nehta

CDA Implementation Guide

PCEHR Prescription and Dispense View
Version 1.0

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Document Information

Document owner

Document Owner
The National Clinical Terminology and Information Service

Related documents

Name	Version/Release Date
Participation Data Specification	Version 3.2, Issued 20 July 2011
PCEHR Prescription and Dispense View Information Requirements	Version 1.0, Issued 23 October 2012
PCEHR Prescription and Dispense View CDA Rendering Specification	Version 1.0
PCEHR Prescription and Dispense View Structured Content Specification	Version 1.0, Issued To be published

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1 Introduction

1.1 Document Purpose and Scope

The purpose of this document is to provide a guide to implementing the 'logical' model detailed by NEHTA's PCEHR Prescription and Dispense View Structured Content Specification (PPDV SCS) as an HL7 Clinical Document Architecture Release 2 (CDA) XML document. This guide is based on Version 1.0 of the PPDV SCS [NEHT2012p]. The primary aim of the guide is to take implementers step by step through mapping each data component of the PPDV SCS to a corresponding CDA attribute or element.

The guide contains descriptions of both constraints on the CDA and, where necessary, custom extensions to the CDA, for the purposes of fulfilling the requirements for Australian implementations of a PCEHR Prescription and Dispense View. The resulting CDA document would be used for the electronic exchange of PCEHR Prescription and Dispense View between healthcare providers.

In addition, this guide presents conformance requirements against which implementers can attest the conformance of their systems.

This release is intended to inform and seek feedback from prospective software system designers and their clinical consultants. The content of this release is not suitable for implementation in live clinical systems. The National Clinical Terminology and Information Service (NCTIS) values your questions, comments and suggestions about this document. Please direct your questions or feedback to <clinicalinformation@nehta.gov.au>.

1.2 PCEHR Prescription and Dispense View Definition

A PCEHR Prescription and Dispense View is defined in the PPDV SCS [NEHT2012p] as:

> A collection of reports about prescribing and dispensing events for a subject of care.

1.3 HL7 Clinical Document Architecture

CDA is a document markup standard that specifies the structure and semantics of clinical documents for the purpose of exchange and unambiguous interpretation both at human and system levels.

CDA has been chosen as the format for electronic clinical documents, as it is consistent with NEHTA's commitment to a service and document oriented approach to electronic information exchange, contributing to future electronic health records.

Some of the advantages of CDA are:

- It is machine computable and human readable.
- It provides a standardised display of clinical information without loss of clinical meaning.
- It provides assurance of clinical quality and safety more effectively than message-based interfaces by storing and displaying the clinical data as entered by the clinician.
- It provides better support than HL7 V2 messages for:
  - more complex information structures, such as pathology synoptic reporting; and
  - terminologies such as SNOMED CT®.[1]

[1] SNOMED CT® is a registered trademark of the International Health Terminology Standards Development Organisation.

- It supports legal attestation by the clinician (requiring that a document has been signed manually or electronically by the responsible individual).
- It is able to be processed by unsophisticated applications (displayed in web browsers, for instance).
- It provides a number of levels of compliance to assist with technical implementation and migration.
- It aligns Australia with e-health initiatives in other countries (such as Canada, UK, USA, Brazil, Germany and Finland).

