Australian Government
Australian Digital Health Agency

Requested Service
Detailed Clinical Model Specification
Version 1.0

5 August 2016

Approved for external use

Document ID: DH-2316:2016

Australian Digital Health Agency
Level 25, 56 Pitt Street
Sydney, NSW 2000
Australia
www.digitalhealth.gov.au

Disclaimer

The Australian Digital Health Agency ("the Agency") makes the information and other material ("Information") in this document available in good faith but without any representation or warranty as to its accuracy or completeness. The Agency cannot accept any responsibility for the consequences of any use of the Information. As the Information is of a general nature only, it is up to any person using or relying on the Information to ensure that it is accurate, complete and suitable for the circumstances of its use.

Document control

This document is maintained in electronic form and is uncontrolled in printed form. It is the responsibility of the user to verify that this copy is the latest revision.

Document Information

Key Information

Owner	General Manager, Clinical Informatics, Terminology and Tooling
Contact for enquiries	Australian Digital Health Agency Help Centre t: 1300 901 001 e: help@digitalhealth.gov.au

Product Version History

Product version	Date	Release comments
1.0	5 Aug 2016	Initial public release. This specification is published to support the Service Referral structured content specification.

Related Documents

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

Included Detailed Clinical Models

This specification contains the following detailed clinical models:

- Requested Service (Action), version 5.1

This page is intentionally left blank.

Acknowledgements

Council of Australian Governments

The Australian Digital Health Agency is jointly funded by the Australian Government and all state and territory governments.

Regenstrief Institute (LOINC)

This material contains content from LOINC™ (http://loinc.org). The LOINC table, LOINC codes, LOINC panels and forms file, and LOINC linguistic variants file are copyright © 1995-2015, Regenstrief Institute, Inc. and the Logical Observation Identifiers Names and Codes (LOINC) Committee and available at no cost under the license at https://loinc.org/terms-of-use/. LOINC is a trademark of Regenstrief Institute, Inc., registered in the United States.

IHTSDO (SNOMED CT)

This material includes SNOMED Clinical Terms™ (SNOMED CT®) which is used by permission of the International Health Terminology Standards Development Organisation (IHTSDO). All rights reserved. SNOMED CT® was originally created by The College of American Pathologists.

“SNOMED” and “SNOMED CT” are registered trademarks of the IHTSDO, (http://www.ihtsdo.org/).

HL7 International

This document includes excerpts of HL7™ International standards and other HL7 International material. HL7 International is the publisher and holder of copyright in the excerpts. The publication, reproduction and use of such excerpts is governed by the HL7 IP Policy (see http://www.hl7.org/legal/ippolicy.cfm) and the HL7 International License Agreement. HL7 and CDA are trademarks of Health Level Seven International and are registered with the United States Patent and Trademark Office.

This product includes all or a portion of the HL7 Vocabulary, or is derived from the HL7 Vocabulary, subject to a license from Health Level Seven International. Your use of the HL7 Vocabulary also is subject to this license, a copy of which is accessible through the following link: http://www.hl7.org/permalink/?VocabTables. The current complete HL7 Vocabulary is also available through this link. The HL7 Vocabulary is copyright © 1989-2010, Health Level Seven International. All rights reserved. THE HL7 VOCABULARY IS PROVIDED "AS IS." ANY EXPRESS OR IMPLIED WARRANTIES ARE DISCLAIMED, INCLUDING, BUT NOT LIMITED TO, THE IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE.

This page is intentionally left blank.

Table of Contents

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) interoperability[1] 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.

[1] Level 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 Requested Service Detailed Clinical Model

This chapter describes version 5.1 of the *Requested Service (Action)* Detailed Clinical Model.

2.1 Purpose

To describe services requested for, or provided to, the subject.

2.2 Use

Use to record a group of one or more services that are to be provided in the future (e.g. referral) or a group of services that have already been provided. All services would have the same value for other data elements such as *Service Category* and *Service Booking Status*.

Use when the initiating provider knows precisely what is required by the service and when the requesting provider has and wishes to exercise the authority (and expertise) to decide exactly what action will be done. For example, an aged care patient might need to have meals on wheels arranged as well as assistance with house cleaning. In this scenario, it would be expected that values would be provided for both *Service Category* and *Service Description*. Other data elements may not be relevant in this scenario, such as *Request Validity Period*.

Use when the initiating provider defers to the expertise of the referred-to provider. This is used when the initiating provider is seeking another provider or organisation to use their own expertise or authority to determine the specific action to take, for example, when referring to an orthopaedic surgeon for management of advanced knee osteoarthritis. The referral requests an assessment by the surgeon and any consequential management that the surgeon determines. The referrer may query whether a total knee replacement is required, but that decision is left to the surgeon. In this scenario, it would be expected that values would only optionally need to be provided for *Service Description*. Other data elements would likely be included in such a request, such as *Request Validity Period*.

Use in relation to services that have already occurred where it can be recorded that an individual is having or has had a number of services. In this scenario, certain data elements may not be necessary, such as some of the details about the original referral that instigated the service (or services). For example, *Request Urgency* and *Request Validity Period*.

2.3 Misuse

Not to be used to specify medication prescriptions.

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.

