Names	

Data Hierarchy



Note

Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. Typically, such identifiers will be generated internally by systems and not displayed to users since they rarely have clinical significance.

		EXCLUSION STATEMENT	
		General Statement	0..*
		INFORMATION PROVIDER	0..1
		SUBJECT	0..1
		Exclusion Statement Instance Identifier	0..1
		RELATED INFORMATION	
		Link Nature	1..1
		Link Role	0..1
		Target	1..1
		Detailed Clinical Model Identifier	1..1

4.6 General Statement

Identification

Label	General Statement
Metadata Type	Data Element
Identifier	DE-16135
OID	1.2.36.1.2001.1001.101.103.16135

Definition


Definition	A general statement about the absence or exclusion of data values.
Definition Source	openEHR Foundation
Synonymous Names	
Context	Any information required to be explicitly recorded within the record as being absent or excluded.
Context Source	openEHR Foundation
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT	0..*

4.7 INFORMATION PROVIDER

Identification

Label	INFORMATION PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	The party who was the source of the information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Generally only used when the recorder needs to make it explicit. Otherwise, the author of the enclosing Structured Document is assumed.
Scope Source	Australian Digital Health Agency
Notes	<p>This does not have to be a person and, in particular, does not have to be a healthcare provider. Types of sources include:</p> <ul style="list-style-type: none"> • the subject of care; • a subject of care agent, e.g. parent, guardian; • the clinician; and • a device or software.

Usage

Conditions of Use	<p>This SHALL NOT be used unless the provider of the information is not the <i>Composer/Author</i> of the enclosing Structured Document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to “Information Provider”. • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or as a DEVICE.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT	0..1

4.8 SUBJECT

Identification

Label	SUBJECT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	The individual about whom the exclusion statement information is being recorded.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Generally only used when the recorder needs to make it explicit. Otherwise, the subject of the enclosing Structured Document is assumed.
Scope Source	Australian Digital Health Agency

Usage

Conditions of Use	<p>This SHALL NOT be used unless the subject of the information is not the <i>Subject of Care</i> of the enclosing Structured Document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to “Subject”. • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT	0..1

4.9 Exclusion Statement Instance Identifier

Identification

Label	Exclusion Statement Instance Identifier
Metadata Type	Data Element
Identifier	DE-16708
OID	1.2.36.1.2001.1001.101.103.16708

Definition


Definition	A globally unique identifier for each instance of an <i>Exclusion Statement</i> evaluation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT	0..1

4.10 RELATED INFORMATION

Identification


Label	RELATED INFORMATION
Metadata Type	Data Group
Identifier	DG-16692
OID	1.2.36.1.2001.1001.101.102.16692

Definition


Definition	Information held elsewhere that is relevant to this instance of <i>Exclusion Statement</i> .
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Items of related information include, but are not limited to, documents, parts of documents, images and web pages.</p> <p>“Elsewhere” includes elsewhere in the same document.</p> <p>1:1 and 1:N relationships between instances of DCMs can be expressed by using one, or more than one, respectively, links. Chains of links can be used to see problem threads or other logical groupings of items.</p> <p>Links are only to be used between instances of DCMs or documents, i.e. between objects representing complete domain concepts. This is because relationships between sub-elements of whole concepts are not necessarily meaningful and may be confusing.</p> <p>When the item of related information is a complete document (including images) or a web page (or part thereof) an appropriate specialisation of the <i>Related Information</i> data group should be used.</p> <p>The document or other data component instance containing the <i>Related Information</i> data group is called the <i>source</i>. The related information is called the <i>target</i>.</p>



Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT	0..*

Children

Data Type	Name	Occurrences
	Link Nature	1..1

Data Type	Name	Occurrences
	Link Role	0..1
	Target	1..1

4.11 Link Nature

Identification

Label	Link Nature
Metadata Type	Data Element
Identifier	DE-16698
OID	1.2.36.1.2001.1001.101.103.16698

Definition


Definition	The general semantic category of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs or document. This attribute is intended to be a coarse-grained category that can be used to enable interoperability between sender and receiver.
Data Type	CodedText
Value Domain	Link Nature Values

Usage

Examples	<ol style="list-style-type: none"> 1) is related to 2) is confirmed by or authorised by 3) is related to the same problem or health issue
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

4.12 Link Nature Values

Identification

Label	Link Nature Values
Metadata Type	Value Domain
Identifier	VD-16698
OID	1.2.36.1.2001.1001.101.104.16698
External Identifier	LINK_NATURE

Definition

Definition	Set of values for the general semantic category of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency

Value Domain


Source	ISO 13606-3:2009	
Permissible Values	The permissible values are those specified in Termlist LINK_NATURE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] . They are listed here.	
	LINK-A0, is related to	A generic category for any Link, the details of which will be given by the value of Link Role.
	LINK-B0, is confirmed by or authorised by	The target link contains [an instance of a DCM or document] that acts as the legal or clinical basis for the activity documented in the source [DCM instance], or is a declaration of intent to provide (or not to provide) requested care. This Link is to be used to connect two [DCM instances or DCM and document], as opposed to the inclusion of a corroborating or authorising participant as an identified party within a single [DCM instance or document].
	LINK-C0, is related to the same problem or health issue	The target [instance of a DCM or document] documents health or health care that pertains to the same clinical situation as the source [DCM instance]. One of the two might be defining a problem for which the other is a manifestation, or the relationship might for example be cause and effect, stages in an evolving clinical history, a different interpretation of an observation, a clinical indication or contraindication.
	LINK-D0, is related to the same care plan, act or episode	The source and the target [instances of DCM or documents] are each documenting parts of the same care plan, act or episode. One of the two might be defining the same care plan, act or episode, or both might be related milestones.

LINK-E0, is a related documentation

The target [instance of a DCM or document] is an alternative documentary form of the source [DCM instance], such as re-expression of the same clinical information or additional supplementary explanatory information.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Nature	1..1

4.13 Link Role

Identification

Label	Link Role
Metadata Type	Data Element
Identifier	DE-16699
OID	1.2.36.1.2001.1001.101.103.16699

Definition


Definition	The detailed semantic description of the relationship between this instance of this DCM (i.e. the source), and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs. This attribute provides for a specific description of the actual role played by the target in relation to the source.</p> <p>This attribute may be populated from any suitable terminology, and therefore might support human readership better than interoperable automated processing.</p>
Data Type	CodeableText
Value Domain	Link Role Values

Usage

Examples	<ol style="list-style-type: none"> 1) unspecified link 2) suggests 3) endorses 4) evidence for 5) outcome 6) is documented by 7) excerpts
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	0..1

4.14 Link Role Values

Identification

Label	Link Role Values
Metadata Type	Value Domain
Identifier	VD-16699
OID	1.2.36.1.2001.1001.101.104.16699
External Identifier	LINK_ROLE

Definition

Definition	Set of values for the detailed semantic description of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Context	These values are used within the context of the value of the <i>Link Nature</i> data element. They provide greater specificity and may be selected more for human readership than for interoperable automated processing.
Context Source	Australian Digital Health Agency

Value Domain

Source	ISO 13606-3:2009										
Permissible Values	<p>Values SHOULD be from Termlist LINK_ROLE in ISO 13606-3:2009 [ISO2009a].</p> <p>Values MAY be from any suitable terminology.</p> <p>Some values from Termlist LINK_ROLE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] are:</p> <table> <tr> <td>LINK-A1, unspecified link</td> <td>The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.</td> </tr> <tr> <td>LINK-A2, suggests</td> <td>The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.</td> </tr> <tr> <td>LINK-B1, endorses</td> <td>The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.</td> </tr> <tr> <td>LINK-C3, evidence for</td> <td>The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.</td> </tr> <tr> <td>LINK-D1, outcome</td> <td>The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.</td> </tr> </table>	LINK-A1, unspecified link	The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.	LINK-A2, suggests	The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.	LINK-B1, endorses	The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.	LINK-C3, evidence for	The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.	LINK-D1, outcome	The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.
LINK-A1, unspecified link	The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.										
LINK-A2, suggests	The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.										
LINK-B1, endorses	The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.										
LINK-C3, evidence for	The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.										
LINK-D1, outcome	The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.										


	LINK-E1, documented by	A clinical situation documented in the source component is more formally documented in the target component.
	LINK-E4, excerpts	The source component is an extract (copy) of part or all of the information contained within the target component.

Usage

Conditions of Use	Each of the link terms in LINK_ROLE from ISO 13606-3:2009 is a subcategory of a corresponding term in <i>Link Nature Values</i> , where that correspondence is indicated by the first letter after the code string “LINK-”. For example the term LINK-A1 is a subcategory of term LINK-A0. If a term in this list is used for the <i>Link Role</i> data element, the appropriate corresponding value SHALL be used from <i>Link Nature Values</i> .
Conditions of Use Source	ISO 13606-3:2009

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Role	1..1

4.15 Target

Identification

Label	Target
Metadata Type	Data Element
Identifier	DE-16700
OID	1.2.36.1.2001.1001.101.103.16700

Definition


Definition	The “linked to” or identified information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Link UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Link , and UniquelIdentifier .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

4.16 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16134

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT	1..1

5 Referral Detail Detailed Clinical Model

This chapter describes version 1.2 of the *Referral Detail* Detailed Clinical Model.

5.1 Purpose

Detailed information about the clinical referral.

5.2 UML Class Diagrams

The following figure represents the data hierarchy using a UML 2.0 class diagram. The diagram displays data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes; data groups are displayed as classes; their label names are represented as association role names. Association role names are only displayed if they differ from the associated class name. When a data element has a choice of data types, the data type of the attribute that represents it is an abstract interface class generalised from the individual data types. The diagram shows the data hierarchy excluding the details of participation. The default multiplicity is 1..1.

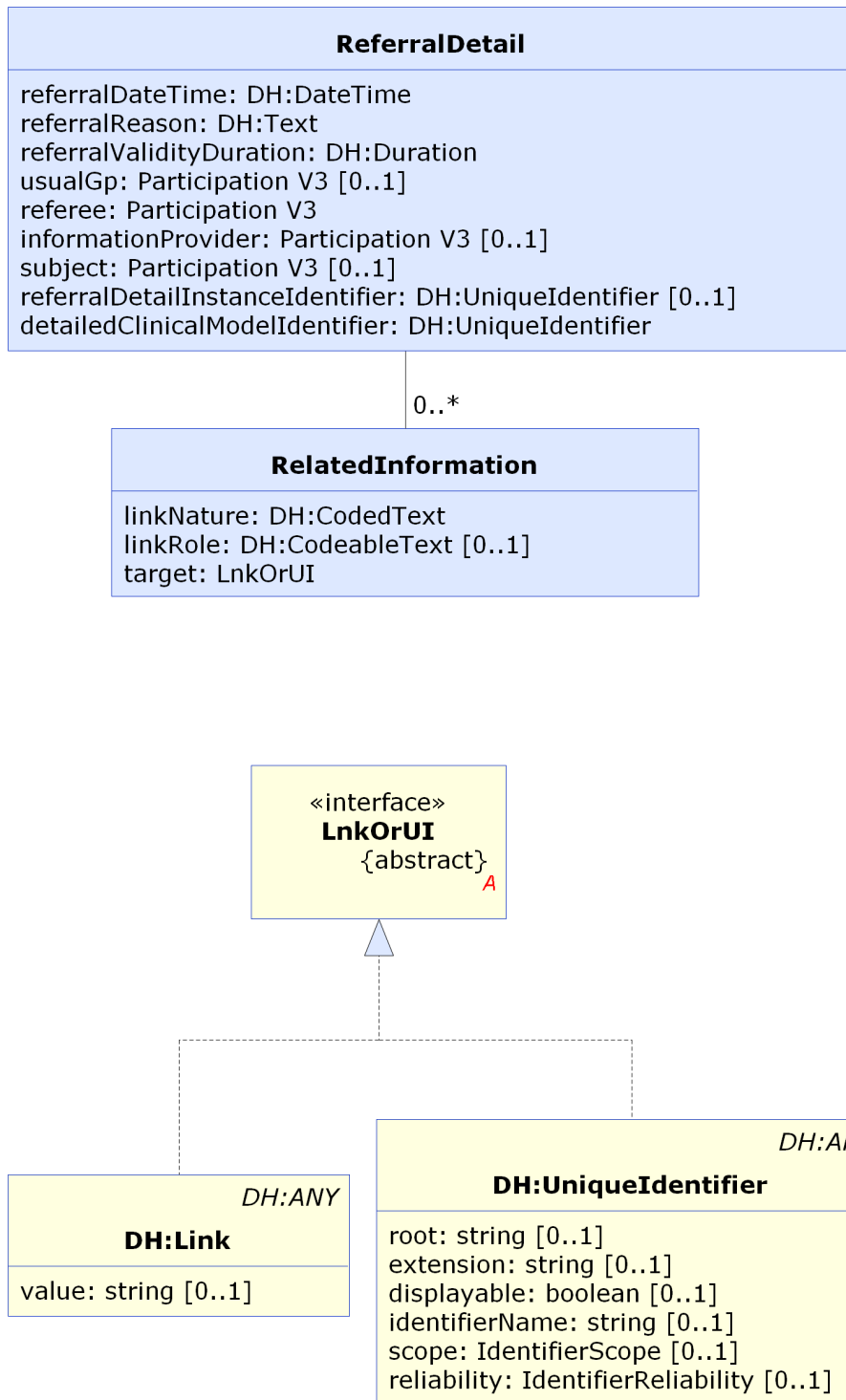


Figure 5.1. Referral Detail

5.3 REFERRAL DETAIL

Identification

Label	REFERRAL DETAIL
Metadata Type	Data Group
Identifier	DG-16347
OID	1.2.36.1.2001.1001.101.102.16347

Definition

Definition	Specific information about the clinical referral.
Definition Source	Australian Digital Health Agency
Synonymous Names	




Data Hierarchy



Note

Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. Typically, such identifiers will be generated internally by systems and not displayed to users since they rarely have clinical significance.