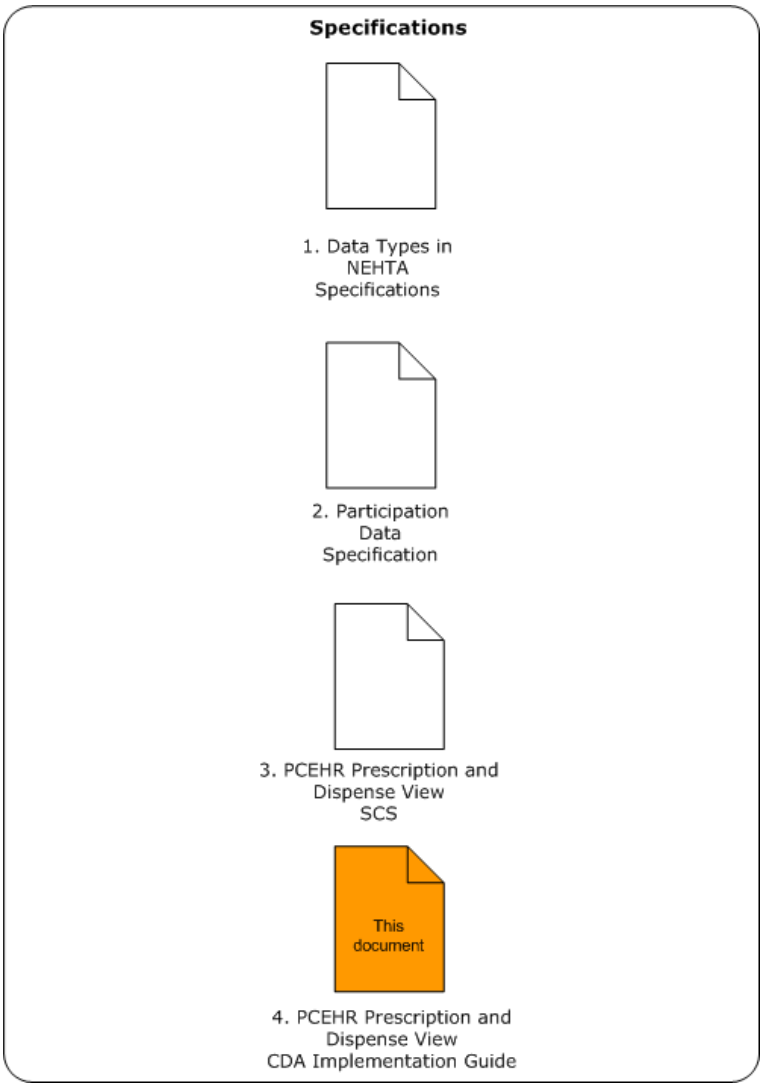
1.4 Intended Audience

This document is intended to be read and understood by software architects and developers, implementers of Clinical Information Systems in various healthcare settings, IT-aware clinicians who wish to evaluate the clinical suitability of NEHTA-endorsed standards and researchers who wish to explore certain aspects of NEHTA-endorsed standards.

This document and related artefacts are very technical in nature and the audience is expected to be familiar with the language of health data specifications and to have some familiarity with health information standards and specifications such as CDA, and "Standards Australia AS 4700.6" [SA2007a]. Definitions and examples are provided to clarify relevant terminology usage and intent.

1.5 Document Map

This Implementation Guide is not intended to be used in isolation. Companion documents are listed below:



1. Data Types in NEHTA Specifications [NEHT2010c] - a detailed description of the data types used within the Structured Content Specification.

2. Participation Data Specification [NEHT2011v] – contains the full specification which forms the basis of all participations contained in NEHTA Structured Content Specifications.

3. PCEHR Prescription and Dispense View – Structured Content Specification [NEHT2012p] – clinical content specification describing the logical data structures, data components, and value domains which constitute a PCEHR Prescription and Dispense View.

1.6 Acronyms

CDA	Clinical Document Architecture
UUID	Universally Unique Identifier
HL7	Health Level Seven
RIM	Reference Information Model
SCS	Structured Content Specification
PPDV	PCEHR Prescription and Dispense View
XHTML	Extensible Hypertext Markup Language
XML	Extensible Markup Language
XSL	Extensible Stylesheet Language
PAI-D	PCEHR Assigned Identity for Device
PAI-O	PCEHR Assigned Identity for Organization

For a complete listing of all relevant acronyms, abbreviations and a glossary of terms please refer to "NEHTA Acronyms, Abbreviations and Glossary of Terms, Version 1.2" [NEHT2005a].

1.7 Keywords

Where used in this document, 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].

Keywords used in this document

Keyword	Interpretation
SHALL	This word, or the terms '**REQUIRED**' or '**MUST**', means that the definition is an absolute requirement of the specification.
SHOULD	This word, or the adjective '**RECOMMENDED**', means that there may exist valid reasons in particular circumstances to ignore a particular item, but the full implications must be understood and carefully weighed before choosing a different course.
MAY	This word, or the adjective '**OPTIONAL**', means that an item is truly optional. One implementer may choose to include the item because a particular implementation requires it, or because the implementer determines that it enhances the implementation while another implementer may omit the same item. An implementation which does not include a particular option must be prepared to interoperate with another implementation which does include the option, perhaps with reduced functionality. In the same vein, an implementation which does include a particular option must be prepared to interoperate with another implementation which does not include the option (except of course, for the feature the option provides).
SHALL NOT	This phrase, or the phrase '**MUST NOT**' means that the definition is an absolute prohibition of the specification.