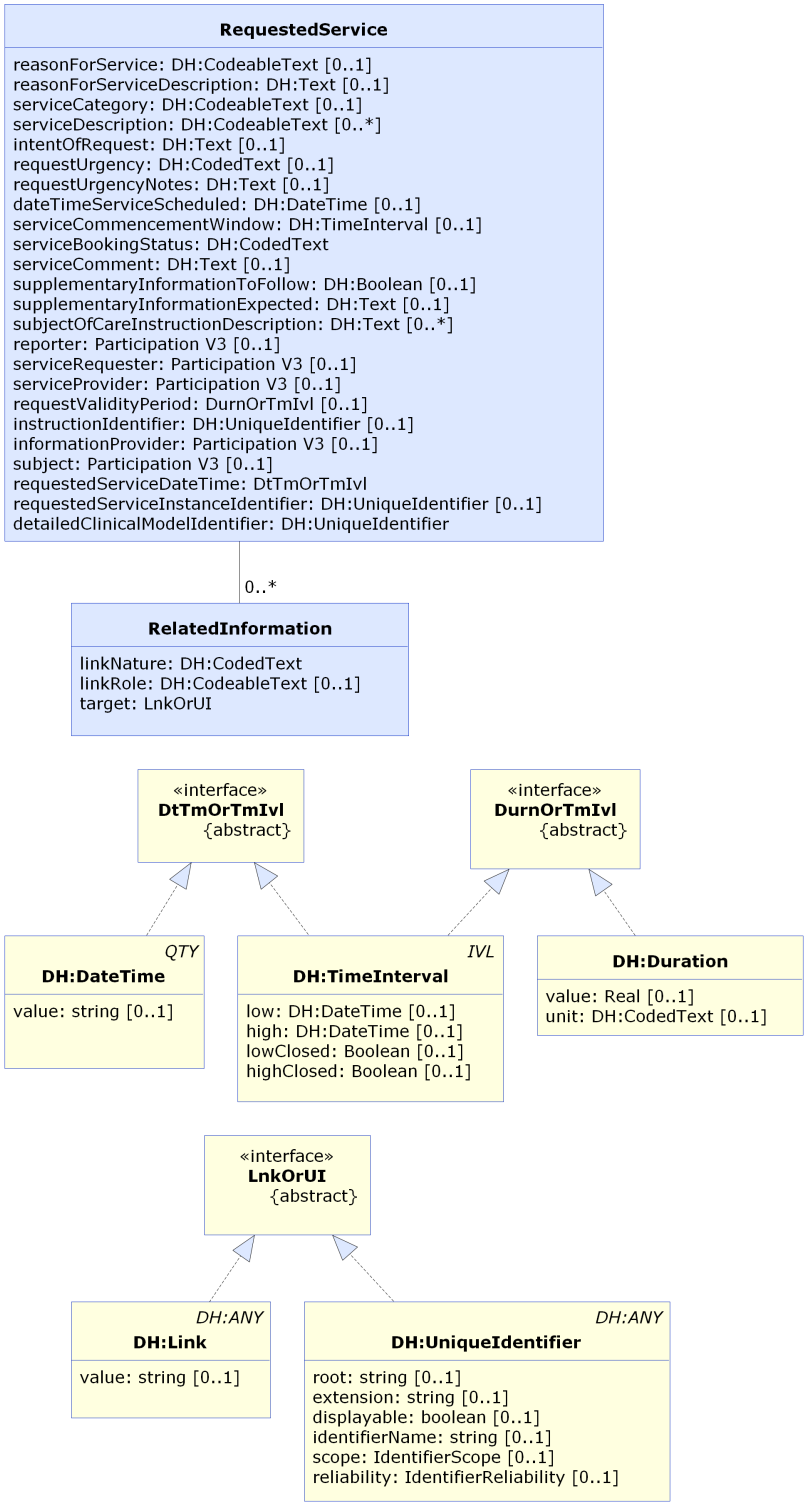

Figure 2.1. Requested Service

2.5 REQUESTED SERVICE

Identification

Label	REQUESTED SERVICE
Metadata Type	Data Group
Identifier	DG-20158
OID	1.2.36.1.2001.1001.101.102.20158

Definition

Definition	Details of services requested for, or provided to, the subject.
Definition Source	Australian Digital Health Agency
Synonymous Names	Service Referral Referral Arranged Service

Usage

Conditions of Use	Each instance of this `data group` **SHALL** contain at least one instance of: • Reason for Service, or • Reason for Service Description, or • Service Category, or • Service Description.
Conditions of Use Source	Australian Digital Health Agency
Misuse	Using to specify medication prescriptions.

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.

	REQUESTED SERVICE		
	001011001	Reason for Service	0..1
		Reason for Service Description	0..1
	001011001	Service Category	0..1

		Service Description		0..*
		Intent of Request		0..1
		Request Urgency		0..1
		Request Urgency Notes		0..1
		DateTime Service Scheduled		0..1
		Service Commencement Window		0..1
		Service Booking Status		1..1
		Service Comment		0..1
		Supplementary Information to Follow		0..1
		Supplementary Information Expected		0..1
		Subject of Care Instruction Description		0..*
		REPORTER		0..1
		SERVICE REQUESTER		0..1
		SERVICE PROVIDER		0..1
		Request Validity Period		0..1
		Request Identifier (Instruction Identifier)		0..1
		INFORMATION PROVIDER		0..1
		SUBJECT		0..1
		Requested Service DateTime		1..1
		Requested Service 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 Reason for Service

Identification

Label	Reason for Service
Metadata Type	Data Element
Identifier	DE-20172
OID	1.2.36.1.2001.1001.101.103.20172

Definition

Definition	Reason for the services being requested or provided.
Definition Source	Australian Digital Health Agency
Synonymous Names	Reason for Requesting Service Service Reason Referral Reason
Context	Used to communicate information about the reason for services; for example, reason for requesting admission if the subject was referred to the organisation, or for requesting services (by the healthcare provider) to be provided to the subject after discharge from the healthcare facility. In a discharge summary, this data component captures information about reasons for requesting services (by the healthcare provider) to be provided to the subject after discharge from the healthcare facility.
Context Source	Australian Digital Health Agency
Data Type	CodeableText
Value Domain	*Not specified.* 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	1) To rule out ischaemic heart disease. 2) To rule out organic brain lesions.

[1] http://www.hl7.org/oid/index.cfm

Relationships

Parents

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

2.7 Reason for Service Description

Identification

Label	Reason for Service Description
Metadata Type	Data Element
Identifier	DE-17030
OID	1.2.36.1.2001.1001.101.103.17030

Definition

Definition	Narrative about the reason for the services being requested or provided.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	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, clinical presentation, etc.
Context Source	Australian Digital Health Agency
Notes	This `data element` is used when there is no coded information available in *Reason for Service*, or to provide additional information that the code cannot provide. In the referral scenario, it complements the structured information contained in the referral specification. The content in this `data element` may vary from a single line in simple cases to many paragraphs for more complex circumstances.
Data Type	Text

Usage

Examples	1) 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 bear weight on it today. I suspect he has a fracture of his right tibia and fibula. 2) Thank you for seeing this 43-year-old lady who has had 2 episodes of cholecystitis in the last month. She is currently well. 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. 3) Thank you for seeing this 88-year-old recently widowed woman. She was previously dependent upon her husband for help around the house for activities such as the heavy cleaning of the house and assistance with driving and shopping. Please arrange assistance for house cleaning and transportation to the local shops once a week.