REFERRAL DETAIL			
	Referral DateTime		1..1
	Referral Reason		1..1
	Referral Validity Duration		1..1
	USUAL GP		0..1
	REFEREE		1..1
	INFORMATION PROVIDER		0..1
	SUBJECT		0..1
	Referral Detail Instance Identifier		0..1
	RELATED INFORMATION		0..*
	Link Nature		1..1

			Link Role	0..1
			Target	1..1
			Detailed Clinical Model Identifier	1..1

5.4 Referral DateTime

Identification

Label	Referral DateTime
Metadata Type	Data Element
Identifier	DE-16620
OID	1.2.36.1.2001.1001.101.103.16620

Definition


Definition	The date and, optionally, time when the referral document was sent.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	DateTime

Usage

Conditions of Use	The exact referral dates SHALL be used.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see DateTime in Appendix B, Specification Guide for Use for examples and usage information on specifying a date or time (or both).
Misuse	Entering approximate dates when an exact date is available.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERRAL DETAIL	1..1

5.5 Referral Reason

Identification

Label	Referral Reason
Metadata Type	Data Element
Identifier	DE-20118
OID	1.2.36.1.2001.1001.101.103.20118

Definition


Definition	A narrative of the reasons for the referral, including the presenting problems, clinical presentation, etc.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	The <i>Referral Reason</i> SHALL be used to communicate to the referee information about the reasons for the referral, which may include information about the problems or issues experienced by the subject of care, as identified by the referrer.
Context Source	Australian Digital Health Agency
Notes	<p>This data element complements the structured information contained in the referral specification. It is used by the referrer to communicate the reasons for referral and any synopsis of clinical information about the subject of care that is relevant to the referral, such as chief complaints, presenting problems and key physical examination findings, etc.</p> <p>The content in this data element may vary from a single line in simple cases to many paragraphs for more complex circumstances.</p>
Data Type	Text

Usage

Examples	<ol style="list-style-type: none"> 1) To rule out ischaemic heart disease. 2) To rule out organic brain lesions. 3) Thank you for seeing this 14-year-old schoolboy who fell whilst playing football at school yesterday. On examination he has a swollen painful R ankle and cannot weight bear on it today. I suspect he has a fracture of his right tibia and fibula. 4) Thank you for seeing this 43-year-old lady who has had 2 episodes of cholecystitis in the last month. She is currently well. <p>Ultrasound of her abdomen done at the Public Hospital Emergency Department shows she has gall stones. She has private cover and wishes to see you to consider cholecystectomy at the Private Hospital.</p>
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERRAL DETAIL	1..1

5.6 Referral Validity Duration

Identification

Label	Referral Validity Duration
Metadata Type	Data Element
Identifier	DE-16622
OID	1.2.36.1.2001.1001.101.103.16622

Definition


Definition	The length of time the referral is valid from the date of the first subject of care and specialist encounter.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<i>Referral Validity Duration</i> captures the valid duration of the referral that may be constrained by, for example, Medicare funding policy.
Data Type	Duration

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Duration .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERRAL DETAIL	1..1

5.7 USUAL GP

Identification

Label	USUAL GP
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	A healthcare provider (person or organisation) nominated by the subject of care as being primarily responsible for their ongoing healthcare.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	In general, this is the healthcare provider nominated by the subject of care at the time as being their main primary healthcare provider or the primary healthcare provider with whom communications should be conducted for the purposes of the healthcare event in question. As such, it is not necessarily the subject of care's "usual GP"; indeed, it may not be a GP at all. However, the <i>current</i> scope is limited to the primary healthcare provider who is deemed to be the subject of care's usual GP.
Scope Source	Australian Digital Health Agency
Notes	This is a person or an organisation. Examples include: <ul style="list-style-type: none"> • a clinician; • a healthcare provider; and • a GP practice.


Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <p>Additional obligation and occurrence constraints:</p> <ul style="list-style-type: none"> • Participation Period is PROHIBITED. • LOCATION OF PARTICIPATION is PROHIBITED. • Entity Identifier is ESSENTIAL. • Relationship to Subject of Care is PROHIBITED. • DEMOGRAPHIC DATA is PROHIBITED. • ENTITLEMENT is PROHIBITED.
-------------------	---

	<ul style="list-style-type: none"> • Qualifications is PROHIBITED. <p>Other additional constraints when the <i>Usual GP</i> is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON):</p> <ul style="list-style-type: none"> • EMPLOYMENT DETAIL is ESSENTIAL. • Entity Identifier is ESSENTIAL. • EMPLOYER ORGANISATION is ESSENTIAL. • EMPLOYER ORGANISATION.Entity Identifier is ESSENTIAL. • Participation Type SHALL have an implementation-specific value equivalent to “Usual GP”. • Role SHOULD have a value chosen from 1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 [ABS2009]. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available MAY be used. • The value of one Entity Identifier SHALL be an Australian HPI-I. • The value of one EMPLOYER ORGANISATION.Entity Identifier SHALL be an Australian HPI-O. • AUSTRALIAN OR INTERNATIONAL ADDRESS SHALL be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON. <p>Other additional constraints when the <i>Usual GP</i> is an Organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an ORGANISATION):</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to “Usual GP”. • Role SHALL have a value representing the type of Facility e.g. Clinic. • The value of one Entity Identifier SHALL be an Australian HPI-O. • AUSTRALIAN OR INTERNATIONAL ADDRESS SHALL be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as an ORGANISATION.
<p>Conditions of Use Source</p>	<p>Australian Digital Health Agency</p>
<p>Misuse</p>	<p>This data group SHALL NOT be recorded if the <i>Usual GP</i> is same as the “document author/referring GP”.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERRAL DETAIL	0..1

5.8 REFEREE

Identification

Label	REFEREE
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	The specialist to whom the subject of care is being referred.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	Types of sources include: <ul style="list-style-type: none"> • a clinician; and • a healthcare provider.

Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <p>Additional obligation and occurrence constraints:</p> <ul style="list-style-type: none"> • Participation Period is PROHIBITED. • LOCATION OF PARTICIPATION is PROHIBITED. • Entity Identifier is ESSENTIAL. • ADDRESS is ESSENTIAL. • ELECTRONIC COMMUNICATION DETAIL is ESSENTIAL. • Relationship to Subject of Care is PROHIBITED. • DEMOGRAPHIC DATA is PROHIBITED. • ENTITLEMENT is PROHIBITED. • Qualifications is PROHIBITED. <p>Other additional constraints when the Referee is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON):</p> <ul style="list-style-type: none"> • EMPLOYMENT DETAIL is ESSENTIAL.
-------------------	---

- Participation Type **SHALL** have an implementation-specific value equivalent to "Referee".
- Role **SHOULD** have a value chosen from [1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 \[ABS2009\]](#). However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used.
- The value of one Entity Identifier **SHALL** be an Australian HPI-I.
- The value of one EMPLOYER ORGANISATION.Entity Identifier **SHALL** be an Australian HPI-O.
- AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.
- PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.

Other additional constraints when the Referee is an Organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an ORGANISATION):


- Participation Type **SHALL** have an implementation-specific value equivalent to "Referee".
- Role **SHALL** have a value representing the type of Facility e.g. Clinic.
- The value of one Entity Identifier **SHALL** be an Australian HPI-O.
- AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.
- PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as an ORGANISATION.

Conditions of Use Source

Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERRAL DETAIL	1..1

5.9 INFORMATION PROVIDER

Identification

Label	INFORMATION PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	Details pertinent to the identification of the source of the information about the referral.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This does not have to be a person and, in particular, does not have to be a healthcare provider. Types of sources include:</p> <ul style="list-style-type: none"> • the subject of care; • a subject of care agent, e.g. parent, guardian; • the clinician; and • a device or software.

Usage

Conditions of Use	<p>This SHALL NOT be used unless the provider of the information is not the <i>Composer/Author</i> of the enclosing Structured Document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to "Information Provider". • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or as a DEVICE.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERRAL DETAIL	0..1

5.10 SUBJECT

Identification

Label	SUBJECT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	The individual who is the subject of care of the referral.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Generally only used when the recorder needs to make it explicit. Otherwise, the subject of the enclosing Structured Document is assumed.
Scope Source	Australian Digital Health Agency

Usage

Conditions of Use	<p>This SHALL NOT be used unless the subject of the procedure is not the <i>Subject of Care</i> of the enclosing Structured Document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to “Subject”. • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERRAL DETAIL	0..1

5.11 Referral Detail Instance Identifier

Identification

Label	Referral Detail Instance Identifier
Metadata Type	Data Element
Identifier	DE-16717
OID	1.2.36.1.2001.1001.101.103.16717

Definition


Definition	A globally unique identifier for each instance of a <i>Referral Detail</i> administration entry.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERRAL DETAIL	0..1

5.12 RELATED INFORMATION

Identification


Label	RELATED INFORMATION
Metadata Type	Data Group
Identifier	DG-16692
OID	1.2.36.1.2001.1001.101.102.16692

Definition


Definition	Information held elsewhere that is relevant to this instance of <i>Exclusion Statement</i> .
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Items of related information include, but are not limited to, documents, parts of documents, images and web pages.</p> <p>“Elsewhere” includes elsewhere in the same document.</p> <p>1:1 and 1:N relationships between instances of DCMs can be expressed by using one, or more than one, respectively, links. Chains of links can be used to see problem threads or other logical groupings of items.</p> <p>Links are only to be used between instances of DCMs or documents, i.e. between objects representing complete domain concepts. This is because relationships between sub-elements of whole concepts are not necessarily meaningful and may be confusing.</p> <p>When the item of related information is a complete document (including images) or a web page (or part thereof) an appropriate specialisation of the <i>Related Information</i> data group should be used.</p> <p>The document or other data component instance containing the <i>Related Information</i> data group is called the <i>source</i>. The related information is called the <i>target</i>.</p>



Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERRAL DETAIL	0..*

Children

Data Type	Name	Occurrences
	Link Nature	1..1

Data Type	Name	Occurrences
	Link Role	0..1
	Target	1..1

5.13 Link Nature

Identification

Label	Link Nature
Metadata Type	Data Element
Identifier	DE-16698
OID	1.2.36.1.2001.1001.101.103.16698

Definition


Definition	The general semantic category of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs or document. This attribute is intended to be a coarse-grained category that can be used to enable interoperability between sender and receiver.
Data Type	CodedText
Value Domain	Link Nature Values

Usage

Examples	<ol style="list-style-type: none"> 1) is related to 2) is confirmed by or authorised by 3) is related to the same problem or health issue
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

5.14 Link Nature Values

Identification

Label	Link Nature Values
Metadata Type	Value Domain
Identifier	VD-16698
OID	1.2.36.1.2001.1001.101.104.16698
External Identifier	LINK_NATURE

Definition

Definition	Set of values for the general semantic category of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency


Value Domain

Source	ISO 13606-3:2009	
Permissible Values	The permissible values are those specified in Termlist LINK_NATURE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] . They are listed here.	
	LINK-A0, is related to	A generic category for any Link, the details of which will be given by the value of Link Role.
	LINK-B0, is confirmed by or authorised by	The target link contains [an instance of a DCM or document] that acts as the legal or clinical basis for the activity documented in the source [DCM instance], or is a declaration of intent to provide (or not to provide) requested care. This Link is to be used to connect two [DCM instances or DCM and document], as opposed to the inclusion of a corroborating or authorising participant as an identified party within a single [DCM instance or document].
	LINK-C0, is related to the same problem or health issue	The target [instance of a DCM or document] documents health or health care that pertains to the same clinical situation as the source [DCM instance]. One of the two might be defining a problem for which the other is a manifestation, or the relationship might for example be cause and effect, stages in an evolving clinical history, a different interpretation of an observation, a clinical indication or contraindication.
	LINK-D0, is related to the same care plan, act or episode	The source and the target [instances of DCM or documents] are each documenting parts of the same care plan, act or episode. One of the two might be defining the same care plan, act or episode, or both might be related milestones.

	LINK-E0, is a related documentation	The target [instance of a DCM or document] is an alternative documentary form of the source [DCM instance], such as re-expression of the same clinical information or additional supplementary explanatory information.
--	-------------------------------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Nature	1..1

5.15 Link Role

Identification

Label	Link Role
Metadata Type	Data Element
Identifier	DE-16699
OID	1.2.36.1.2001.1001.101.103.16699

Definition


Definition	The detailed semantic description of the relationship between this instance of this DCM (i.e. the source), and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs. This attribute provides for a specific description of the actual role played by the target in relation to the source.</p> <p>This attribute may be populated from any suitable terminology, and therefore might support human readership better than interoperable automated processing.</p>
Data Type	CodeableText
Value Domain	Link Role Values

Usage

Examples	<ol style="list-style-type: none"> 1) unspecified link 2) suggests 3) endorses 4) evidence for 5) outcome 6) is documented by 7) excerpts
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	0..1

5.16 Link Role Values

Identification

Label	Link Role Values
Metadata Type	Value Domain
Identifier	VD-16699
OID	1.2.36.1.2001.1001.101.104.16699
External Identifier	LINK_ROLE

Definition

Definition	Set of values for the detailed semantic description of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Context	These values are used within the context of the value of the <i>Link Nature</i> data element. They provide greater specificity and may be selected more for human readership than for interoperable automated processing.
Context Source	Australian Digital Health Agency

Value Domain

Source	ISO 13606-3:2009										
Permissible Values	<p>Values SHOULD be from Termlist LINK_ROLE in ISO 13606-3:2009 [ISO2009a].</p> <p>Values MAY be from any suitable terminology.</p> <p>Some values from Termlist LINK_ROLE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] are:</p> <table border="1"> <tr> <td>LINK-A1, unspecified link</td> <td>The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.</td> </tr> <tr> <td>LINK-A2, suggests</td> <td>The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.</td> </tr> <tr> <td>LINK-B1, endorses</td> <td>The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.</td> </tr> <tr> <td>LINK-C3, evidence for</td> <td>The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.</td> </tr> <tr> <td>LINK-D1, outcome</td> <td>The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.</td> </tr> </table>	LINK-A1, unspecified link	The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.	LINK-A2, suggests	The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.	LINK-B1, endorses	The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.	LINK-C3, evidence for	The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.	LINK-D1, outcome	The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.
LINK-A1, unspecified link	The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.										
LINK-A2, suggests	The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.										
LINK-B1, endorses	The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.										
LINK-C3, evidence for	The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.										
LINK-D1, outcome	The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.										


	LINK-E1, documented by	A clinical situation documented in the source component is more formally documented in the target component.
	LINK-E4, excerpts	The source component is an extract (copy) of part or all of the information contained within the target component.

Usage

Conditions of Use	Each of the link terms in LINK_ROLE from ISO 13606-3:2009 is a subcategory of a corresponding term in <i>Link Nature Values</i> , where that correspondence is indicated by the first letter after the code string “LINK-”. For example the term LINK-A1 is a subcategory of term LINK-A0. If a term in this list is used for the <i>Link Role</i> data element, the appropriate corresponding value SHALL be used from <i>Link Nature Values</i> .
Conditions of Use Source	ISO 13606-3:2009

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Role	1..1

5.17 Target

Identification

Label	Target
Metadata Type	Data Element
Identifier	DE-16700
OID	1.2.36.1.2001.1001.101.103.16700

Definition


Definition	The “linked to” or identified information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Link UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Link , and UniquelIdentifier .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

5.18 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16347

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERRAL DETAIL	1..1

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6 Summary of Medication Entries Detailed Clinical Model

This chapter describes version 1.1 of the *Summary of Medication Entries* Detailed Clinical Model.

6.1 Purpose

To support summary views involving information about prescribing and dispensing.

6.2 Use

Use to hold a summary of information from a set of instances of Medication Instruction and Medication Action.

One use is to be a summary of one prescription (with or without repeats) and the dispense records associated with it.

Another use is to be a summary of several prescriptions for the one therapeutic good (with or without repeats) and their associated dispense records.

6.3 UML Class Diagrams

The following figure represents the data hierarchy using a UML 2.0 class diagram. The diagram displays data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes; data groups are displayed as classes; their label names are represented as association role names. Association role names are only displayed if they differ from the associated class name. When a data element has a choice of data types, the data type of the attribute that represents it is an abstract interface class generalised from the individual data types. The diagram shows the data hierarchy excluding the details of participation. The default multiplicity is 1..1.