Keyword	Interpretation
SHOULD NOT	This phrase, or the phrase '**NOT RECOMMENDED**' 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.

1.8 Conformance

This document describes how a PCEHR Prescription and Dispense View SCS is implemented as a CDA document. Conformance claims are not made against this Implementation Guide directly; rather, they are made against additional conformance profiles documented elsewhere. Any document that claims conformance to any derived conformance profile must meet these base requirements:

- It **SHALL** be a valid HL7 CDA instance. In particular:
  - It **SHALL** be valid against the HL7 CDA Schema (once extensions have been removed, see W3C XML Schema).
  - It **SHALL** conform to the HL7 V3 R1 data type specification.
  - It **SHALL** conform to the semantics of the RIM and Structural Vocabulary.
- It **SHALL** be valid against the Australian CDA Schema that accompanies this specification after any additional extension not in the NEHTA extension namespace have been removed, along with any other CDA content not described by this implementation guide.
- It **SHALL** use the mappings as they are stated in this document.
- It **SHALL** use all fixed values as specified in the mappings. (e.g. @attribute="`FIXED_VALUE`").
- If the vocabulary has been explicitly stated as 'NS' it must be interpreted as:

  > *NS = 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.*

- It **SHALL** be valid against the additional conformance requirements that are established in this document (i.e. any use of the word "SHALL" in uppercase and bold typeface).
- The narrative **SHALL** conform to the requirements described in this guide.
- The document **SHALL** conform to the requirements specified in the PCEHR Prescription and Dispense View - CDA Rendering Guide [NEHT2012t].
- The data as contained in the data types **SHALL** conform to the additional data type specification [NEHT2010c].
- Any additional content included in the CDA document that is not described by this implementation guide **SHALL** not qualify or negate content described by this guide and it **SHALL** be clinically safe for receivers of the document to ignore the non-narrative additions when interpreting the existing content.

A system that *consumes* PCEHR Prescription and Dispense View CDA documents may claim conformance if it correctly processes conformant instance documents, including correctly understanding all the information in the header. It may, but is not required to, reject non-conformant documents. Conformant systems that consume PCEHR Prescription and Dispense View CDA documents are not required to process any or all of the structured data entries in the CDA document but they **SHALL** be able to correctly render the document for end-users when appropriate (see 2.1 Clinical Document Architecture Release 2).

[2] http://www.hl7.org/oid/index.cfm?ref=footer

Conformance Profiles of this document may make additional rules that override this document in regard to:

- Allowing the use of alternative value sets in place of the value sets specified in this document
- Allowing the use of alternative identifiers in place of the HI Service identifiers
- Making required data elements and/or section divisions optional

1.9 Known Issues

This section lists known issues with this specification at the time of publishing. NEHTA are working on solutions to these issues, but we encourage and invite comments to further assist the development of these solutions.

Reference	Description
Document name	The document name is to be confirmed.
AS 5017-2006: Health Care Client Identifier Geographic Area	The Health Care Client Identifier Geographic Area vocabulary table lists displayName, code, codeSystemName and codeSystem while only the displayName is used in the mapping. Verification of using only the displayName needs to be performed.
<code>	The explanation of how to use the code element in the Common Patterns chapter needs to be revisited.
6.1 PCEHR PRESCRIPTION AND DISPENSE VIEW :: CDA Mapping :: Earliest Date for Filtering (DateTime Health Event Started)	Incorrect description for [Earliest Date for Filtering (DateTime Health Event Started)] It is NOT the date the document was authored as stated: "The date, or date and time, on or after which all source documents were authored." It is the prescription/dispense serviceStartTime. Revise to: 'The date, or date and time, on or after which all health events described in the source documents occurred'.
6.1 PCEHR PRESCRIPTION AND DISPENSE VIEW :: CDA Mapping :: Latest Date for Filtering (DateTime Health Event Ended)	Incorrect description for [Latest Date for Filtering (DateTime Health Event Ended)] It is NOT the date the document was authored as stated: 'The date, or date and time, on or before which all source documents were authored' It is the prescription/dispense serviceStartTime. Revise to: 'The date, or date and time, on or before which all health events described in the source documents occurred'.
Throughout document	While every effort has been taken to ensure that the examples are consistent with the normative mappings in this message specification, care needs to be taken when copying XML examples for implementation and validation.