Relationships

Parents

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

2.8 Service Category

Identification

Label	Service Category
Metadata Type	Data Element
Identifier	DE-17021
OID	1.2.36.1.2001.1001.101.103.17021

Definition

Definition	Specialty of the services requested or provided.
Definition Source	Australian Digital Health Agency
Synonymous Names	Specialty
Notes	In the context of referral (GP to a specialist), this information is often inferred and does not need to be explicitly stated.
Data Type	CodeableText
Value Domain	*Not specified.* 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[2] 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	1) Gynaecology 2) Paediatric Cardiology 3) Podiatry 4) Disability supported accommodation

Relationships

Parents

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

[2] http://www.hl7.org/oid/index.cfm

2.9 Service Description

Identification

Label	Service Description
Metadata Type	Data Element
Identifier	DE-20117
OID	1.2.36.1.2001.1001.101.103.20117

Definition

Definition	Description of the services requested or provided.
Definition Source	Australian Digital Health Agency
Synonymous Names	Service Requested Arranged Service Description
Context	Used to identify clinical services (e.g. diagnostic procedures, clinical procedures and clinical management) and non-clinical services (e.g. community care services).
Context Source	Australian Digital Health Agency
Notes	In a service request where more than one instance of this `data element` is supplied, *Service Category* is also to be supplied.
Data Type	CodeableText
Value Domain	*Not specified.* 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[3] 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	1) Dialysis 2) Adjustment of heart failure/hypertensive medications 3) Adjust INR to therapeutic range 4) Elective orthopaedic surgery for TKR

[3] http://www.hl7.org/oid/index.cfm

Relationships

Parents

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

2.10 Intent of Request

Identification

Label	Intent of Request
Metadata Type	Data Element
Identifier	DE-16126
OID	1.2.36.1.2001.1001.101.103.16126

Definition

Definition	The purpose for which the referrer made the request.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	Description of what the service requester is hoping to achieve through this request; for example, referral to a specialist with the intent of full transfer of care of the subject, palliation vs curative management, etc.
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)
	REQUESTED SERVICE	0..1

2.11 Request Urgency

Identification

Label	Request Urgency
Metadata Type	Data Element
Identifier	DE-16128
OID	1.2.36.1.2001.1001.101.103.16128

Definition

Definition	Assessment of the criticality of a rapid response.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	Used in the service request scenario.
Context Source	Australian Digital Health Agency
Notes	Only include this `data element` to identify urgent requests. The absence of data in this `data element` cannot be assumed to mean that the request is not urgent or that the request is routine.
Data Type	CodedText
Value Domain	Request Urgency Values

Usage

Examples	Please see Appendix B, *Specification Guide for Use* for examples and usage information for CodedText.
Exceptional Values	Absent values are **PROHIBITED**. Abnormal values are **PROHIBITED**.

Relationships

Parents

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

2.12 Request Urgency Values

Identification

Label	Request Urgency Values
Metadata Type	Value Domain
Identifier	VD-16127
OID	1.2.36.1.2001.1001.101.104.16127

Definition

Definition	Set of values to describe the urgency of a request.
Definition Source	Australian Digital Health Agency

Value Domain

Source	Australian Digital Health Agency	
Permissible Values	01, Urgent	The request requires immediate or prioritised attention.
	02, Routine	The request does not require prioritised attention.

Relationships

Parents

Data Type	Name	**Occurrences** (child within parent)
	Request Urgency	1..1

2.13 Request Urgency Notes

Identification

Label	Request Urgency Notes
Metadata Type	Data Element
Identifier	DE-17022
OID	1.2.36.1.2001.1001.101.103.17022

Definition

Definition	Narrative about the request urgency that is not captured in other fields.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This `data element` is used to explain the reason for an urgent request.
Data Type	Text

Usage

Examples	1) This is urgent because the patient has had sudden onset of severe headache, with minor neurological impairment and is at risk of quick deterioration. 2) The patient's full-time carer has suddenly fallen ill and is unable to provide needed assistance for activities of daily living.

Relationships

Parents

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

2.14 DateTime Service Scheduled

Identification

Label	DateTime Service Scheduled
Metadata Type	Data Element
Identifier	DE-16054
OID	1.2.36.1.2001.1001.101.103.16054

Definition

Definition	Date, and optionally time, at which the arranged services are scheduled to be provided.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	This `data element` is used to record the date, and optionally time, on which the service is actually performed or scheduled to be performed, depending on the value of *Service Booking Status* `data element`.
Context Source	Australian Digital Health Agency
Notes	For a request to supply a service, if the service provision has not been confirmed, the service date may be omitted. For supply of a service, this is the date, and optionally time, of completion of supply, and will have the same value as *Requested Service DateTime* `data element`.
Data Type	DateTime

Usage

Conditions of Use	This `data element` **SHALL NOT** be included if *Service Commencement Window* is included.
Conditions of Use Source	Australian Digital Health Agency
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)
	REQUESTED SERVICE	0..1

2.15 Service Commencement Window

Identification

Label	Service Commencement Window
Metadata Type	Data Element
Identifier	DE-20173
OID	1.2.36.1.2001.1001.101.103.20173

Definition

Definition	The period of time during which it would be ideal for the subject to be seen, in the opinion of the requester.
Definition Source	Australian Digital Health Agency
Synonymous Names	Service Commences
Notes	Specifies the range of time within which the requesting provider is expecting the arranged service to be provided to the subject. It can be used as a means of conveying objective urgency.
Data Type	TimeInterval

Usage

Conditions of Use	This `data element` **SHALL NOT** be included if *DateTime Service Scheduled* is included.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix B, *Specification Guide for Use* for examples and usage information for TimeInterval.