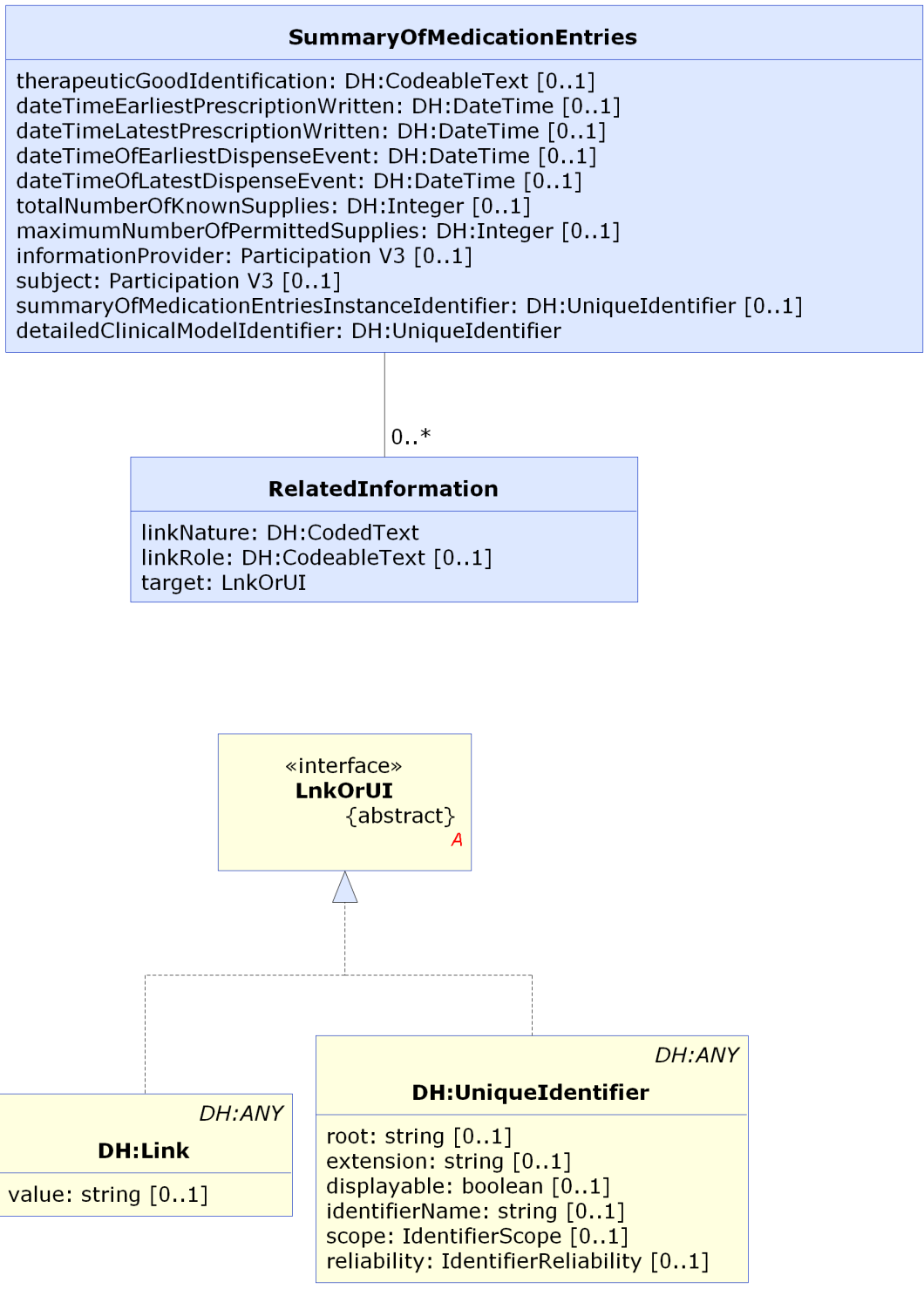


Figure 6.1. Summary Of Medication Entries

6.4 SUMMARY OF MEDICATION ENTRIES

Identification

Label	SUMMARY OF MEDICATION ENTRIES
Metadata Type	Data Group
Identifier	DG-16798
OID	1.2.36.1.2001.1001.101.102.16798

Definition











Definition	A summary of the information contained in a set of medication entries.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	One use of <i>Summary of Medication Entries</i> is to summarise one prescription and its dispense records; another is to summarise one therapeutic good and its prescriptions and dispense records.







Data Hierarchy



Note

Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. Typically, such identifiers will be generated internally by systems and not displayed to users since they rarely have clinical significance.

 SUMMARY OF MEDICATION ENTRIES			
		Therapeutic Good Identification	0..1
		DateTime Earliest Prescription Written	0..1
		DateTime Latest Prescription Written	0..1
		DateTime of Earliest Dispense Event	0..1
		DateTime of Latest Dispense Event	0..1
		Total Number of Known Supplies	0..1
		Maximum Number of Permitted Supplies	0..1
		INFORMATION PROVIDER	0..1
		SUBJECT	0..1

	Summary of Medication Entries Instance Identifier		0..1
	RELATED INFORMATION		0..*
		Link Nature	1..1
		Link Role	0..1
		Target	1..1
	Detailed Clinical Model Identifier		1..1

6.5 Therapeutic Good Identification

Identification

Label	Therapeutic Good Identification
Metadata Type	Data Element
Identifier	DE-10194
OID	1.2.36.1.2001.1001.101.103.10194

Definition

Definition	The medicine, vaccine or other therapeutic good being ordered for, administered to or used by the subject of care.
Definition Source	Australian Digital Health Agency
Synonymous Names	Item Name
Context	This includes medications and medical devices. It includes drugs, appliances, dressings, and reagents.
Context Source	Australian Digital Health Agency
Notes	<p>Identifies a therapeutic good, which is broadly defined as a good which is represented in any way to be, or is likely to be taken to be, for therapeutic use (unless specifically excluded or included under Section 7 of the <i>Therapeutic Goods Act 1989</i>).</p> <p>Therapeutic use means use in or in connection with:</p> <ul style="list-style-type: none"> • preventing, diagnosing, curing or alleviating a disease, ailment, defect or injury; or • influencing, inhibiting or modifying a physiological process; or • testing the susceptibility of persons to a disease or ailment; or • influencing, controlling or preventing conception; or • testing for pregnancy; or • replacement or modification of parts of the anatomy. <p>From the <i>Therapeutic Goods Act 1989</i> [TGA1989a].</p> <p>The formal definition of a therapeutic good is given in Section 3 of the <i>Therapeutic Goods Act 1989</i>.</p>
Data Type	CodeableText
Value Domain	Medicines Terminology


Usage

Conditions of Use	<p>Where the therapeutic good can be identified by an Australian Medicines Terminology (AMT) concept, the value of this data element SHOULD be the AMT ConceptID and Preferred Term. For details see Medicines Terminology.</p> <p>For items without an AMT code (including some extemporaneous preparations), a text description is suitable. For a medication, this SHALL include the name of the medication</p>
-------------------	--

Conditions of Use Source	(brand name or generic name equivalent), the strength and, where appropriate, the dose form. Australian Digital Health Agency
Examples	Some examples of AMT ConceptIDs and their AMT Preferred Terms are: <ol style="list-style-type: none"> 1) 23641011000036102 <i>paracetamol 500 mg + codeine phosphate 30 mg tablet</i> 2) 28329011000036108 <i>paracetamol 500 mg + codeine phosphate 30 mg tablet, 20</i> 3) 13362011000036106 <i>Panadeine Forte tablet: uncoated, 20</i> 4) 6647011000036101 <i>Panadeine Forte tablet: uncoated</i> 5) 20138011000036107 <i>Panadeine Forte tablet: uncoated, 20, blister pack</i> 6) 51295011000036108 <i>bandage compression 10 cm x 3.5 m bandage: high stretch</i> 7) 48667011000036100 <i>Eloflex (2480) 10 cm x 3.5 m bandage: high stretch</i> 8) 926706011000036104 <i>Engerix-B Paediatric 10 microgram/0.5 mL injection: suspension, 0.5 mL syringe</i>
Misuse	Detailing the formula of a compounded (extemporaneous) medication.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SUMMARY OF MEDICATION ENTRIES	0..1

6.6 Medicines Terminology

Identification

Label	Medicines Terminology
Metadata Type	Value Domain
Identifier	VD-16115
OID	1.2.36.1.2001.1001.101.104.16115

Definition


Definition	A set of values used to refer to medicines and other therapeutic goods.
Definition Source	Australian Digital Health Agency
Notes	An explanation of AMT concepts can be found in Australian Medicines Terminology v3 Model - Editorial Rules v2.0 [NEHT2014ag] .

Value Domain

Source	Australian Medicines Terminology
Permissible Values	<p>The permissible values are the members of the following seven AMT reference sets:</p> <ul style="list-style-type: none"> • 929360061000036106 <i>Medicinal product reference set</i> • 929360081000036101 <i>Medicinal product pack reference set</i> • 929360071000036103 <i>Medicinal product unit of use reference set</i> • 929360021000036102 <i>Trade product reference set</i> • 929360041000036105 <i>Trade product pack reference set</i> • 929360031000036100 <i>Trade product unit of use reference set</i> • 929360051000036108 <i>Containerized trade product pack reference set</i>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Therapeutic Good Identification	1..1

6.7 DateTime Earliest Prescription Written

Identification

Label	DateTime Earliest Prescription Written
Metadata Type	Data Element
Identifier	DE-16799
OID	1.2.36.1.2001.1001.101.103.16799

Definition


Definition	The date and, optionally, time when the earliest prescription in a set was written.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	DateTime

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for DateTime .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SUMMARY OF MEDICATION ENTRIES	0..1

6.8 DateTime Latest Prescription Written

Identification

Label	DateTime Latest Prescription Written
Metadata Type	Data Element
Identifier	DE-16800
OID	1.2.36.1.2001.1001.101.103.16800

Definition


Definition	The date and, optionally, time when the latest prescription in a set was written.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	This is only applicable when the summary involves more than one prescription.
Context Source	Australian Digital Health Agency
Data Type	DateTime

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for DateTime .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SUMMARY OF MEDICATION ENTRIES	0..1

6.9 DateTime of Earliest Dispense Event

Identification

Label	DateTime of Earliest Dispense Event
Metadata Type	Data Element
Identifier	DE-16801
OID	1.2.36.1.2001.1001.101.103.16801

Definition


Definition	The date and, optionally, time when the earliest dispense event in a set occurred.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	The earliest dispense record may not be for the earliest prescription.
Data Type	DateTime

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for DateTime .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SUMMARY OF MEDICATION ENTRIES	0..1

6.10 DateTime of Latest Dispense Event

Identification

Label	DateTime of Latest Dispense Event
Metadata Type	Data Element
Identifier	DE-16802
OID	1.2.36.1.2001.1001.101.103.16802

Definition


Definition	The date and, optionally, time when the latest dispense event in a set occurred.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	The latest dispense record may not be for the latest prescription.
Data Type	DateTime

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for DateTime .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SUMMARY OF MEDICATION ENTRIES	0..1

6.11 Total Number of Known Supplies

Identification

Label	Total Number of Known Supplies
Metadata Type	Data Element
Identifier	DE-16804
OID	1.2.36.1.2001.1001.101.103.16804

Definition


Definition	The total number of times a therapeutic good was supplied, according to a set of dispense records.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>If the summary involves dispense records from only one prescription, this is the highest value of the <i>Number of this Dispense</i> data element from those dispense records.</p> <p>If the summary involves dispense records from more than one prescription, this is the sum of the highest value <i>Number of this Dispense</i> data element from the dispense records for each prescription.</p>
Data Type	Integer

Usage

Conditions of Use	The value SHALL be ≥ 0 .
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Integer .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SUMMARY OF MEDICATION ENTRIES	0..1

6.12 Maximum Number of Permitted Supplies

Identification

Label	Maximum Number of Permitted Supplies
Metadata Type	Data Element
Identifier	DE-16805
OID	1.2.36.1.2001.1001.101.103.16805

Definition


Definition	The total number of times a therapeutic good was supplied, according to a set of prescriptions.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>If the summary involves only one prescription, this data element has as its value: (one {for the original prescription} + <i>Maximum Number of Repeats</i>).</p> <p>If the summary involves more than one prescription, this data element has as its value: sum of (one {for the original prescription} + <i>Maximum Number of Repeats</i>) for every prescription.</p>
Data Type	Integer

Usage

Conditions of Use	The value SHALL be ≥ 1 .
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Integer .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SUMMARY OF MEDICATION ENTRIES	0..1

6.13 INFORMATION PROVIDER

Identification

Label	INFORMATION PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	Details pertinent to the identification of the source of the information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This does not have to be a person and, in particular, does not have to be a healthcare provider. Types of sources include:</p> <ul style="list-style-type: none"> • the subject of care; • a subject of care agent, e.g. parent, guardian; • the clinician; and • a device or software.

Usage

Conditions of Use	<p>This SHALL NOT be used unless the provider of the information is not the <i>Composer/Author</i> of the enclosing Structured Document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to "Information Provider". • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or as a DEVICE.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SUMMARY OF MEDICATION ENTRIES	0..1

6.14 SUBJECT

Identification

Label	SUBJECT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	The individual about whom the medication action and medication instruction information was recorded.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Generally only used when the recorder needs to make it explicit. Otherwise, the subject of the enclosing Structured Document is assumed.
Scope Source	Australian Digital Health Agency

Usage

Conditions of Use	<p>This SHALL NOT be used unless the subject of the information is not the <i>Subject of Care</i> of the enclosing Structured Document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> Participation Type SHALL have an implementation-specific value equivalent to "Subject". PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SUMMARY OF MEDICATION ENTRIES	0..1

6.15 Summary of Medication Entries Instance Identifier

Identification

Label	Summary of Medication Entries Instance Identifier
Metadata Type	Data Element
Identifier	DE-16806
OID	1.2.36.1.2001.1001.101.103.16806

Definition


Definition	A globally unique identifier for each instance of a <i>Summary of Medication Entries</i> administration entry.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SUMMARY OF MEDICATION ENTRIES	0..1

6.16 RELATED INFORMATION

Identification


Label	RELATED INFORMATION
Metadata Type	Data Group
Identifier	DG-16692
OID	1.2.36.1.2001.1001.101.102.16692

Definition


Definition	Information held elsewhere that is relevant to this instance of <i>Exclusion Statement</i> .
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Items of related information include, but are not limited to, documents, parts of documents, images and web pages.</p> <p>“Elsewhere” includes elsewhere in the same document.</p> <p>1:1 and 1:N relationships between instances of DCMs can be expressed by using one, or more than one, respectively, links. Chains of links can be used to see problem threads or other logical groupings of items.</p> <p>Links are only to be used between instances of DCMs or documents, i.e. between objects representing complete domain concepts. This is because relationships between sub-elements of whole concepts are not necessarily meaningful and may be confusing.</p> <p>When the item of related information is a complete document (including images) or a web page (or part thereof) an appropriate specialisation of the <i>Related Information</i> data group should be used.</p> <p>The document or other data component instance containing the <i>Related Information</i> data group is called the <i>source</i>. The related information is called the <i>target</i>.</p>



Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SUMMARY OF MEDICATION ENTRIES	0..*

Children

Data Type	Name	Occurrences
	Link Nature	1..1

Data Type	Name	Occurrences
	Link Role	0..1
	Target	1..1

6.17 Link Nature

Identification

Label	Link Nature
Metadata Type	Data Element
Identifier	DE-16698
OID	1.2.36.1.2001.1001.101.103.16698

Definition


Definition	The general semantic category of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs or document. This attribute is intended to be a coarse-grained category that can be used to enable interoperability between sender and receiver.
Data Type	CodedText
Value Domain	Link Nature Values

Usage

Examples	<ol style="list-style-type: none"> 1) is related to 2) is confirmed by or authorised by 3) is related to the same problem or health issue
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

6.18 Link Nature Values

Identification

Label	Link Nature Values
Metadata Type	Value Domain
Identifier	VD-16698
OID	1.2.36.1.2001.1001.101.104.16698
External Identifier	LINK_NATURE

Definition

Definition	Set of values for the general semantic category of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency


Value Domain

Source	ISO 13606-3:2009	
Permissible Values	The permissible values are those specified in Termlist LINK_NATURE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] . They are listed here.	
	LINK-A0, is related to	A generic category for any Link, the details of which will be given by the value of Link Role.
	LINK-B0, is confirmed by or authorised by	The target link contains [an instance of a DCM or document] that acts as the legal or clinical basis for the activity documented in the source [DCM instance], or is a declaration of intent to provide (or not to provide) requested care. This Link is to be used to connect two [DCM instances or DCM and document], as opposed to the inclusion of a corroborating or authorising participant as an identified party within a single [DCM instance or document].
	LINK-C0, is related to the same problem or health issue	The target [instance of a DCM or document] documents health or health care that pertains to the same clinical situation as the source [DCM instance]. One of the two might be defining a problem for which the other is a manifestation, or the relationship might for example be cause and effect, stages in an evolving clinical history, a different interpretation of an observation, a clinical indication or contraindication.
	LINK-D0, is related to the same care plan, act or episode	The source and the target [instances of DCM or documents] are each documenting parts of the same care plan, act or episode. One of the two might be defining the same care plan, act or episode, or both might be related milestones.