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2 Guide for Use

This document describes how to properly implement the Australian PPDV SCS as a conformant HL7 CDA XML document. The PCEHR Prescription and Dispense View is built in two parts:

1. A *Structured Content Specification* (SCS), which, in conjunction with its related documents (see Document Map), describes the PCEHR Prescription and Dispense View, in a form that is consistent with other NEHTA specifications. It has the potential to be implemented in multiple different exchange formats as is most suitable for a particular context. It describes the data content of a PCEHR Prescription and Dispense View as an hierarchy of data components, and provides documentation concerning their use and meaning.

2. A *CDA Implementation Guide* (this document) which specifies how the data described in the SCS is properly represented in a CDA document.

In order to properly implement this specification, the reader should be familiar with the PPDV SCS, with the HL7 CDA documentation and how to read this document.

For further information regarding NEHTA Structured Content Specifications, see the links in Document Map.

2.1 Clinical Document Architecture Release 2

A CDA document is an XML document built following the rules described in the CDA specification which conforms to the HL7 CDA Schema provided by HL7. The CDA document is based on the semantics provided by the HL7 Reference Information Model, Data Types, and Vocabulary.

A CDA document has two main parts: the header and the body.

The CDA document header is consistent across all CDA documents regardless of document type. The header identifies and classifies the document and provides information on authentication, the encounter, the patient, and the involved providers.

The body contains the clinical report, and can be marked-up text (narrative, renderable text) or a combination of both marked-up text and structured data. The marked up text can be transformed to XHTML and displayed to a human. The structured data allows machine processing of the information shown in the narrative section.

CDA contains a requirement that all of its clinical information must be marked up in CDA narratives. These narratives are CDA defined hypertext, able to be rendered in web browsers with only a standard accompanying transformation. This transformation is produced and distributed by HL7.

As noted, it is a conformance requirement that the rendered narrative must be able to stand alone as a source of authenticated information for consuming parties. No content from the CDA body may be omitted from the narrative.

Further information and guidance on the CDA narrative is available in Appendix A, *CDA Narratives*.

These references are recommended to gain a better understanding of CDA:

- CDA specification: [HL7CDAR2]
- RIM, Data types and Vocabulary: [HL7V3DT]
- Useful CDA examples repository: [RING2009]
- CDA validation tools: [INFO2009]

2.2 Mapping Interpretation

The core of this guide is a mapping from the PPDV SCS to the CDA document representation.

The mappings may not be deterministic; in some cases the differences in approach between the logical model specified in SCS and CDA document implementation specifications makes it inappropriate to have a 1:1 mapping, or any simple mapping that can be represented in a transform. This is especially true for names and addresses, where the SCS requirements, based on Australian Standards such as AS 5017 2006, differ from the HL7 data types and vocabularies which are not based on these standards.

Many of the mappings use one of a few common patterns for mapping between the SCS and the CDA document. These common mapping patterns are described in 8 *Common Patterns*.

An example of a mapping section of this guide is illustrated below:

x.x ITEM NAME

Identification (normative)

Name	ITEM NAME
Metadata type	Metadata type e.g. Section, Data Group or Data Element

Relationships (normative)

Children

Data Type	Name	Occurrence
Icon illustrating the Metadata or Data type.	ITEM NAME This is a link to another section containing the mapping for this item. Item names in upper case indicate that the item is a section or data group. Item names in start case indicate that the item is a data element.	The number of instances of this child item that may occur.

Parent

Data Type	Name	Occurrences (child within parent)
Icon illustrating the Metadata or Data type.	ITEM NAME This is a link to another section containing the mapping for this item. Item names in upper case indicate that the item is a section or data group. Item names in start case indicate that the item is a data element.	The number of instances of the child item within the parent that may occur.