Relationships

Parents

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

2.16 Service Booking Status

Identification

Label	Service Booking Status
Metadata Type	Data Element
Identifier	DE-16056
OID	1.2.36.1.2001.1001.101.103.16056

Definition

Definition	Indication of the status of the requested or provided services.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	Provides the meaning for the date recorded in *Requested Service DateTime* `data element`; for example, whether it is the date that the service is first requested, the date that the booking was made, or the date that the service was supplied.
Context Source	Australian Digital Health Agency
Notes	For a service request (request for a service to be provided in the future), it is expected that a status value “EVN” would not be used for this `data element`.
Data Type	CodedText
Value Domain	Service Booking Status Values

Usage

Examples	Please see Appendix B, *Specification Guide for Use* for examples and usage information for CodedText.
Exceptional Values	Absent values are **PROHIBITED**. Abnormal values are **PROHIBITED**.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REQUESTED SERVICE	1..1

2.17 Service Booking Status Values

Identification

Label	Service Booking Status Values
Metadata Type	Value Domain
Identifier	VD-16055
OID	1.2.36.1.2001.1001.101.104.16055

Definition

Definition	Set of values that indicate the status of the requested or provided services.
Definition Source	Australian Digital Health Agency

Value Domain

Source	HL7 v3 CDA: Act.moodCode.	
Permissible Values	APT, Appointment	Planned act for specific time and place
	ARQ, Appointment Request	Request for Booking of an Appointment
	EVN, Event	Service actually happens or happened or is ongoing
	RQO, Request	Request or Order for a service

Relationships

Parents

Data Type	Name	**Occurrences** (child within parent)
	Service Booking Status	1..1

2.18 Service Comment

Identification

Label	Service Comment
Metadata Type	Data Element
Identifier	DE-17035
OID	1.2.36.1.2001.1001.101.103.17035

Definition

Definition	Additional narrative about the services that is not captured in other fields.
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)
	REQUESTED SERVICE	0..1

2.19 Supplementary Information to Follow

Identification

Label	Supplementary Information to Follow
Metadata Type	Data Element
Identifier	DE-16129
OID	1.2.36.1.2001.1001.101.103.16129

Definition

Definition	Whether any further information will be sent in support of this request.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	Used in service request scenario only.
Context Source	Australian Digital Health Agency
Notes	True indicates that additional information has been identified and will be forwarded when available e.g. incomplete pathology test results.
Data Type	Boolean

Usage

Examples	Please see Appendix B, *Specification Guide for Use* for examples and usage information for Boolean.

Relationships

Parents

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

2.20 Supplementary Information Expected

Identification

Label	Supplementary Information Expected
Metadata Type	Data Element
Identifier	DE-16130
OID	1.2.36.1.2001.1001.101.103.16130

Definition

Definition	Details of the nature of supplementary information that is to follow.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	1) X-ray image of left ankle.

Relationships

Parents

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

2.21 Subject of Care Instruction Description

Identification

Label	Subject of Care Instruction Description
Metadata Type	Data Element
Identifier	DE-10146
OID	1.2.36.1.2001.1001.101.103.10146

Definition

Definition	Instructions, advice or information that has been given to the subject from a care provider in relation to the requested services.
Definition Source	Australian Digital Health Agency
Synonymous Names	Patient Instructions
Context	Used in service request scenario only. In the context of referral, the information includes instructions about clinical procedures requested for the subject.
Context Source	Australian Digital Health Agency
Data Type	Text

Usage

Examples	1) Bring post-op instruction materials and any old private x-rays.

Relationships

Parents

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

2.22 REPORTER

Identification

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

Definition

Definition	Party who reports the information in this service request.
Definition Source	Australian Digital Health Agency
Synonymous Names	Author
Scope	Only used when the recorder needs to make it explicit. Otherwise, it is assumed to be the author of the enclosing structured document.
Scope Source	Australian Digital Health Agency

Usage

Conditions of Use	This **SHOULD NOT** be used if the reporter is the *DOCUMENT AUTHOR* of the enclosing structured document. This is a reuse of the *PARTICIPATION* `data group`, which is described in *Participation Data Specification [NEHT2011v]*. Further constraints on this data group that apply to this reuse of it are listed below. • Participation Type **SHALL** have an implementation-specific value equivalent to "Reporter". Terms used in obligation and occurrence constraints are explained in Appendix B, *Specification Guide for Use*.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

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

2.23 SERVICE REQUESTER

Identification

Label	SERVICE REQUESTER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	Party that arranges provision of a service.
Definition Source	Australian Digital Health Agency
Synonymous Names	Referred by Provider Referred by Referrer

Usage

Conditions of Use	This is a reuse of the *PARTICIPATION* `data group`, which is described in *Participation Data Specification [NEHT2011v]*. Further constraints on this data group that apply to this reuse of it are listed below. • Participation Type **SHALL** have an implementation-specific value equivalent to “Service Requester”. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON or ORGANISATION. Terms used in obligation and occurrence constraints are explained in Appendix B, *Specification Guide for Use*.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

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

2.24 SERVICE PROVIDER

Identification

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

Definition

Definition	The provider (individual or organisation) that has been arranged to provide the service.
Definition Source	Australian Digital Health Agency
Synonymous Names	Referred to Provider Referred to Referee
Scope	A service request would normally be sent to an authorised healthcare provider, but could go directly to a carer or to a representative of an organisation to provide services, other than those normally deemed to be healthcare services, such as a Child Protection Agency, Police, etc.
Scope Source	Australian Digital Health Agency
Notes	In the context of service request, this is the provider to whom the original request is initially made, or the provider that is booked to provide the service. In the context of service provision, this is the provider that supplied the service.