	LINK-E0, is a related documentation	The target [instance of a DCM or document] is an alternative documentary form of the source [DCM instance], such as re-expression of the same clinical information or additional supplementary explanatory information.
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Nature	1..1

6.19 Link Role

Identification

Label	Link Role
Metadata Type	Data Element
Identifier	DE-16699
OID	1.2.36.1.2001.1001.101.103.16699

Definition


Definition	The detailed semantic description of the relationship between this instance of this DCM (i.e. the source), and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs. This attribute provides for a specific description of the actual role played by the target in relation to the source.</p> <p>This attribute may be populated from any suitable terminology, and therefore might support human readership better than interoperable automated processing.</p>
Data Type	CodeableText
Value Domain	Link Role Values

Usage

Examples	<ol style="list-style-type: none"> 1) unspecified link 2) suggests 3) endorses 4) evidence for 5) outcome 6) is documented by 7) excerpts
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	0..1

6.20 Link Role Values

Identification

Label	Link Role Values
Metadata Type	Value Domain
Identifier	VD-16699
OID	1.2.36.1.2001.1001.101.104.16699
External Identifier	LINK_ROLE

Definition

Definition	Set of values for the detailed semantic description of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Context	These values are used within the context of the value of the <i>Link Nature</i> data element. They provide greater specificity and may be selected more for human readership than for interoperable automated processing.
Context Source	Australian Digital Health Agency

Value Domain

Source	ISO 13606-3:2009										
Permissible Values	<p>Values SHOULD be from Termlist LINK_ROLE in ISO 13606-3:2009 [ISO2009a].</p> <p>Values MAY be from any suitable terminology.</p> <p>Some values from Termlist LINK_ROLE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] are:</p> <table border="1"> <tr> <td>LINK-A1, unspecified link</td> <td>The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.</td> </tr> <tr> <td>LINK-A2, suggests</td> <td>The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.</td> </tr> <tr> <td>LINK-B1, endorses</td> <td>The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.</td> </tr> <tr> <td>LINK-C3, evidence for</td> <td>The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.</td> </tr> <tr> <td>LINK-D1, outcome</td> <td>The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.</td> </tr> </table>	LINK-A1, unspecified link	The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.	LINK-A2, suggests	The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.	LINK-B1, endorses	The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.	LINK-C3, evidence for	The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.	LINK-D1, outcome	The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.
LINK-A1, unspecified link	The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.										
LINK-A2, suggests	The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.										
LINK-B1, endorses	The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.										
LINK-C3, evidence for	The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.										
LINK-D1, outcome	The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.										


LINK-E1, documented by	A clinical situation documented in the source component is more formally documented in the target component.
LINK-E4, excerpts	The source component is an extract (copy) of part or all of the information contained within the target component.

Usage

Conditions of Use	Each of the link terms in LINK_ROLE from ISO 13606-3:2009 is a subcategory of a corresponding term in <i>Link Nature Values</i> , where that correspondence is indicated by the first letter after the code string "LINK-". For example the term LINK-A1 is a subcategory of term LINK-A0. If a term in this list is used for the <i>Link Role</i> data element, the appropriate corresponding value SHALL be used from <i>Link Nature Values</i> .
Conditions of Use Source	ISO 13606-3:2009

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Role	1..1

6.21 Target

Identification

Label	Target
Metadata Type	Data Element
Identifier	DE-16700
OID	1.2.36.1.2001.1001.101.103.16700

Definition


Definition	The “linked to” or identified information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Link UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Link , and UniquelIdentifier .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

6.22 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16798

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SUMMARY OF MEDICATION ENTRIES	1..1

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7 General Observation Detailed Clinical Model

This chapter describes version 1.1 of the *General Observation* Detailed Clinical Model.

7.1 Purpose

To allow a clinician or other person to record an observation concerning a subject of care where the observation is a general one or where no other suitable archetype is available.

7.2 Use

One use is for a single achievement in *Consumer Entered Achievements*.

7.3 UML Class Diagrams

The following figure represents the data hierarchy using a UML 2.0 class diagram. The diagram displays data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes; data groups are displayed as classes; their label names are represented as association role names. Association role names are only displayed if they differ from the associated class name. When a data element has a choice of data types, the data type of the attribute that represents it is an abstract interface class generalised from the individual data types. The diagram shows the data hierarchy excluding the details of participation. The default multiplicity is 1..1.

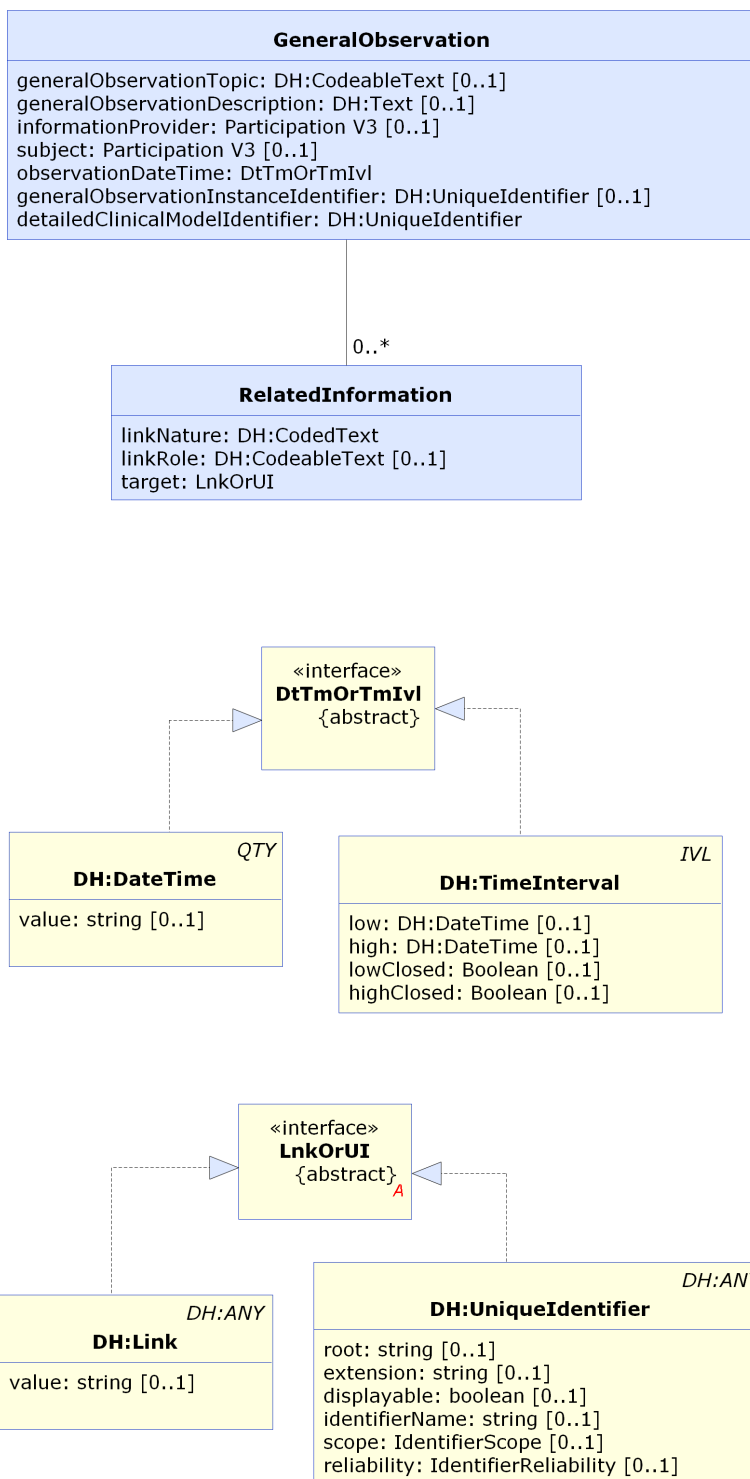


Figure 7.1. General Observation

7.4 GENERAL OBSERVATION

Identification

Label	GENERAL OBSERVATION
Metadata Type	Data Group
Identifier	DG-16823
OID	1.2.36.1.2001.1001.101.102.16823

Definition











Definition	An observation concerning a subject of care.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	This can be used for observations of a general nature and also for observations that cannot be included in available specific observation DCMs, such as <i>Body Weight</i> .
Scope Source	Australian Digital Health Agency




Data Hierarchy



Note

Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. Typically, such identifiers will be generated internally by systems and not displayed to users since they rarely have clinical significance.

 GENERAL OBSERVATION		
	General Observation Topic	0..1
	General Observation Description	0..1
	INFORMATION PROVIDER	0..1
	SUBJECT	0..1
 	Observation DateTime	1..1
	General Observation Instance Identifier	0..1
 RELATED INFORMATION		0..*
	Link Nature	1..1

			Link Role	0..1
			Target	1..1
			Detailed Clinical Model Identifier	1..1

7.5 General Observation Topic

Identification

Label	General Observation Topic
Metadata Type	Data Element
Identifier	DE-16825
OID	1.2.36.1.2001.1001.101.103.16825

Definition


Definition	The title or topic.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ¹ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	GENERAL OBSERVATION	0..1

¹ <http://www.hl7.org/oid/index.cfm>

7.6 General Observation Description

Identification

Label	General Observation Description
Metadata Type	Data Element
Identifier	DE-16826
OID	1.2.36.1.2001.1001.101.103.16826

Definition


Definition	The details, written in free text.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	GENERAL OBSERVATION	0..1

7.7 INFORMATION PROVIDER

Identification

Label	INFORMATION PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	Details pertinent to the identification of the source of the information about the observation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This does not have to be a person and, in particular, not a healthcare provider. Types of sources include:</p> <ul style="list-style-type: none"> • the subject of care; • a subject of care agent, e.g. parent, guardian; • the clinician; and • a device or software.

Usage

Conditions of Use	<p>This SHALL NOT be used unless the provider of the information is not the <i>Composer/Author</i> of the enclosing Structured Document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to "Information Provider". • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or as a DEVICE.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	GENERAL OBSERVATION	0..1

7.8 SUBJECT

Identification

Label	SUBJECT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	The person about whom the observation information is being recorded.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Generally only used when the recorder needs to make it explicit. Otherwise, the subject of the enclosing Structured Document is assumed.
Scope Source	Australian Digital Health Agency

Usage

Conditions of Use	<p>This SHALL NOT be used unless the subject of the information is not the <i>Subject of Care</i> of the enclosing Structured Document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> Participation Type SHALL have an implementation-specific value equivalent to "Subject". PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	GENERAL OBSERVATION	0..1

7.9 Observation DateTime

Identification

Label	Observation DateTime
Metadata Type	Data Element
Identifier	DE-15561
OID	1.2.36.1.2001.1001.101.103.15561

Definition

Definition	Date, and optionally time, when an observation is clinically significant to the condition of the subject of the observation.
Definition Source	Australian Digital Health Agency
Synonymous Names	Clinically Significant DateTime Effective DateTime
Context	For a <i>Pathology Test Result</i> the value is the date, and optionally time, of collection of the specimen. For an <i>Imaging Examination Result</i> the value is the date, and optionally time, of the imaging examination. For a series of images this is the date, and optionally time, when the last image was taken.
Context Source	Australian Digital Health Agency
Notes	<p>Associated with every observation of a subject are two different times that often, but not always, coincide, and are consequently often conflated: the time that the activity of observing occurred (the time the subject was observed, the <i>measuring time</i>), and the time that the subject was the way it looked (the time the subject was as observed, the <i>state time</i>.)</p> <p>Generally, there is no delay between a person being in a state, and an observation of the person being in that state. For example, if a pulse of 72 bpm is recorded at 13:45 on 12 February 2015, one can assume that the heart rate was 72 bpm at that time. (Pulse is a surrogate for heart rate.) In such cases the <i>measuring time</i> and the <i>state time</i> are the same.</p> <p>Sometimes, when there is a delay between the time the person is in a state and the time when they are measured, the delay is important. For example, if a sample is taken from a person and its testing is completed over a period of days, the test results will provide information about the state of the person at the time the sample was taken, not the time the test was completed.</p> <p>The clinically significant time in all clinical observations is the time that the person was as observed, the <i>state time</i>. In observations involving specimens, the time that the specimen was taken is the closest practicable proxy for the <i>state time</i>.</p> <p>The meaning of <i>Observation DateTime</i> is always the time that the person was as observed.</p> <p>This approach follows that of openEHR.</p>
Data Type	DateTime TimeInterval


Usage

Examples

Please see [Appendix B, Specification Guide for Use](#) for examples and usage information for [DateTime](#), and [TimeInterval](#).