Usage

Conditions of Use	This is a reuse of the *PARTICIPATION* `data group`, which is described in *Participation Data Specification [NEHT2011v]*. Further constraints on this data group that apply to this reuse of it are listed below. • Participation Type **SHALL** have an implementation-specific value equivalent to “Service Provider” or “Referee”. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON or as an ORGANISATION. Terms used in obligation and occurrence constraints are explained in Appendix B, *Specification Guide for Use*.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

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

2.25 Request Validity Period

Identification

Label	Request Validity Period
Metadata Type	Data Element
Identifier	DE-16132
OID	1.2.36.1.2001.1001.101.103.16132

Definition

Definition	The period during which the request is valid.
Definition Source	Australian Digital Health Agency
Synonymous Names	Referral Validity Duration
Context	This data element is only applicable in the service request scenario.
Context Source	Australian Digital Health Agency
Notes	This may be open ended. In the context of referral, this `data element` captures the valid duration of the referral that may be constrained by, for example, Medicare funding policy.
Data Type	TimeInterval Duration

Usage

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

Relationships

Parents

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

2.26 Instruction Identifier

Identification

Label	Request Identifier
Metadata Type	Data Element
Identifier	DE-16995
OID	1.2.36.1.2001.1001.101.103.16995

Definition

Definition	Identifier of the *Requested Service* instruction that initiated this *Requested Service* action.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Examples	Please see Appendix B, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.

Relationships

Parents

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

2.27 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	Source of the information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Only used when the recorder needs to make it explicit. Otherwise, it is assumed to be the subject of care of the enclosing structured document.
Scope Source	Australian Digital Health Agency
Notes	This does not have to be a person and, in particular, does not have to be a healthcare provider. Types of sources include: • an agent of a subject of care, e.g. parent, guardian; • a clinician; • a device or software; and • the subject of the DCM, when not the subject of care of the enclosing structured document.

Usage

Conditions of Use	This **SHALL NOT** be used if the source of the information is the *SUBJECT OF CARE* of the enclosing structured document. This is a reuse of the *PARTICIPATION* `data group`, which is described in *Participation Data Specification [NEHT2011v]*. Further constraints on this data group that apply to this reuse of it are listed below. • 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. Terms used in obligation and occurrence constraints are explained in Appendix B, *Specification Guide for Use*.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

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

2.28 SUBJECT

Identification

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

Definition

Definition	Individual upon whom the service is (to be) performed.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Only used when the recorder needs to make it explicit. Otherwise, it is assumed to be the subject of care of the enclosing structured document.
Scope Source	Australian Digital Health Agency

Usage

Conditions of Use	This **SHALL NOT** be used unless the subject of the information is not the *SUBJECT OF CARE* of the enclosing structured document. This is a reuse of the *PARTICIPATION* `data group`, which is described in *Participation Data Specification [NEHT2011v]*. Further constraints on this data group that apply to this reuse of it are listed below. • Participation Type **SHALL** have an implementation-specific value equivalent to “Subject”. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON. Terms used in obligation and occurrence constraints are explained in Appendix B, *Specification Guide for Use*.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

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

2.29 Requested Service DateTime

Identification

Label	Requested Service DateTime
Metadata Type	Data Element
Identifier	DE-16635
OID	1.2.36.1.2001.1001.101.103.16635

Definition

Definition	Period or date (and optionally time) of completion of the *Requested Service* action.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	The status of the request changes on this date, and optionally time, or at the end of this period. For a service request, this is the date, and optionally time, of the request. There is no point in recording the period during which the request is created. For supply of a service, this is the period during which the service is supplied or the date, and optionally time, of completion of supply of service. The completion of this period or this date will have the same value as *DateTime Service Scheduled* `data element`.
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)
	REQUESTED SERVICE	1..1

2.30 Requested Service Instance Identifier

Identification

Label	Requested Service Instance Identifier
Metadata Type	Data Element
Identifier	DE-16716
OID	1.2.36.1.2001.1001.101.103.16716

Definition

Definition	A globally unique identifier for each instance of a *Requested Service* action.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Examples	Please see Appendix B, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Exceptional Values	Absent values are **PROHIBITED**. Abnormal values are **PROHIBITED**.

Relationships

Parents

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

2.31 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 *Requested Service*.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	Items of related information include, but are not limited to, documents, parts of documents, images and web pages. “Elsewhere” includes elsewhere in the same document. 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. 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. When the item of related information is a complete document (including images) or a web page (or part thereof) an appropriate specialisation of the *Related Information* `data group` should be used. The document or other data component instance containing the *Related Information* `data group` is called the *source*. The related information is called the *target*.

Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Link Nature	1..1

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

2.32 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	1) is related to 2) is confirmed by or authorised by 3) is related to the same problem or health issue
Exceptional Values	Absent values are **PROHIBITED**. Abnormal values are **PROHIBITED**.

Relationships

Parents

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

2.33 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]*. The values are listed here with brief descriptions.	
	LINK-A0, is related to	The most general category of Link.
	LINK-B0, is confirmed by or authorised by	The link target contains an instance of a DCM or document that is either a legal or authoritative basis for what is documented in the source DCM instance, or is a declaration of intent to provide (or not provide) requested care.
	LINK-C0, is related to the same problem or health issue	The target instance of a DCM or document describes health or healthcare that concerns the same clinical situation as the source DCM instance.
	LINK-D0, is related to the same care plan, act or episode	The source and the target instances of DCMs or documents both describe parts of the same care plan, act or episode.
	LINK-E0, is a related documentation	The target instance of a DCM or document is an alternative documentary form of the source DCM instance. For example, a re-expression of the same clinical information or supplementary explanatory information.

Relationships

Parents

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

2.34 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 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. This attribute provides for a specific description of the actual role played by the target in relation to the source. This attribute may be populated from any suitable terminology and therefore might support human readership better than interoperable automated processing.
Data Type	CodeableText
Value Domain	Link Role Values

Usage

Examples	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

2.35 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 *Link Nature* `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	Values **SHOULD** be from Termlist LINK_ROLE in ISO 13606-3:2009 [ISO2009a]. Values **MAY** be from any suitable terminology. 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]*, together with brief descriptions, are: LINK-A1, unspecified link — This can be used to say explicitly “there is no semantic information available for this Link”. LINK-B1, endorses — The source endorses (agrees with, confirms or verifies) the situation (or interpretation) described in the target. LINK-C3, evidence for — The source describes evidence for the situation (or interpretation) described in the target. LINK-D1, outcome — The source describes an outcome of the situation (or interpretation) that the target describes. LINK-E1, documented by — The source is a less formal description of the situation (or interpretation) documented by the target. LINK-E4, excerpts — The source is an extract (copy) of part or all of the information contained within the target. LINK-E5, derived from — The source contains information that has been derived (e.g. calculated) from information in the target.

Usage

Conditions of Use	Each of the values in LINK_ROLE from ISO 13606-3:2009 identifies a subcategory of a corresponding value in *Link Nature Values*. 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 *Link Role* `data element`, the appropriate corresponding value **SHALL** be used for *Link Nature Values*.
Conditions of Use Source	ISO 13606-3:2009

Relationships

Parents

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

2.36 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 UniqueIdentifier

Usage

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

Relationships

Parents

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

2.37 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	UniqueIdentifier

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 UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.102.20158
Exceptional Values	Absent values are **PROHIBITED**. Abnormal values are **PROHIBITED**.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REQUESTED SERVICE	1..1

This page is intentionally left blank.

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 Hierarchy	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	The following data elements lack a defined value domain: *Reason for Service*, *Service Category* and *Service Description*. 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.
Requested Service DCM	This DCM is being used for both instruction for requesting a service and an action for reporting supply of a service. In the future it might be split into two DCMs.
Requested Service DCM	This DCM has been designed for one-off services, not recurring services.
Requested Service DCM - including single request with multiple Service Description	There is no guidance on the expected life cycle of a requested service, especially when more than one *Service Description* is supplied. Nor is there guidance on how a single request with more than one *Service Description* is expected to split into multiple requests with typically, but not necessarily, a single *Service Description* as it moves through the booking life cycle, i.e. from request to booked to performed.
Service Commencement Window	There is no clear way of distinguishing between an open-ended request with no date of expiry and a request where date of expiry is unknown.
Request Urgency Values	There is no widely accepted definition of "Urgent" and "Routine". This may vary between clinical contexts, clinical systems and the nature of the requests themselves.
Request Validity Period	There is no clearly defined starting point for the validity period, e.g. in case of a clinical referral this might be the date of referral or the date of the first consultation with the specialist.
Subject of Care Instruction Description	Name of this data element should be *Subject Instruction Description*.
Subject of Care Instruction Description	Cardinality of this data element might change to 0..1 in the future.
DateTime Service Scheduled and Requested Service DateTime	There is a strong overlap between *DateTime Service Scheduled* and *Requested Service DateTime*. In the future they might be merged into a single data element.

This page is intentionally left blank.

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.

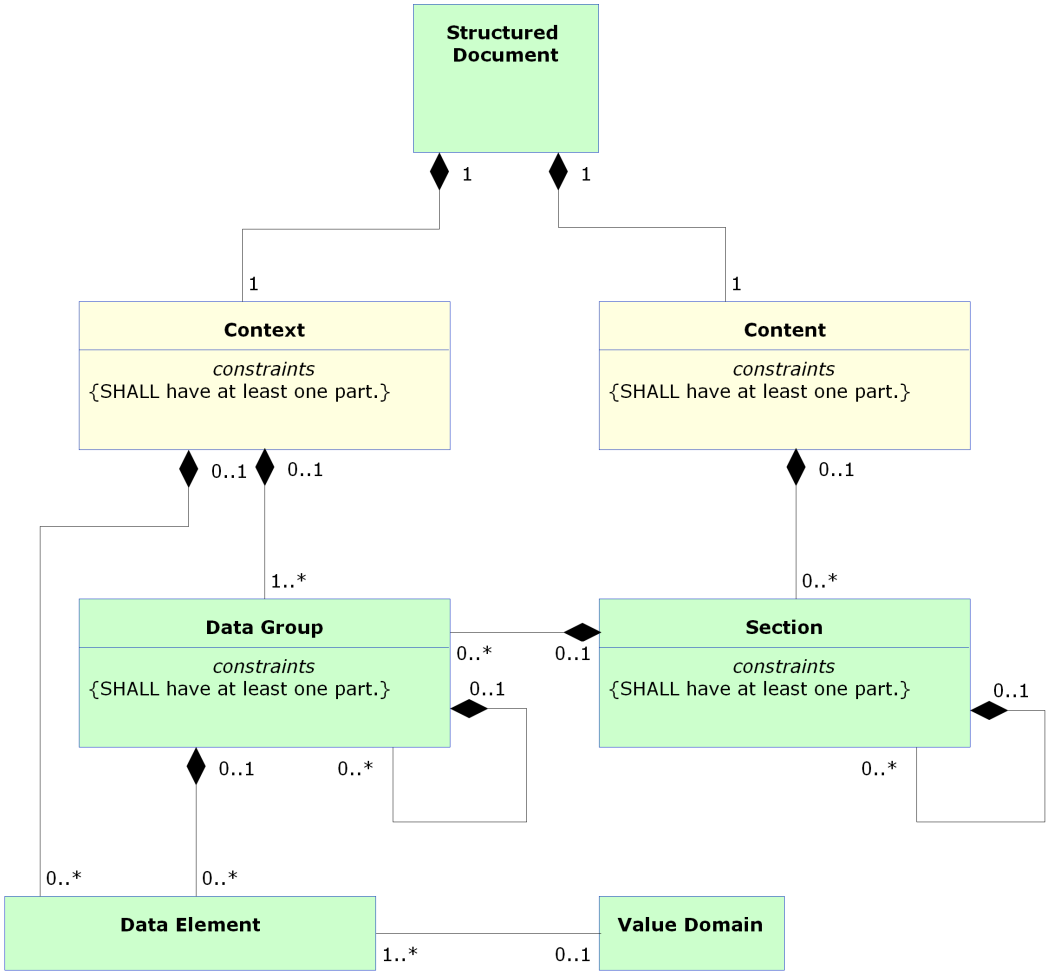

Figure 1: SCS Metamodel

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

<table>
<tr><th>Data Element</th><th>Data Type</th><th>Example of Value Domain</th></tr>
<tr><td>Sex</td><td>CodedText</td><td>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><tr><th>Value</th><th>Meaning</th></tr><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></table></td></tr>
<tr><td>Diagnosis</td><td>CodeableText</td><td>A SNOMED CT-AU reference set that references concepts such as “Bronchitis” (Concept ID: 32398004).</td></tr>
<tr><td>Therapeutic Good Identification</td><td>CodeableText</td><td>An AMT reference set that references concepts such as “Ibuprofen Blue (Herron) (ibuprofen 200 mg) tablet: film-coated, 1 tablet” (Concept ID: 54363011000036107).</td></tr>
<tr><td>Individual Pathology Test Result Name</td><td>CodeableText</td><td>A LOINC subset that references concepts such as “Cholesterol [Moles/volume] in Serum or Plasma” (ID: 14647-2).</td></tr>
</table>

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: *true* and *false*. Many systems represent true as *non-zero* (often 1, or -1) and false as *zero*. **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 ☑.