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	GENERAL OBSERVATION	1..1

7.10 General Observation Instance Identifier

Identification

Label	General Observation Instance Identifier
Metadata Type	Data Element
Identifier	DE-16829
OID	1.2.36.1.2001.1001.101.103.16829

Definition


Definition	A globally unique identifier for each instance of a <i>General Observation</i> observation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	GENERAL OBSERVATION	0..1

7.11 RELATED INFORMATION

Identification


Label	RELATED INFORMATION
Metadata Type	Data Group
Identifier	DG-16692
OID	1.2.36.1.2001.1001.101.102.16692

Definition


Definition	Information held elsewhere that is relevant to this instance of <i>Exclusion Statement</i> .
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Items of related information include, but are not limited to, documents, parts of documents, images and web pages.</p> <p>“Elsewhere” includes elsewhere in the same document.</p> <p>1:1 and 1:N relationships between instances of DCMs can be expressed by using one, or more than one, respectively, links. Chains of links can be used to see problem threads or other logical groupings of items.</p> <p>Links are only to be used between instances of DCMs or documents, i.e. between objects representing complete domain concepts. This is because relationships between sub-elements of whole concepts are not necessarily meaningful and may be confusing.</p> <p>When the item of related information is a complete document (including images) or a web page (or part thereof) an appropriate specialisation of the <i>Related Information</i> data group should be used.</p> <p>The document or other data component instance containing the <i>Related Information</i> data group is called the <i>source</i>. The related information is called the <i>target</i>.</p>



Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	GENERAL OBSERVATION	0..*

Children

Data Type	Name	Occurrences
	Link Nature	1..1

Data Type	Name	Occurrences
	Link Role	0..1
	Target	1..1

7.12 Link Nature

Identification

Label	Link Nature
Metadata Type	Data Element
Identifier	DE-16698
OID	1.2.36.1.2001.1001.101.103.16698

Definition


Definition	The general semantic category of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs or document. This attribute is intended to be a coarse-grained category that can be used to enable interoperability between sender and receiver.
Data Type	CodedText
Value Domain	Link Nature Values

Usage

Examples	<ol style="list-style-type: none"> 1) is related to 2) is confirmed by or authorised by 3) is related to the same problem or health issue
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

7.13 Link Nature Values

Identification

Label	Link Nature Values
Metadata Type	Value Domain
Identifier	VD-16698
OID	1.2.36.1.2001.1001.101.104.16698
External Identifier	LINK_NATURE

Definition

Definition	Set of values for the general semantic category of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency

Value Domain


Source	ISO 13606-3:2009	
Permissible Values	The permissible values are those specified in Termlist LINK_NATURE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] . They are listed here.	
	LINK-A0, is related to	A generic category for any Link, the details of which will be given by the value of Link Role.
	LINK-B0, is confirmed by or authorised by	The target link contains [an instance of a DCM or document] that acts as the legal or clinical basis for the activity documented in the source [DCM instance], or is a declaration of intent to provide (or not to provide) requested care. This Link is to be used to connect two [DCM instances or DCM and document], as opposed to the inclusion of a corroborating or authorising participant as an identified party within a single [DCM instance or document].
	LINK-C0, is related to the same problem or health issue	The target [instance of a DCM or document] documents health or health care that pertains to the same clinical situation as the source [DCM instance]. One of the two might be defining a problem for which the other is a manifestation, or the relationship might for example be cause and effect, stages in an evolving clinical history, a different interpretation of an observation, a clinical indication or contraindication.
	LINK-D0, is related to the same care plan, act or episode	The source and the target [instances of DCM or documents] are each documenting parts of the same care plan, act or episode. One of the two might be defining the same care plan, act or episode, or both might be related milestones.

LINK-E0, is a related documentation

The target [instance of a DCM or document] is an alternative documentary form of the source [DCM instance], such as re-expression of the same clinical information or additional supplementary explanatory information.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Nature	1..1

7.14 Link Role

Identification

Label	Link Role
Metadata Type	Data Element
Identifier	DE-16699
OID	1.2.36.1.2001.1001.101.103.16699

Definition


Definition	The detailed semantic description of the relationship between this instance of this DCM (i.e. the source), and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs. This attribute provides for a specific description of the actual role played by the target in relation to the source.</p> <p>This attribute may be populated from any suitable terminology, and therefore might support human readership better than interoperable automated processing.</p>
Data Type	CodeableText
Value Domain	Link Role Values

Usage

Examples	<ol style="list-style-type: none"> 1) unspecified link 2) suggests 3) endorses 4) evidence for 5) outcome 6) is documented by 7) excerpts
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	0..1

7.15 Link Role Values

Identification

Label	Link Role Values
Metadata Type	Value Domain
Identifier	VD-16699
OID	1.2.36.1.2001.1001.101.104.16699
External Identifier	LINK_ROLE

Definition

Definition	Set of values for the detailed semantic description of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Context	These values are used within the context of the value of the <i>Link Nature</i> data element. They provide greater specificity and may be selected more for human readership than for interoperable automated processing.
Context Source	Australian Digital Health Agency

Value Domain

Source	ISO 13606-3:2009										
Permissible Values	<p>Values SHOULD be from Termlist LINK_ROLE in ISO 13606-3:2009 [ISO2009a].</p> <p>Values MAY be from any suitable terminology.</p> <p>Some values from Termlist LINK_ROLE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] are:</p> <table border="1"> <tr> <td>LINK-A1, unspecified link</td> <td>The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.</td> </tr> <tr> <td>LINK-A2, suggests</td> <td>The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.</td> </tr> <tr> <td>LINK-B1, endorses</td> <td>The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.</td> </tr> <tr> <td>LINK-C3, evidence for</td> <td>The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.</td> </tr> <tr> <td>LINK-D1, outcome</td> <td>The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.</td> </tr> </table>	LINK-A1, unspecified link	The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.	LINK-A2, suggests	The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.	LINK-B1, endorses	The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.	LINK-C3, evidence for	The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.	LINK-D1, outcome	The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.
LINK-A1, unspecified link	The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.										
LINK-A2, suggests	The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.										
LINK-B1, endorses	The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.										
LINK-C3, evidence for	The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.										
LINK-D1, outcome	The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.										


	LINK-E1, documented by	A clinical situation documented in the source component is more formally documented in the target component.
	LINK-E4, excerpts	The source component is an extract (copy) of part or all of the information contained within the target component.

Usage

Conditions of Use	Each of the link terms in LINK_ROLE from ISO 13606-3:2009 is a subcategory of a corresponding term in <i>Link Nature Values</i> , where that correspondence is indicated by the first letter after the code string “LINK-”. For example the term LINK-A1 is a subcategory of term LINK-A0. If a term in this list is used for the <i>Link Role</i> data element, the appropriate corresponding value SHALL be used from <i>Link Nature Values</i> .
Conditions of Use Source	ISO 13606-3:2009

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Role	1..1

7.16 Target

Identification

Label	Target
Metadata Type	Data Element
Identifier	DE-16700
OID	1.2.36.1.2001.1001.101.103.16700

Definition


Definition	The “linked to” or identified information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Link UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Link , and UniquelIdentifier .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

7.17 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16823

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	GENERAL OBSERVATION	1..1

8 Document Use Authorisation Detailed Clinical Model

This chapter describes version 1.0 of the *Document Use Authorisation (Instruction)* Detailed Clinical Model.

8.1 Purpose

To record authorisations to use documents. This includes authorisations to post to a shared repository.

8.2 Use

Record an authority to post a document to the My Health Record system.

Record an authority to make a document in a shared repository private or public.

Record an authority to post all future documents for the subject to a shared repository.

8.3 Misuse

Recording an authority to change or alter a document.

8.4 UML Class Diagrams

The following figure represents the data hierarchy using a UML 2.0 class diagram. The diagram displays data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes; data groups are displayed as classes; their label names are represented as association role names. Association role names are only displayed if they differ from the associated class name. When a data element has a choice of data types, the data type of the attribute that represents it is an abstract interface class generalised from the individual data types. The diagram shows the data hierarchy excluding the details of participation. The default multiplicity is 1..1.

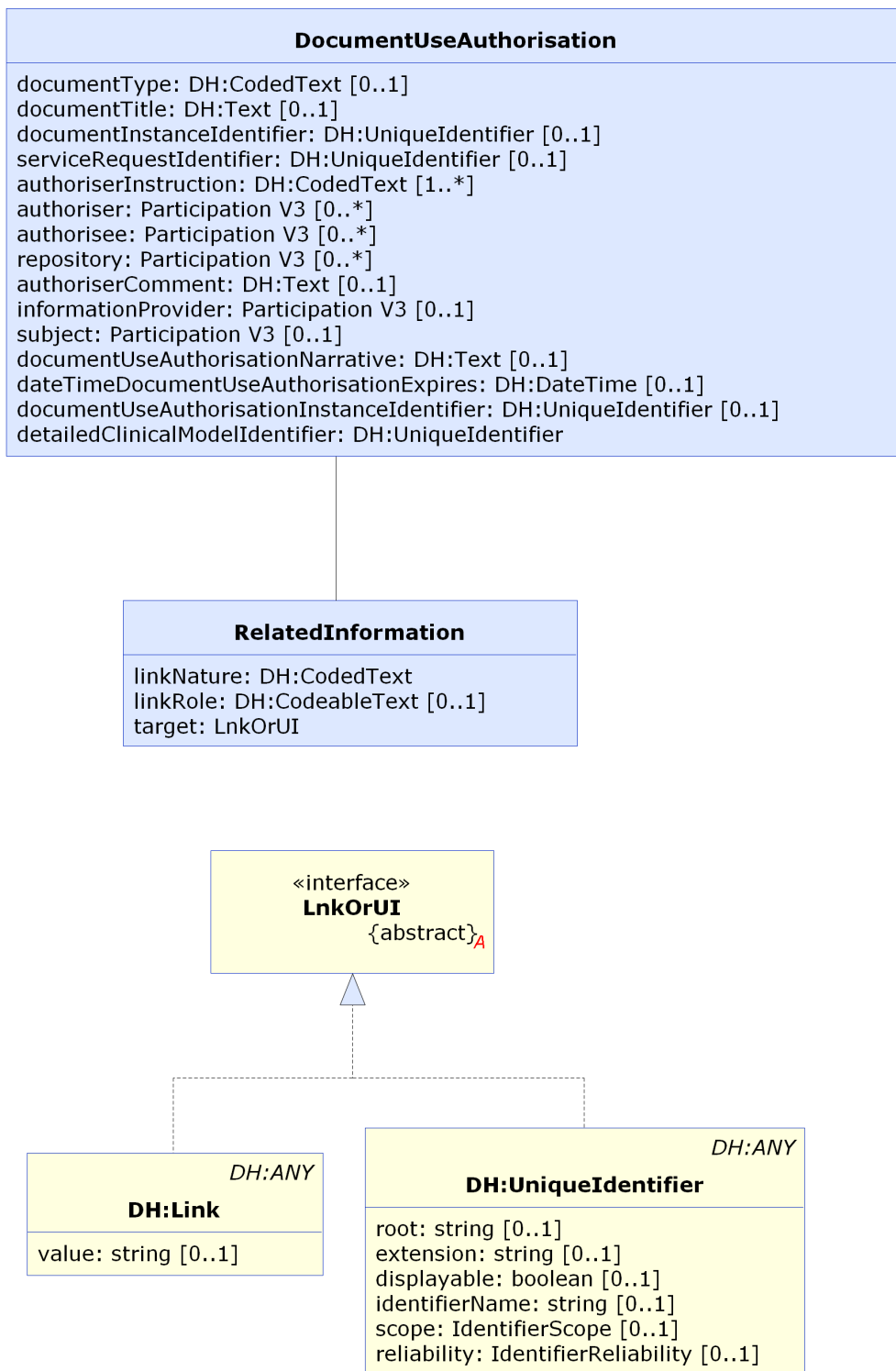


Figure 8.1. Document Use Authorisation

8.5 DOCUMENT USE AUTHORISATION

Identification

Label	DOCUMENT USE AUTHORISATION
Metadata Type	Data Group
Identifier	DG-16982
OID	1.2.36.1.2001.1001.101.102.16982

Definition












Definition	Details of an authorisation to perform an action with a document.
Definition Source	Australian Digital Health Agency
Synonymous Names	


Data Hierarchy



Note

Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. Typically, such identifiers will be generated internally by systems and not displayed to users since they rarely have clinical significance.

 DOCUMENT USE AUTHORISATION			
		Document Type	0..1
		Document Title	0..1
		Document Instance Identifier	0..1
		Service Request Identifier	0..1
		Authoriser Instruction	1..*
		AUTHORISER	0..*
		AUTHORISEE	0..*
		REPOSITORY	0..*
		Authoriser Comment	0..1
		INFORMATION PROVIDER	0..1

	SUBJECT		0..1
	Document Use Authorisation Narrative		0..1
	DateTime Document Use Authorisation Expires		0..1
	Document Use Authorisation Instance Identifier		0..1
	RELATED INFORMATION		0..*
		Link Nature	1..1
		Link Role	0..1
	 	Target	1..1
	Detailed Clinical Model Identifier		1..1

8.6 Document Type

Identification

Label	Document Type
Metadata Type	Data Element
Identifier	DE-10335
OID	1.2.36.1.2001.1001.101.103.10335

Definition


Definition	Type of the document of interest.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	Each clinical document contains as a coded value an identification of its Document Type. This data element contains the coded value of Document Type from the document of interest.
Data Type	CodedText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ¹ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for CodedText .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT USE AUTHORISATION	0..1

¹ <http://www.hl7.org/oid/index.cfm>

8.7 Document Title

Identification

Label	Document Title
Metadata Type	Data Element
Identifier	DE-16966
OID	1.2.36.1.2001.1001.101.103.16966

Definition


Definition	Title of the document of interest.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT USE AUTHORISATION	0..1

8.8 Document Instance Identifier

Identification

Label	Document Instance Identifier
Metadata Type	Data Element
Identifier	DE-20101
OID	1.2.36.1.2001.1001.101.103.20101

Definition


Definition	Identifier of the document of interest.
Definition Source	Australian Digital Health Agency
Synonymous Names	Document or Report Identifier
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT USE AUTHORISATION	0..1

8.9 Service Request Identifier

Identification

Label	Service Request Identifier
Metadata Type	Data Element
Identifier	DE-16986
OID	1.2.36.1.2001.1001.101.103.16986

Definition


Definition	Requester's identifier of the service request which lead to the creation of the document of interest.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT USE AUTHORISATION	0..1

8.10 Authoriser Instruction

Identification

Label	Authoriser Instruction
Metadata Type	Data Element
Identifier	DE-16988
OID	1.2.36.1.2001.1001.101.103.16988

Definition


Definition	Action authorised to be performed with the document of interest.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodedText
Value Domain	Authoriser Instruction Values

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for CodedText .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT USE AUTHORISATION	1..*

8.11 Authoriser Instruction Values

Identification

Label	Authoriser Instruction Values
Metadata Type	Value Domain
Identifier	VD-16987
OID	1.2.36.1.2001.1001.101.104.16987

Definition


Definition	Set of values for <i>Authoriser Instruction</i> .
Definition Source	Australian Digital Health Agency
Notes	Currently only one value is defined.

Value Domain

Source	NCTIS Authoriser Instruction Values
Permissible Values	1, Post document Post the identified document to the identified repositories.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Authoriser Instruction	1..1

8.12 AUTHORISER

Identification

Label	AUTHORISER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	Party who authorises action.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	The date of authorisation is contained in the <i>Participation Period</i> of the <i>Authoriser</i> .

Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> Participation Type SHALL have an implementation-specific value equivalent to “Authoriser”. PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT USE AUTHORISATION	0..*

8.13 AUTHORISEE

Identification

Label	AUTHORISEE
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	Party who is authorised to perform action.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <p>ALL DOCUMENTS</p> <p>The following constraints are applicable to all documents:</p> <ul style="list-style-type: none"> • Other additional constraints: <ul style="list-style-type: none"> ○ Participation Type SHALL have an implementation-specific value equivalent to “authorised party”. ○ PERSON OR ORGANISATION OR DEVICE SHALL NOT be instantiated as a DEVICE. <p>HEALTHCARE PROVIDER</p> <p>The following constraints are applicable when the party who is authorised is a healthcare provider and the context is exchange with the My Health Record system:</p> <ul style="list-style-type: none"> • Additional obligation and occurrence constraints: <ul style="list-style-type: none"> ○ Participation Period is PROHIBITED. ○ LOCATION OF PARTICIPATION is PROHIBITED. ○ Entity Identifier is ESSENTIAL. ○ Relationship to Subject of Care is PROHIBITED. ○ EMPLOYMENT DETAIL is ESSENTIAL. ○ EMPLOYER ORGANISATION is ESSENTIAL.
-------------------	---

- EMPLOYER ORGANISATION.Entity Identifier is **ESSENTIAL**.
- DEMOGRAPHIC DATA is **PROHIBITED**.
- Other additional constraints:
 - Role **SHOULD** have a value chosen from [1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 \[ABS2009\]](#). However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used.
 - The value of one Entity Identifier **SHOULD** be an Australian HPI-I.
 - The value of one EMPLOYER ORGANISATION.Entity Identifier **SHALL** be an Australian HPI-O.
 - PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.