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.

 Duration (ISO 21090: PQ.TIME)	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. **Usage/Examples** • 3 hours • 6 months • 1 year
 EncapsulatedData (ISO 21090: ED)	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). **Usage/Examples** • JPEG images • HTML documents • [RFC1521] MIME types
 Integer (ISO 21090: INT)	The mathematical data type comprising the exact integral values. **Usage/Examples** • 1 • -50 • 125
 Link (ISO 21090: TEL)	A general link, reference or pointer to an object, data or application that exists logically or is stored electronically in a computer system. **Usage/Examples** • 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 – *http://www.google.com*. • 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 *C:\Documents and Settings\GuestUser\MyDocuments\letter.doc*
 Quantity (ISO 21090: PQ)	A magnitude value with a unit of measurement. 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 *Quantity*. **Usage/Examples** • 100 centimetres • 25.5 grams • 3 per month

 QuantityRange (ISO 21090: IVL)	A range of *Quantity* values. It may be identified using a combination of an optional minimum *Quantity* and an optional maximum *Quantity* (i.e. lower and upper bounds). 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 *Quantity* value. **Usage/Examples** • -20 to 100 Celsius • 30-50 mg • >10 kg • 2-3 hours
 QuantityRatio (ISO 21090: RTO)	A relative magnitude of two *Quantity* values. Usually recorded as numerator and denominator. **Usage/Examples** • 25 mg / 500 ml • 200 mmol per litre
 Real (ISO 21090: REAL)	A computational approximation to the standard mathematical concept of real numbers. These are often called floating-point numbers. **Usage/Examples** • 1.075 • -325.1 • 3.14157
 Text (ISO 21090: ST)	A character string (with optional language) containing any combination of alpha, numeric, or symbols from the Unicode character set. Also referred to as *free text*. **Usage/Examples** “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.”
 TimeInterval (ISO 21090:IVL)	An interval in time. It is identified using a combination of an optional start *DateTime*, an optional end *DateTime*, and an optional *Duration*. **Usage/Examples** • 20080101+1000 - 20081231+1000 • 200801010130+1000 - 200801011800+1000 • 200801010130+1000, duration=16.5 hours

	UniqueIdentifier (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 UniqueIdentifier 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 UniqueIdentifier 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	Indicates that the data component is considered a mandatory item of information and **SHALL** be populated. **Usage/Examples:** The Participant data component for a Subject of Care **SHALL** include an Entity Identifier data component in order to hold the IHI.
OPTIONAL	Indicates that the data component is not considered a mandatory item of information and **MAY** be populated. **Usage/Examples:** Such data components will be implemented, only inclusion and population are optional. 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.
PROHIBITED	On a data component this indicates that the data component is considered a forbidden item of information and **SHALL NOT** be included. In a statement about values this indicates that the use of the specified values is considered forbidden and they **SHALL NOT** be used. **Usage/Examples:** Within a Participation data group depicting a Subject of Care, the Participation Healthcare Role **SHALL NOT** be populated.

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. *Therapeutic Good Identification* is used in both *Medication Instruction* and *Medication Action*), 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.

	Implementers may prefer to use synonymous names to refer to the data component in specific contexts.
Scope	Situations in which the data component may be used, including the Scope circumstances where specified data are required or recommended. 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.
Scope Source	The authoritative source for the Scope statement.
Context	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. For example, Street Name has a context of Address. This item is applicable only to data elements.
Assumptions	Suppositions and notions used in defining the data component.
Assumptions Source	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. This item is applicable only to data elements.
Value Domain	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: 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. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. 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: • 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 Introduced in this Version

The last version of this DCM was v5.0. It was published in *Miscellaneous Detailed Clinical Model Specification [NEHT2015I]*. As this is a new document, only changes to the model are listed, not changes to the document. Supporting chapters, such as the Guide for Use, have been updated since *Miscellaneous Detailed Clinical Model Specification [NEHT2015I]* was published.

Generic changes

Various changes to rebrand the model 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”.

Chapter 2 Requested Service Detailed Clinical Model

In 2.1 Purpose, there are various editorial changes to wording.

Section 2.2 Use has been added.

In 2.3 Misuse, there are various editorial changes to wording.

In 2.4 UML Class Diagram, the diagram has been updated.

In 2.5 Requested Service, there were editorial changes to the definition and misuse, updates to synonymous names, removal of notes, and the addition of a constraint in conditions of use, regarding the mandatory choices for the data group.

In 2.5 Data Hierarchy, the following data components have been added:

- *REQUESTED SERVICE* > *Reason for Service Description*;
- *REQUESTED SERVICE* > *Service Category*;
- *REQUESTED SERVICE* > *Request Urgency Notes*;
- *REQUESTED SERVICE* > *Service Comment*; and
- *REQUESTED SERVICE* > *REPORTER*.

In 2.5 Data Hierarchy, *REQUESTED SERVICE* > *Service Description* data element, the name has been changed from the original *Requested Service Description*. The cardinality has also changed from 1..1 to 0..*.

In 2.5 Data Hierarchy, the following data components have had their data type changed:

- *REQUESTED SERVICE* > *Request Urgency* (from *CodeableText* to *CodedText*);
- *REQUESTED SERVICE* > *Request Validity Period* (from *TimeInterval* to *TimeInterval* or *Duration*); and
- *REQUESTED SERVICE* > *Requested Service DateTime* (from *DateTime* to *DateTime* or *TimeInterval*).

Guidance on data elements with exceptional values has been added. This affects all uses of the following data elements:

- *REQUESTED SERVICE > Request Urgency;*
- *REQUESTED SERVICE > Service Booking Status;*
- *REQUESTED SERVICE > Requested Service Instance Identifier;*
- *REQUESTED SERVICE > RELATED INFORMATION > Link Nature*; and
- *REQUESTED SERVICE > Detailed Clinical Model Identifier*

In 2.6 Reason for Service, there were editorial changes to the definition and context, updates to synonymous names, removal of notes and the addition of examples.