PERSON OTHER THAN A HEALTHCARE PROVIDER

The following constraints are applicable when the party who is authorised is a person other than a healthcare provider and the context is exchange with the My Health Record system:

- Additional obligation and occurrence constraints:
 - Participation Period is **PROHIBITED**.
 - LOCATION OF PARTICIPATION is **PROHIBITED**.
 - DEMOGRAPHIC DATA is **PROHIBITED**.
- Other additional constraints:
 - Role **SHOULD** have a value chosen from [1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 \[ABS2009\]](#). However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used.
 - PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.

ORGANISATION

The following constraints are applicable when the party who is authorised is an organisation and the context is exchange with the My Health Record system:


- Additional obligation and occurrence constraints:
 - Participation Period is **PROHIBITED**.
 - LOCATION OF PARTICIPATION is **PROHIBITED**.
 - Entity Identifier is **ESSENTIAL**.
 - ENTITLEMENT is **PROHIBITED**.
 - Qualifications is **PROHIBITED**.
- Other additional constraints:
 - Role **SHOULD** have a value representing the type of Healthcare Facility e.g. Hospital, Clinic. Role **MAY** have an implementation-specific null flavour.
 - The value of one Entity Identifier **SHALL** be an Australian HPI-O.

Conditions of Use Source

o PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as an ORGANISATION.
 Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT USE AUTHORISATION	0..*

8.14 REPOSITORY

Identification

Label	REPOSITORY
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	Repository of documents.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B: Specification Guide for Use.</p> <p>Additional obligation and occurrence constraints:</p> <ul style="list-style-type: none"> • Participation Period is PROHIBITED. • LOCATION OF PARTICIPATION is PROHIBITED. • Entity Identifier is ESSENTIAL. • ADDRESS is PROHIBITED. • ELECTRONIC COMMUNICATION DETAIL is PROHIBITED. • ENTITLEMENT is PROHIBITED. • Qualifications is PROHIBITED. <p>Other additional constraints:</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to "Repository". • Role SHALL have an implementation-specific value equivalent to "Not Applicable". • The value of one Entity Identifier SHALL be an Australian PAI-R. • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a DEVICE.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT USE AUTHORISATION	0..*

8.15 Authoriser Comment

Identification

Label	Authoriser Comment
Metadata Type	Data Element
Identifier	DE-16044
OID	1.2.36.1.2001.1001.101.103.16044

Definition


Definition	A comment relevant to the authorisation to perform an action.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT USE AUTHORISATION	0..1

8.16 INFORMATION PROVIDER

Identification

Label	INFORMATION PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	Details pertinent to the identification of the source of the information about the instruction.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This does not necessarily have to be a person and, in particular, not a healthcare provider. Types of sources include:</p> <ul style="list-style-type: none"> • the subject of care; • a subject of care agent, e.g. parent, guardian; • the clinician; and • a device or software.

Usage

Conditions of Use	<p>This SHALL NOT be used unless the provider of the information is not the <i>Composer/Author</i> of the enclosing Structured Document.</p> <p>This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to "Information Provider". • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or as a DEVICE.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT USE AUTHORISATION	0..1

8.17 SUBJECT

Identification

Label	SUBJECT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	The person whose health record this authorisation is intended to affect.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Generally only used when the recorder needs to make it explicit. Otherwise, subject of the enclosing structured document is assumed.
Scope Source	Australian Digital Health Agency
Notes	If the authorisation is to post a document to a person's record in a repository, this is the person who is the subject of the repository record of interest.

Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to "Subject". • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT USE AUTHORISATION	0..1

8.18 Document Use Authorisation Narrative

Identification

Label	Document Use Authorisation Narrative
Metadata Type	Data Element
Identifier	DE-16989
OID	1.2.36.1.2001.1001.101.103.16989

Definition


Definition	A textual narrative describing what the Document Use Authorisation instruction is about.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT USE AUTHORISATION	0..1

8.19 DateTime Document Use Authorisation Expires

Identification

Label	DateTime Document Use Authorisation Expires
Metadata Type	Data Element
Identifier	DE-16990
OID	1.2.36.1.2001.1001.101.103.16990

Definition


Definition	The date and, optionally, time after which the Document Use Authorisation instruction is no longer effective or in force.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	DateTime

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for DateTime .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT USE AUTHORISATION	0..1

8.20 Document Use Authorisation Instance Identifier

Identification

Label	Document Use Authorisation Instance Identifier
Metadata Type	Data Element
Identifier	DE-16991
OID	1.2.36.1.2001.1001.101.103.16991

Definition


Definition	A globally unique identifier for each instance of a <i>Document Use Authorisation</i> instruction.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This data element is intended for machine/system use only and hence need not be displayed on documents.
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT USE AUTHORISATION	0..1

8.21 RELATED INFORMATION

Identification


Label	RELATED INFORMATION
Metadata Type	Data Group
Identifier	DG-16692
OID	1.2.36.1.2001.1001.101.102.16692

Definition


Definition	Information held elsewhere that is relevant to this instance of <i>Exclusion Statement</i> .
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Items of related information include, but are not limited to, documents, parts of documents, images and web pages.</p> <p>“Elsewhere” includes elsewhere in the same document.</p> <p>1:1 and 1:N relationships between instances of DCMs can be expressed by using one, or more than one, respectively, links. Chains of links can be used to see problem threads or other logical groupings of items.</p> <p>Links are only to be used between instances of DCMs or documents, i.e. between objects representing complete domain concepts. This is because relationships between sub-elements of whole concepts are not necessarily meaningful and may be confusing.</p> <p>When the item of related information is a complete document (including images) or a web page (or part thereof) an appropriate specialisation of the <i>Related Information</i> data group should be used.</p> <p>The document or other data component instance containing the <i>Related Information</i> data group is called the <i>source</i>. The related information is called the <i>target</i>.</p>



Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT USE AUTHORISATION	0..*

Children

Data Type	Name	Occurrences
	Link Nature	1..1

Data Type	Name	Occurrences
	Link Role	0..1
	Target	1..1

8.22 Link Nature

Identification

Label	Link Nature
Metadata Type	Data Element
Identifier	DE-16698
OID	1.2.36.1.2001.1001.101.103.16698

Definition


Definition	The general semantic category of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs or document. This attribute is intended to be a coarse-grained category that can be used to enable interoperability between sender and receiver.
Data Type	CodedText
Value Domain	Link Nature Values

Usage

Examples	<ol style="list-style-type: none"> 1) is related to 2) is confirmed by or authorised by 3) is related to the same problem or health issue
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

8.23 Link Nature Values

Identification

Label	Link Nature Values
Metadata Type	Value Domain
Identifier	VD-16698
OID	1.2.36.1.2001.1001.101.104.16698
External Identifier	LINK_NATURE

Definition

Definition	Set of values for the general semantic category of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency


Value Domain

Source	ISO 13606-3:2009	
Permissible Values	The permissible values are those specified in Termlist LINK_NATURE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] . They are listed here.	
	LINK-A0, is related to	A generic category for any Link, the details of which will be given by the value of Link Role.
	LINK-B0, is confirmed by or authorised by	The target link contains [an instance of a DCM or document] that acts as the legal or clinical basis for the activity documented in the source [DCM instance], or is a declaration of intent to provide (or not to provide) requested care. This Link is to be used to connect two [DCM instances or DCM and document], as opposed to the inclusion of a corroborating or authorising participant as an identified party within a single [DCM instance or document].
	LINK-C0, is related to the same problem or health issue	The target [instance of a DCM or document] documents health or health care that pertains to the same clinical situation as the source [DCM instance]. One of the two might be defining a problem for which the other is a manifestation, or the relationship might for example be cause and effect, stages in an evolving clinical history, a different interpretation of an observation, a clinical indication or contraindication.
	LINK-D0, is related to the same care plan, act or episode	The source and the target [instances of DCM or documents] are each documenting parts of the same care plan, act or episode. One of the two might be defining the same care plan, act or episode, or both might be related milestones.

	LINK-E0, is a related documentation	The target [instance of a DCM or document] is an alternative documentary form of the source [DCM instance], such as re-expression of the same clinical information or additional supplementary explanatory information.
--	-------------------------------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Nature	1..1

8.24 Link Role

Identification

Label	Link Role
Metadata Type	Data Element
Identifier	DE-16699
OID	1.2.36.1.2001.1001.101.103.16699

Definition


Definition	The detailed semantic description of the relationship between this instance of this DCM (i.e. the source), and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs. This attribute provides for a specific description of the actual role played by the target in relation to the source.</p> <p>This attribute may be populated from any suitable terminology, and therefore might support human readership better than interoperable automated processing.</p>
Data Type	CodeableText
Value Domain	Link Role Values

Usage

Examples	<ol style="list-style-type: none"> 1) unspecified link 2) suggests 3) endorses 4) evidence for 5) outcome 6) is documented by 7) excerpts
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	0..1

8.25 Link Role Values

Identification

Label	Link Role Values
Metadata Type	Value Domain
Identifier	VD-16699
OID	1.2.36.1.2001.1001.101.104.16699
External Identifier	LINK_ROLE

Definition

Definition	Set of values for the detailed semantic description of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Context	These values are used within the context of the value of the <i>Link Nature</i> data element. They provide greater specificity and may be selected more for human readership than for interoperable automated processing.
Context Source	Australian Digital Health Agency

Value Domain

Source	ISO 13606-3:2009										
Permissible Values	<p>Values SHOULD be from Termlist LINK_ROLE in ISO 13606-3:2009 [ISO2009a].</p> <p>Values MAY be from any suitable terminology.</p> <p>Some values from Termlist LINK_ROLE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] are:</p> <table border="1"> <tr> <td>LINK-A1, unspecified link</td> <td>The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.</td> </tr> <tr> <td>LINK-A2, suggests</td> <td>The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.</td> </tr> <tr> <td>LINK-B1, endorses</td> <td>The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.</td> </tr> <tr> <td>LINK-C3, evidence for</td> <td>The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.</td> </tr> <tr> <td>LINK-D1, outcome</td> <td>The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.</td> </tr> </table>	LINK-A1, unspecified link	The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.	LINK-A2, suggests	The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.	LINK-B1, endorses	The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.	LINK-C3, evidence for	The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.	LINK-D1, outcome	The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.
LINK-A1, unspecified link	The term is used when no semantic information is available for this Link in the EHR system from which the EXTRACT has been created.										
LINK-A2, suggests	The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.										
LINK-B1, endorses	The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.										
LINK-C3, evidence for	The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.										
LINK-D1, outcome	The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.										


	LINK-E1, documented by	A clinical situation documented in the source component is more formally documented in the target component.
	LINK-E4, excerpts	The source component is an extract (copy) of part or all of the information contained within the target component.

Usage

Conditions of Use	Each of the link terms in LINK_ROLE from ISO 13606-3:2009 is a subcategory of a corresponding term in <i>Link Nature Values</i> , where that correspondence is indicated by the first letter after the code string “LINK-”. For example the term LINK-A1 is a subcategory of term LINK-A0. If a term in this list is used for the <i>Link Role</i> data element, the appropriate corresponding value SHALL be used from <i>Link Nature Values</i> .
Conditions of Use Source	ISO 13606-3:2009

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Role	1..1

8.26 Target

Identification

Label	Target
Metadata Type	Data Element
Identifier	DE-16700
OID	1.2.36.1.2001.1001.101.103.16700

Definition


Definition	The “linked to” or identified information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Link UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Link , and UniquelIdentifier .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

8.27 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16982

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT USE AUTHORISATION	1..1

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Appendix A. Known Issues

This appendix lists known issues with this specification at the time of publishing. We are working on solutions to these issues and encourage comments to help us develop these solutions.

Reference	Description
Links to external resources	Certain combinations of web browsers and PDF readers have problems opening URL links (usually found in reference sections) that span more than one line.
Data Hierarchies	Only the parts of these detailed clinical models (DCMs) required for current structured content specifications have been mapped to HL7 CDA. Mapping the remaining parts to CDA may reveal inconsistencies in the data hierarchies, requiring normative change.
Undefined Value Domains	<p>The following data elements lack a defined value domain: <i>General Observation Topic</i> and <i>Document Type</i>.</p> <p>We are in the process of developing national code sets for these items. In the meantime, you are free to use your own code sets, providing any code set used SHALL be registered, i.e. registered through the HL7 code set registration procedure with an appropriate object identifier (OID), and SHALL be publicly available. Note that when national standard code sets do become available, they SHALL be used and the non-standard code sets SHALL be deprecated.</p>
Information Provider	We are considering making <i>Information Provider</i> one of a pair of data components: <i>Information Provider</i> for the source of the information, typically the subject of care of the enclosing structured document and <i>Reporter</i> for the author of the information, typically the author of the enclosing structured document. <i>Reporter</i> has not been added to these DCMs. More investigation is needed to make a decision.
Global Statement Values Value Domain	The list of permissible values is a sample set to initiate discussion and collaboration to develop the correct set of values.
Exclusion Statement	The exclusion statement DCMs are the subject of ongoing development and review and may well change in the future.

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Appendix B. Specification Guide for Use

B.1 Overview

Each detailed clinical model (DCM) and structured content specification (SCS) is designed to be a shared basis for data interpretation. It specifies rigorous business and technical definitions of data that systems may need to share. It is intended to be a logical specification of the data to be persisted within or communicated between systems. It is also the foundation for the compliance, conformance, and declaration process. Our CDA implementation guides are guides to the implementation of HL7 CDA R2 messages based upon these DCMs and SCSs.

Each DCM specifies all of the data components required for any use of a clinical concept; for instance, an entry in a medical record such as a procedure or an imaging test. As such, they are maximal data sets. DCMs are building blocks, which are trimmed to size for use in the construction of SCSs.

Each SCS describes a template of a [Structured Document](#). It specifies the data for a single type of clinical document or information exchange, such as a discharge summary. It is assembled using DCMs that have been constrained to eliminate data components not relevant to the particular context. For example, *Procedure* in a discharge summary uses only some of the data components required by *Procedure* in a specialist report.

B.2 The Structured Content Specification Metamodel

Our metamodel for structured content specifications (see Figure 1) is used to specify the overall structure of a structured content specification. The structure is a tree, so every item in the tree, other than the root node, has a parent node. For an SCS, the root node is a Structured Document. For a DCM, the root node is a Data Group.