2.7 Reason for Service Description has been added.

2.8 Service Category has been added.

In 2.9 Service Description, there were editorial changes to the definition, context, notes and examples.

In 2.10 Intent of Request, Notes has been added.

In 2.11 Request Urgency, there were editorial changes to the definition, and the addition of context, notes and value domain. The data type has been changed from *CodeableText* to *CodedText*.

2.12 Request Urgency Values has been added.

2.13 Request Urgency Notes has been added.

In 2.14 DateTime Service Scheduled, there were editorial changes to the definition, and the addition of context, notes, and a constraint added in conditions of use (regarding when not to include this data element).

In 2.15 Service Commencement Window, there were editorial changes to the definition and notes, and a constraint added in conditions of use (regarding when not to include this data element).

In 2.16 Service Booking Status, there were editorial changes to the definition and the addition of context and notes.

In 2.17 Service Booking Status Values, there were editorial changes to the definition, and the list of permissible values was revised.

2.18 Service Comment has been added.

In 2.19 Supplementary Information to Follow, there were editorial changes to the definition and the addition of context and context source.

In 2.21 Subject of Care Instruction Description, there were editorial changes to the definition and the addition of context and context source.

2.22 REPORTER has been added.

In 2.23 SERVICE REQUESTER, there were editorial changes to the conditions of use and synonymous names was updated.

In 2.24 SERVICE PROVIDER, scope, scope source and notes were added. A number of constraints in the conditions of use have been removed.

In 2.25 Request Validity Period, additions were made to synonymous names and notes, context and context source were added. The data type was changed from *TimeInterval* to *TimeInterval* or *Duration*.

In 2.26 Instruction Identifier, there were editorial changes to the definition.

In 2.27 INFORMATION PROVIDER, this follows current design for specifying Information Provider.

In 2.28 SUBJECT, there were editorial changes to the definition, scope and conditions of use.

In 2.29 Requested Service DateTime, there were editorial changes to the definition and notes. The data type was changed from *DateTime* to *DateTime* or *TimeInterval*.

In 2.31 RELATED INFORMATION, the definition has been corrected (to refer to *Requested Service* rather than *Exclusion Statement*).

In 2.33 Link Nature Values, there were editorial changes to the permissible values.

In 2.34 Link Role, there were editorial changes to the notes.

In 2.35 Link Role Values, the permissible values have been updated and there were editorial changes to the conditions of use.

This page is intentionally left blank.

Reference List

[ABS2009] Australian Bureau of Statistics, 25 June 2009, *1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1*, accessed 28 August 2013.
http://www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/-E8A05691E35F4376CA257B9500138A52?opendocument

[ISO2009a] International Organization for Standardization, 14 Jan 2009, *ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists*, Edition 1 (Monolingual), accessed 24 June 2015.
https://infostore.saiglobal.com/store/Details.aspx?ProductID=1092099

[NEHT2007b] National E-Health Transition Authority, 17 August 2007, *Interoperability Framework*, Version 2.0, accessed 11 July 2016.
http://www.digitalhealth.gov.au/implementation-resources/ehealth-foundations/EP-1144-2007/-NEHTA-1146-2007

[NEHT2010c] National E-Health Transition Authority, September 2010, *Data Types in NEHTA Specifications: A Profile of the ISO 21090 Specification*, Version 1.0, accessed 11 July 2016.
https://www.digitalhealth.gov.au/implementation-resources/clinical-documents/EP-1135-2010/-NEHTA-1136-2010

[NEHT2011v] National E-Health Transition Authority, 20 July 2011, *Participation Data Specification*, Version 3.2, accessed 11 Jul 2016.
https://www.digitalhealth.gov.au/implementation-resources/clinical-documents/EP-1224-2011/-NEHTA-0794-2011

[NEHT2014ag] National E-Health Transition Authority, 8 July 2014, *Australian Medicines Terminology v3 Model - Editorial Rules v2.0*, Version 2.0, accessed 12 July 2016.
https://www.digitalhealth.gov.au/implementation-resources/ehealth-foundations/-EP-1805-2014/NEHTA-1716-2014

[NEHT2015l] National E-Health Transition Authority, 18 December 2015, *Miscellaneous Detailed Clinical Model Specification*, Version 1.4, accessed 12 July 2016.
https://www.digitalhealth.gov.au/implementation-resources/clinical-documents/-detailed-clinical-model-library

[OEHR2008a] openEHR Foundation, 16 August 2008, *EHR Information Model*, Release 1.0.2, accessed 30 November 2013.
http://www.openehr.org/releases/1.0.2/architecture/rm/ehr_im.pdf

[RFC1521] Network Working Group, 1993, *RFC1521 - MIME (Multipurpose Internet Mail Extensions) Part One*, accessed 17 July 2014.
http://www.faqs.org/rfcs/rfc1521.html

[RFC2119] Network Working Group, 1997, *Key Words for Use in RFCs to Indicate Requirement Levels*, accessed 29 October 2015.
https://tools.ietf.org/html/rfc2119

[SA2006a] Standards Australia, 2006, *AS 4846 (2006) – Health Care Provider Identification*, accessed 17 July 2014.
http://infostore.saiglobal.com/store/Details.aspx?ProductID=318554

[SA2006b] Standards Australia, 2006, *AS 5017 (2006) – Health Care Client Identification*, accessed 17 July 2014.
http://infostore.saiglobal.com/store/Details.aspx?ProductID=320426

[TGA1989a] Commonwealth of Australia, 1989, *Therapeutic Goods Act 1989 - Section 3*, accessed 17 July 2014.
http://www.austlii.edu.au/au/legis/cth/consol_act/tga1989191/s3.html#therapeutic_goods

[WALJ2005a] Walker et al., January 2005, *The Value Of Health Care Information Exchange And Interoperability*, *Health Affairs*, 2005, accessed 17 July 2014. http://content.healthaffairs.org/content/early/2005/01/19/hlthaff.w5.10.short

Index

This page is intentionally left blank.