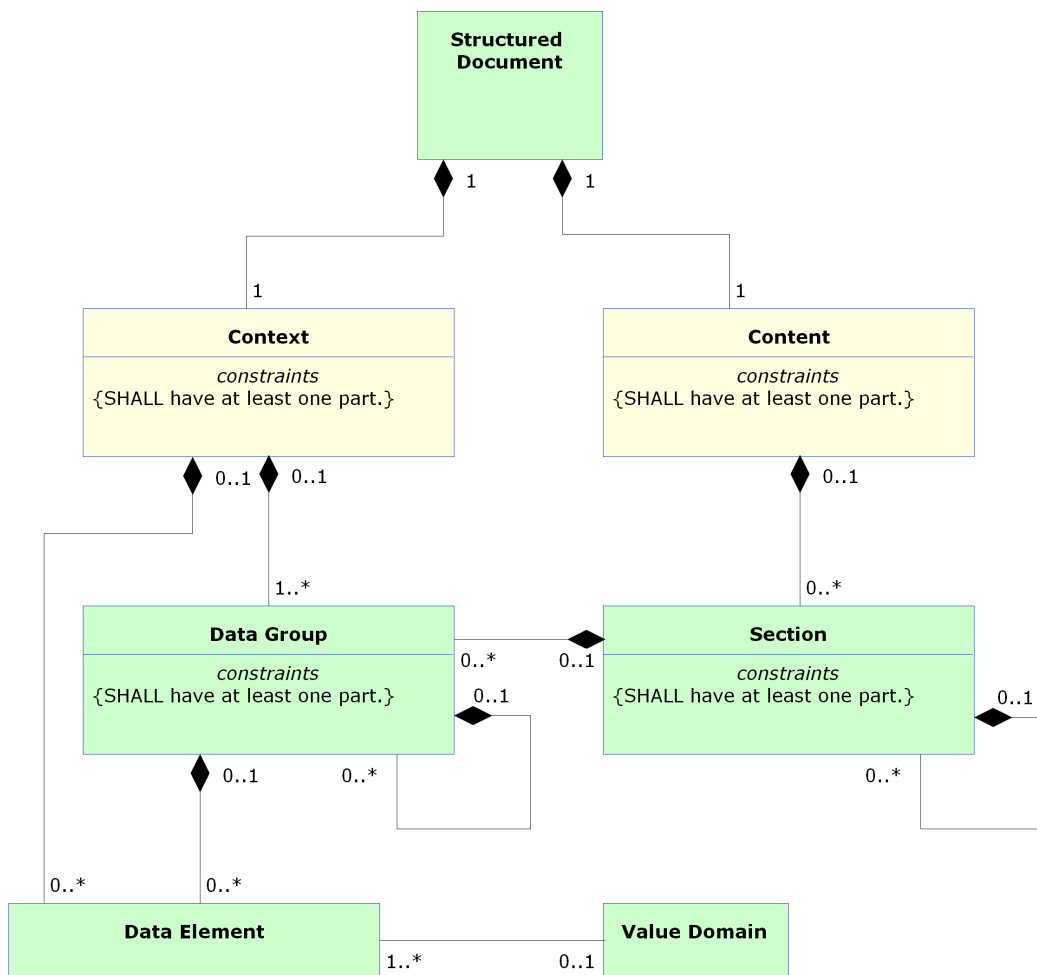


Figure 1: SCS Metamodel

There are two main items used to organise information within an SCS as follows:

Context: This contains information related to the overall context of the document.

Content: This contains information that changes between different SCSs, but is always structured as shown in Figure 1, and consists of the following data components:

- Section
- Data Group
- Data Element
- Value Domain

These data components are described in more detail below.

Structured Document

A structured document is a collection of health information about a subject of care that is relevant to the ongoing care of that person. They are composed of one or more data groups and data elements that are organised into

sections. Examples of structured documents are *Discharge Summary*, *Shared Health Summary*, and *Advance Care Directive Custodian Record*.

Context

The purpose of the context is to identify and classify the document and to provide subjects of care and involved healthcare providers with the information related to the relevant healthcare events.

Content

Content contains a collection of personal information and health information pertinent to a subject of care that is derived from the healthcare event described in the document. The detail is organised into one or more data groups, which are optionally grouped into sections.

Section

A section is composed of data groups, other sections, or both. It is an organising container that cues the reader about expected content. A section organises information in a manner suitable for the primary purpose for which it is collected and provides a way to navigate through the data components within the document, thereby enabling more efficient querying. It is recommended that the section support safe reuse for secondary purposes, e.g. clinical coding or inclusion in a summarised form in an electronic health record. A section is context-specific to the document in which it resides.

Data Group

Each data group is used to represent one concept. A data group consists of other data groups, data elements, or both. Some data groups are reused across DCMs.

Every instance of a data group **SHALL** have at least one child data component instantiated.

Participation

Participation is a special case of a data group that is based on a data group template, which is reused throughout the DCMs and SCSs. Participations are an amalgam of the Actors (see below) operating within a defined healthcare domain and the Roles they are playing within that domain.

A Participant has been defined to align with the concepts of the Agency's [Interoperability Framework \[NEHT2007b\]](#). It equates to an *Entity* that is related to the action described in an SCS as an *Actor*. A Participant can be a human, an organisation, or an IT system.

Our [Participation Data Specification \[NEHT2011v\]](#) defines the full Participation specification.

Choice

Choice represents a selection, to be made at run-time, of a single member from a set of data groups, where the set is defined at design-time, i.e. one and only one member of the set is chosen for each instance of the choice.

For example, at design-time a healthcare provider provides a service, but it is not until run-time that a decision can be made as to whether the provider is a person or an organisation. Hence, when a healthcare provider *Participant* is instantiated, it will contain either an instance of the *Person* data group or an instance of the *Organisation* data group.

Data Element

A data element is the smallest named unit of information in the model that can be assigned a value. For example, *DateTime of Observation* and *Observation Note*. Data elements are bound to data types (see [Data Types Legend](#)). Some data elements are reused in different data groups.

While all data elements are constrained by their data type, some data elements are further constrained by value domains (see [Value Domain](#) below).

Value Domain

A value domain constrains the permissible values for a data element. The values are often a subset of values based on a generic data type.

Value domains are reusable items, therefore the same value domain can be referred to by different data elements in different contexts. Value domains are often specified with reference to a *reference set*. A reference set is a constrained list of SNOMED CT-AU concepts that are appropriate to a particular context or use. Since many of these reference sets have been developed specifically for the context in which they appear, it is recommended that an assessment of fitness for purpose be undertaken before using any of the reference sets in another context.

Value domains constrain either by specifying a lower or upper bound (or both) on the range of permissible values or by specifying a finite set of prescribed values. Such a set of prescribed values can be specified directly within the definition of the data element, or in a separate but associated specification, or else by reference to one or more vocabulary or terminology reference sets. The table below provides some examples of value domains.

Table 1: Value Domain Examples

Data Element	Data Type	Example of Value Domain										
Sex	CodedText	Standards Australia AS 4846 (2006) – Health Care Provider Identification [SA2006a] and Standards Australia AS 5017 (2006) – Health Care Client Identification [SA2006b] derive their values from METeOR 287316, which includes values such as: <table border="1" data-bbox="651 1301 1433 1532"> <thead> <tr> <th>Value</th> <th>Meaning</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Male</td> </tr> <tr> <td>2</td> <td>Female</td> </tr> <tr> <td>3</td> <td>Intersex or Indeterminate</td> </tr> <tr> <td>9</td> <td>Not Stated/Inadequately Described</td> </tr> </tbody> </table>	Value	Meaning	1	Male	2	Female	3	Intersex or Indeterminate	9	Not Stated/Inadequately Described
Value	Meaning											
1	Male											
2	Female											
3	Intersex or Indeterminate											
9	Not Stated/Inadequately Described											
Diagnosis	CodeableText	A SNOMED CT-AU reference set that references concepts such as “Bronchitis” (Concept ID: 32398004).										
Therapeutic Good Identification	CodeableText	An AMT reference set that references concepts such as “Ibuprofen Blue (Herron) (ibuprofen 200 mg) tablet: film-coated, 1 tablet” (Concept ID: 54363011000036107).										
Individual Pathology Test Result Name	CodeableText	A LOINC subset that references concepts such as “Cholesterol [Moles/volume] in Serum or Plasma” (ID: 14647-2).										






B.3 Icon Legend

These legends describe all icons that are used in the Agency's DCMs and SCSs.

Metadata Types Legend

The following table explains each of the icons used to represent the metadata types within DCMs and SCSs.



Table 2: Metadata Types Legend

Icon	Metadata Types
	Structured Document
	Section
	Data Group
	Participation
	Choice

Data Types Legend

The following table explains each of the icons used to represent the data types bound to each data element in the SCSs. These data types are a profile of the **ISO 21090-2011** data types as specified in [Data Types in NEHTA Specifications: A Profile of the ISO 21090 Specification \[NEHT2010c\]](#).

Table 3: Data Types Legend

Icon	Data type	Explanation
	Any (ISO 21090: ANY)	Use of this icon indicates that instances of the data element can be of any concrete data type. There are no limitations on the data type of the data element. The values that can be required will vary considerably depending on the context. This is an abstract data type that is the basis for all data types and SHOULD NOT be used in an actual implementation.
	Boolean (ISO 21090: BL)	A data type, sometimes called the logical data type, having one of the two values: <i>true</i> and <i>false</i> . Many systems represent true as <i>non-zero</i> (often 1, or -1) and false as <i>zero</i> . Usage/Examples • An actual value entered by a user might be “yes” or could be chosen by a mouse click on an icon such as <input checked="" type="checkbox"/> .



CodeableText
(ISO 21090: CD)

Coded text *with* exceptions; supports various ways of holding text, both free text and coded text.

Often used to support compliance for early adopters of the structured content specifications.

While it is recommended that the values in this data type come from the bound value domain, it allows other value domains to also be used (with or without translations to the bound value domain) or free text alternatives. This is useful when it is not possible to define an entire value domain for a complex concept (e.g. *Diagnosis*) and when there are competing code sets in existence. Note that within exchange specifications or message profiles this data type **MAY** be constrained to mandate compliance with the bound value domain.

Usage/Examples

- The Australian Institute of Health and Welfare (AIHW) defines a data element concept *Episode of admitted patient care-separation mode* (the status at separation of a subject of care and the place to which they are released). An early adopter could have a similar concept (coded or otherwise) that maps to this data element but does not strictly comply with the AIHW values.
- A SNOMED CT-AU coded/complex expression that embodies single or multiple concepts. The SNOMED CT-AU concepts behind these CodeableText data elements are specified in the structured content specification value domains.



CodedText
(ISO 21090: CD)

Coded text *without* exceptions; text with code mappings. Values in this data type **SHALL** come from the bound value domain, with no exceptions.

Often used for reference sets with only a small number of applicable values, e.g. Gender and Document Status.

Usage/Examples

[Standards Australia AS 5017 \(2006\) – Health Care Client Identification \[SA2006b\]](#) specifies the following value domain representing a type of address:

Value	Meaning
1	Business
2	Mailing or Postal
3	Temporary Accommodation
4	Residential (permanent)
9	Not Stated/Unknown/Inadequately Described



DateTime
(ISO 21090: TS)






A single date, optionally with a time of day.

Has the ability to indicate a level of precision, but not whether the date or time is estimated. Cannot represent a time alone.

String representations of known dates **SHALL** conform to the format within the **ISO 21090-2011** standard without the use of extensions, i.e. YYYY[MM[DD[HH[MM[SS[U[U[U[U]]]]]]][+|-ZZzz].

Usage/Examples

- Partial dates: 2008, 20081001.
- To indicate 1:20 pm on May the 31st, 1999 for a time zone that is 10 hours ahead of Coordinated Universal Time (UTC): 19990531132000+1000.

	<p>Duration (ISO 21090: PQ.TIME)</p>	<p>The period of time during which something continues. Consists of a value and a unit that represents the time value, e.g. hours, months. Compound durations are not allowed, e.g. 10 days 3 weeks 5 hours.</p>
Usage/Examples		
<ul style="list-style-type: none"> • 3 hours • 6 months • 1 year 		
	<p>EncapsulatedData (ISO 21090: ED)</p>	<p>Data that is primarily intended for human interpretation or for further machine processing outside the scope of this specification. This includes unformatted or formatted written language, multimedia data, or structured information as defined by a different standard (e.g. XML signatures).</p>
Usage/Examples		
<ul style="list-style-type: none"> • JPEG images • HTML documents • [RFC1521] MIME types 		
	<p>Integer (ISO 21090: INT)</p>	<p>The mathematical data type comprising the exact integral values.</p>
Usage/Examples		
<ul style="list-style-type: none"> • 1 • -50 • 125 		
	<p>Link (ISO 21090: TEL)</p>	<p>A general link, reference or pointer to an object, data or application that exists logically or is stored electronically in a computer system.</p>
Usage/Examples		
<ul style="list-style-type: none"> • URL (Uniform Resource Locator) – the World Wide Web address of a site on the internet, such as the URL for the Google internet search engine – <i>http://www.google.com</i>. • An absolute or relative path within a file or directory structure – e.g. in the Windows operating system, the “link” or absolute path to a particular letter could be <i>C:\Documents and Settings\GuestUser\MyDocuments\letter.doc</i> 		
	<p>Quantity (ISO 21090: PQ)</p>	<p>A magnitude value with a unit of measurement.</p>
<p>This is used for recording many real world measurements and observations. As the default unit of measure is 1, even counts of items can be recorded with <i>Quantity</i>.</p>		
Usage/Examples		
<ul style="list-style-type: none"> • 100 centimetres • 25.5 grams • 3 per month 		

	<p>QuantityRange (ISO 21090: IVL)</p>	<p>A range of <i>Quantity</i> values.</p> <p>It may be identified using a combination of an optional minimum <i>Quantity</i> and an optional maximum <i>Quantity</i> (i.e. lower and upper bounds).</p> <p>This is typically used for defining the valid range of values for a particular measurement or observation. Unbounded quantity ranges can be identified by not including a minimum or a maximum <i>Quantity</i> value.</p>
Usage/Examples		
<ul style="list-style-type: none"> • -20 to 100 Celsius • 30-50 mg • >10 kg • 2-3 hours 		
	<p>QuantityRatio (ISO 21090: RTO)</p>	<p>A relative magnitude of two <i>Quantity</i> values.</p> <p>Usually recorded as numerator and denominator.</p>
Usage/Examples		
<ul style="list-style-type: none"> • 25 mg / 500 ml • 200 mmol per litre 		
	<p>Real (ISO 21090: REAL)</p>	<p>A computational approximation to the standard mathematical concept of real numbers.</p> <p>These are often called floating-point numbers.</p>
Usage/Examples		
<ul style="list-style-type: none"> • 1.075 • -325.1 • 3.14157 		
	<p>Text (ISO 21090: ST)</p>	<p>A character string (with optional language) containing any combination of alpha, numeric, or symbols from the Unicode character set. Also referred to as <i>free text</i>.</p> <p>Usage/Examples</p> <p>“The patient is a 37 year old man who was referred for cardiac evaluation after complaining of occasional palpitations, racing heart beats and occasional dizziness.”</p>
	<p>TimeInterval (ISO 21090:IVL)</p>	<p>An interval in time.</p> <p>It is identified using a combination of an optional start <i>DateTime</i>, an optional end <i>DateTime</i>, and an optional <i>Duration</i>.</p>
Usage/Examples		
<ul style="list-style-type: none"> • 20080101+1000 - 20081231+1000 • 200801010130+1000 - 200801011800+1000 • 200801010130+1000, duration=16.5 hours 		



UniquelIdentifier

(ISO 21090: II)

A unique value used to identify a physical or virtual object or concept.

In using this data type, the attributes of the UniquelIdentifier data type **SHOULD** be populated from the identifiers as defined in [AS 4846 \(2006\) – Health Care Provider Identification \[SA2006a\]](#) and [AS 5017 \(2006\) – Health Care Client Identification \[SA2006b\]](#) as follows:

- *root*: a globally unique object identifier that identifies the combination of geographic area, issuer and type. If no such globally unique object identifier exists, it **SHALL** be created.
- *extension*: a unique identifier within the scope of the root that is directly equivalent to the identifier designation element.
- *identifierName*: a human readable name for the namespace represented by the root that is populated with the issuer or identifier type values, or a concatenation of both, as appropriate. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used for that purpose.
- *identifierScope*: the geographic span or coverage that applies to or constrains the identifier. It is directly equivalent to the geographic area element. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used as such.

Also, the following constraints apply on the UniquelIdentifier data type:

- 1) The *root* attribute **SHALL** be used.
- 2) For an Entity Identifier, the *root* attribute **SHALL** be an OID that consists of a node in a hierarchically assigned namespace, formally defined using the ITU-T's ASN.1 standard.
- 3) For an Entity Identifier, the *root* attribute **SHALL NOT** be a UUID.
- 4) The *extension* attribute **SHALL** be used.

Usage/Examples

Australian health identifiers (e.g. IHI, HPI-I and HPI-O) and patient hospital medical record numbers are examples of identifiers that may be carried by data elements of this data type.

Keywords Legend

Where used in this document and in DCMs and SCSs, the keywords **SHALL**, **SHOULD**, **MAY**, **SHALL NOT** and **SHOULD NOT** are to be interpreted as described in [Key Words for Use in RFCs to Indicate Requirement Levels \[RFC2119\]](#). Our specifications use the terms **SHALL** in place of “MUST” and **SHALL NOT** in place of “MUST NOT”. The key word definitions in RFC 2119, adjusted to remove the key words not used in the Agency specifications, are presented in the following table.

Table 4: Keywords Legend

Keyword	Definition
SHALL	This word means that the statement is an absolute requirement of the specification.
SHOULD	This word means that there may exist valid reasons in particular circumstances to ignore a particular data component, but the full implications must be understood and carefully weighed before choosing a different course.

MAY	This word means that a data component is truly optional. One implementer may choose to include the data component because a particular implementation requires it, or because the implementer determines that it enhances the implementation, while another implementer may omit the same data component. An implementation that does not include a particular option shall be prepared to interoperate with another implementation that does include the option, perhaps with reduced functionality. In the same vein, an implementation that does include a particular option shall be prepared to interoperate with another implementation that does not include the option (except of course, for the feature the option provides).
SHALL NOT	This phrase means that the statement is an absolute prohibition of the specification.
SHOULD NOT	This phrase means that there may exist valid reasons in particular circumstances when the particular behaviour is acceptable or even useful, but the full implications should be understood and the case carefully weighed before implementing any behaviour described with this label.

Obligation Legend

In DCMs and SCSs obligations on a data component specify whether or not it **SHALL** be populated in the logical record architecture of a message. We intend that all data components that are not **PROHIBITED** will be implemented.

Obligations in statements about values specify whether or not certain values are permitted.

Implementation guides specify the rules and formats for implementing and populating data components in specific messaging formats.

The following table defines the obligations.

Table 5: Obligations Legend

Keyword	Interpretation
ESSENTIAL	<p>Indicates that the data component is considered a mandatory item of information and SHALL be populated.</p> <p>Usage/Examples:</p> <p>The Participant data component for a Subject of Care SHALL include an Entity Identifier data component in order to hold the IHI.</p>
OPTIONAL	<p>Indicates that the data component is not considered a mandatory item of information and MAY be populated.</p> <p>Usage/Examples:</p> <p>Such data components will be implemented, only inclusion and population are optional.</p> <p>This is only needed when a DCM incorrectly asserts that a data component is ESSENTIAL. It will be used with a note stating that the DCM needs revision.</p>
PROHIBITED	<p>On a data component this indicates that the data component is considered a forbidden item of information and SHALL NOT be included.</p> <p>In a statement about values this indicates that the use of the specified values is considered forbidden and they SHALL NOT be used.</p> <p>Usage/Examples:</p> <p>Within a Participation data group depicting a Subject of Care, the Participation Healthcare Role SHALL NOT be populated.</p>

CONDITIONAL Indicates that a data component is considered **ESSENTIAL** only on satisfaction of a given condition. Individual data components specify the obligation of the data component when the condition is not met.

When a condition is met, the data component is considered to be **ESSENTIAL** and **SHALL** be populated.

When a condition is not met, the data component may be considered **PROHIBITED**, or the data component may be considered **OPTIONAL**.

Usage/Examples:

Within a Pathology Result Report, the *Specimen Detail* data group is **ESSENTIAL** if the requested test is to be performed on a specimen; otherwise it **SHALL NOT** be included.

Obligations follow the usual scope rules: where **ESSENTIAL** child data components are contained within **OPTIONAL** parent data components, the child data components **SHALL NOT** be included when the parent is not included.

B.4 Exceptional Values

Occasionally a data element will have an exceptional value: an abnormal value (i.e. the value cannot be described using the expected set of values) or an absent value (i.e. no value is provided). Some abnormal values are only relevant to data elements of certain data types (e.g. positive infinity is relevant to numbers but not Booleans).

Unless otherwise specified, all data elements are permitted to have exceptional values. Constraints on the use of exceptional values are contained in the [Exceptional Values row](#) of the Usage section, except for instances of [Participation](#), when they are in the [Conditions of Use row](#). The most common statements constraining exceptional values are:

- Absent values are **PROHIBITED**.
- Abnormal values are **PROHIBITED**.

The commonly used implementation specifications ISO 21090 and HL7 CDA R2 use *nullFlavor* to manage abnormal and absent values.

The following table provides a classification of *nullFlavor* values as abnormal or absent.

Table 6: Classification of ISO 21090 nullFlavor values as absent or abnormal

Level	Code	Term	Abnormal	Absent
1	NI	No information		Absent
2	INV	Invalid	Abnormal	
3	OTH	Other	Abnormal	
4	PINF	Positive infinity	Abnormal	
4	NINF	Negative infinity	Abnormal	
3	UNC	Unencoded	Abnormal	
3	DER	Derived	Abnormal	
2	UNK	Unknown		Absent
3	ASKU	Asked but unknown		Absent
4	NAV	Temporarily unavailable		Absent
3	NASK	Not asked		Absent
3	QS	Sufficient quantity	Abnormal	

Level	Code	Term	Abnormal	Absent
3	TRC	Trace	Abnormal	
2	MSK	Masked		Absent
2	NA	Not applicable		Absent

B.5 Information Model Specification Parts Legends

This section illustrates the format and parts used to define each section, data group and data element within the Agency’s DCMs and SCSs, and identifies when each part is applicable.

Chapter Name

Each section, data group, data element, value domain or choice has its own eponymous chapter. The chapter name is used in all data hierarchies.

Identification Section Legend

The following table illustrates the layout of the Identification section and describes the various parts of the section.

Table 7: Identification Section Legend

Label	A suggested display name for the data component.
Metadata Type	The type of the data component, e.g. section, data group or data element.
Identifier	An Agency-assigned internal identifier of the data component. Note that if one data component is used twice (e.g. <i>Therapeutic Good Identification</i> is used in both <i>Medication Instruction</i> and <i>Medication Action</i>), both uses of the data component will have the same identifier. A data component identifier identifies a data component, not a use of a data component.
OID	An object identifier equivalent to the data component identifier.
External Identifier	An identifier of the concept represented by the data component that is assigned by an organisation other than the Agency.

Definition Section Legend

The following table illustrates the layout of the Definition section and describes the various parts of the section.

Table 8: Definition Section Legend

Definition	The meaning, description or explanation of the data component. For data groups used in a particular context, the definition MAY be a refinement of the generic data group definition.
Definition Source	The authoritative source for the Definition statement.
Synonymous Names	A list of any names the data component may also be known as.

Scope	Implementers may prefer to use synonymous names to refer to the data component in specific contexts.
	Situations in which the data component may be used, including the Scope circumstances where specified data are required or recommended.
Scope Source	For example, Medication Instruction (data group) has a scope that includes all prescribable therapeutic goods, both medicines and non-medicines.
	This item is not relevant to data elements or value domains.
Context	The authoritative source for the Scope statement.
	The environment in which the data component is meaningful, i.e. the circumstance, purpose and perspective under which this data component is defined or used.
Assumptions	For example, Street Name has a context of Address.
	This item is applicable only to data elements.
Assumptions Source	Suppositions and notions used in defining the data component.
	The authoritative source for the Assumptions statement.
Notes	Informative text that further describes the data component, or assists in the understanding of how the data component can be used.
Data Type	The data type (or data types) of the data element, e.g. DateTime or Text.
	The valid data types are specified in the Data Types Legend .
Value Domain	This item is applicable only to data elements.
	The name of the Value Domain used to define the range of values of the data element, or a statement describing what values to use in the absence of a defined value domain for the related data element.
	The statement is:
	<p>In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure with an appropriate object identifier (OID), and SHALL be publicly available.</p> <p>When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.</p>
	This item is applicable only to data elements with data type CodedText or CodeableText.

Data Hierarchy

The top-level data components (a Structured Document in an SCS or Data Groups in a DCM) contain a data hierarchy. Each row contains information about a single data component. The entries are nested to represent inclusion of one data component in another. Each entry contains at least three occupied cells. The left-most cell contains an icon to indicate the entry's data type. The next cell to the right contains the label of the data component (if the label is different from the name, the name is displayed in brackets after the label). The next cell to the right contains the multiplicity range for the data component.

If a row is shaded grey, this indicates that the data component **SHOULD NOT** be used. This will be because analysis of requirements either did not find reasons to use it or found reasons to not use it.

If the text in a row is in a ~~strike-through~~ font and the multiplicity is 0..0, this indicates that the data component **SHALL NOT** be used. This will be because analysis of requirements found reasons to prohibit the use of it.

In some documents the right-hand side of the data hierarchy contains one or more columns under the heading “Core Requirement”. Each column contains information for one document exchange scenario. A cell that is empty indicates that the data component on that row is **OPTIONAL** to implement. That is, software that creates documents made in conformance with this specification **MAY** exclude the data component, and software that reads documents made in conformance with this specification **MAY** ignore the data component. All other data components **SHALL** be implemented.















Sample SCS Data Hierarchy



Note

Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. Typically, such identifiers will be generated internally by systems and not displayed to users since they rarely have clinical significance.

Items below with a grey background are data components that are included in the relevant detailed clinical model specification, but whose use is discouraged in this particular scenario.

 SPECIALIST LETTER			
CONTEXT			
		SUBJECT OF CARE	1..1
		DOCUMENT AUTHOR	1..1
		ENCOUNTER	1..1
		DateTime Subject of Care Seen (DateTime Health Event Started)	1..1
		DateTime Health Event Ended	0..0
		HEALTHCARE FACILITY	0..0
		Document Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Document Type	1..1
CONTENT			
		RESPONSE DETAILS	1..1
		Diagnosis (PROBLEM/DIAGNOSIS)	0..*
		 Diagnosis Name (Problem/Diagnosis Identification)	1..1
		 Clinical Description	0..0
	and more		

Value Domain Section Legend

The following table illustrates the layout of the Value Domain section and describes the various parts of the section.

Table 9: Value Domain Section Legend

Source	The name of the terminology or vocabulary from which the value domain's permissible values are sourced, e.g. SNOMED CT-AU, LOINC.
Version Number	Version number of the value domain source.
Permissible Values	A specification of the permissible values in the value domain. This may be a list of codes. (Each code is typically presented as a triple with code values, text equivalent, and description) for example: 1, Registered No result yet available. This may be a conformance statement (e.g. "The permissible values are the members of the following seven AMT reference sets: ...").

Usage Section Legend

The following table illustrates the layout of the Usage section and describes the various parts of the section.

Table 10: Usage Section Legend

Examples	Sample values for the data element, with or without notes about sample values. Where a data element has an associated value domain, examples representative of that domain are used where possible. Where the value domain is yet to be determined, indicative examples are provided. Implementation guides may contain specific examples of how data elements may be populated and how they relate to each other. This item is applicable only to data elements.
Conditions of Use	Prerequisites, provisos or restrictions for use of the data component.
Conditions of Use Source	The authoritative source for the Conditions of Use statement.
Misuse	Incorrect, inappropriate or wrong uses of the data component.
Default Value	A common denomination, or at least a usable denomination, from the Value Domain where available or applicable, typically assigned at the creation of an instance of the data component.
Exceptional Values	A statement of limitations on the use of exceptional values, see Exceptional Values . Unless otherwise specified, all data elements are permitted to have exceptional values. The most common statements constraining exceptional values are: <ul style="list-style-type: none"> Abnormal values are PROHIBITED. Absent values are PROHIBITED. This item is applicable only to data elements.

Relationships Section Legend

The Relationships section specifies the cardinality between parent and child data components.

The following table illustrates the layout of the Parent relationships table. Note that the occurrences in the relationships described by this table are from the parent to the child data component, i.e. from the data component listed in the table to the data component described by the section.

Table 11: Parent Legend

Data Type	Name	Occurrences (child within parent)
The icon illustrating the metadata type or data type.	Parent Data Component Name	The minimum and maximum number of instances of the data component described on this page that SHALL occur.

The following table illustrates the layout of the Children relationships table.

Table 12: Children Legend

Data Type	Name	Occurrences
The icon illustrating the metadata type or data type.	Child Data Component Name	The minimum and maximum number of instances of the data component described on this page that SHALL occur.

Appendix C. Change History

A summary of changes from one document version to the next. Changes to the change history are excluded.

C.1 Changes Since Version 1.4 - 18 December 2015

Generic changes

Various changes to rebrand the document from the National E-Health Transition Authority (NEHTA) to the Australian Digital Health Agency (the Agency):

- Definition Source, Scope Source, Context Source, Condition of Use Source and Value Domain Source updated from “NEHTA” to “Australian Digital Health Agency”;
- references to “National E-Health Transition Authority” and “NEHTA” have been replaced with references to the “Australian Digital Health Agency” and “the Agency” respectively; and
- all NEHTA URLs have been updated to redirect to the Agency website.

Preliminary Pages

Document Information section has been changed to include the latest release details.

Chapter 1 Introduction

Various editorial changes to presentation and wording, including replacing the expression “PCEHR” with “My Health Record”.

Chapter 2 Clinical Synopsis Detailed Clinical Model

Rebranding changes.

Chapter 3 Recommendation Detailed Clinical Model

Rebranding changes.

Chapter 4 Exclusion Statement Detailed Clinical Model

Rebranding changes.

Chapter 5 Referral Detail Detailed Clinical Model

Rebranding changes.

Chapter 6 Requested Service Detail Detailed Clinical Model

This chapter has been removed.

Chapter 6 Summary of Medication Entries Detailed Clinical Model

Rebranding changes.

Chapter 7 General Observation Detailed Clinical Model

In 7.9 Observation DateTime, there was a change in hyperlink in examples.

Rebranding changes.

Chapter 8 Document Use Authorisation Detailed Clinical Model

Rebranding changes including replacing the expression “PCEHR” with “My Health Record”.

Appendix A. Known Issues

Removed known issues related to the *Requested Service* DCM.

Appendix B. Specification Guide for Use

Various editorial changes.

Renamed the section B.4 “Abnormal and Absent Values” to “Exceptional Values” and updated explanatory text throughout accordingly.

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