CDA R-MIM Representation

The text contains an explanation of the mapping (this text is non-normative).

The model is a constrained representation of the R-MIM (this diagram is non-normative). The colours used in the CDA model align with the usage in the R-MIM. In many cases the cardinalities shown in the model will be less constrained than those shown in the mapping table.

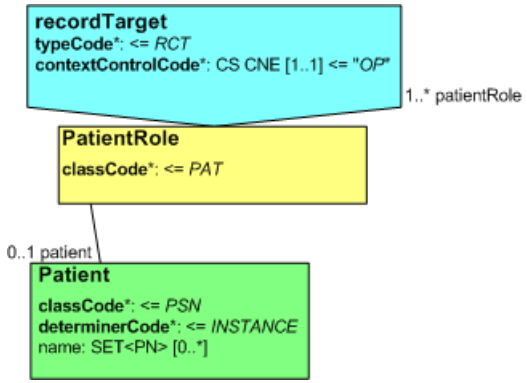

Figure 2.1. Example - Header Part

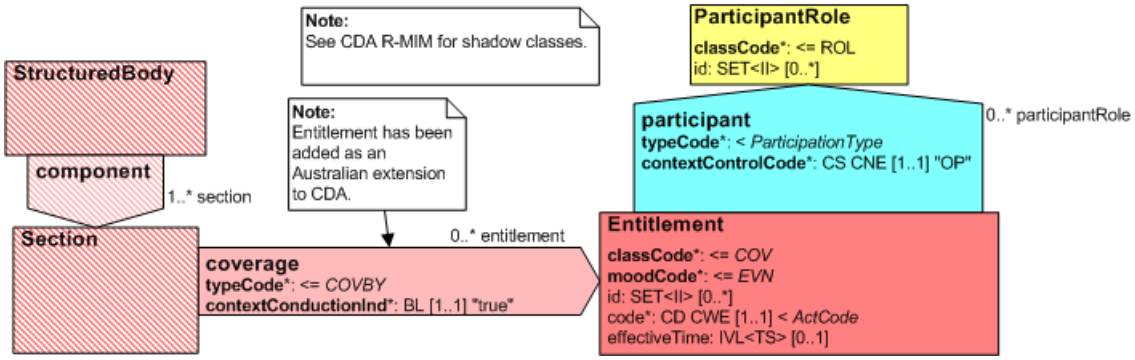

Figure 2.2. Example - Body Part

CDA Mapping (normative)

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Element Type (Header, Body Level 2 etc.)			Context: Parent of elements below		
The path in the SCS. Each section in this document corresponds to an SCS section or data group, and is scoped by that section or data group. The hierarchical path uses ">" as a separator for paths within the SCS data hierarchy. If there is a name in round brackets after the path, this is the name of the reused data group for the SCS component. The data component in **bold** text (the last in the path) is the data component for this row. i.e. Parent Data Component > **Child Data Component**	The definition of the item from the SCS.	The cardinality of the data element in the SCS. The cardinality of the data element in the SCS maps to the cardinality of the element in the CDA document. Where the cardinality of the SCS data element is more constrained than the cardinality of the CDA element then the SCS cardinality takes precedence. i.e. if an element is mandatory in the SCS and optional in CDA then it will also become mandatory in the CDA document. If an item with a maximum cardinality > 1 maps to an xml attribute, the attribute will contain multiple values separated by spaces. No such item will have valid values that themselves contain spaces.	The schema element(s) in the CDA document that correspond(s) to the SCS data component. The syntax for this is similar to XPath: {/name{[index]}}n{/<pattern>} Where: • {} indicates optional • {}n means a section that may repeat • <pattern> contains a link to a common pattern • [index] differentiates two similar mappings Examples: 1. component/act/participation[inf_prov]/role/ **<Address>** 2. **participant** participant/**@typeCode="ORG"** participant/**associatedEntity** participant/associatedEntity/**@classCode="SDLOC"** participant/associatedEntity/**code** A sequence of names refers to the XML path in the CDA document. The path always starts from a defined context which is defined in the grey header row above each group of mapping rows. The last name is shown in bold to make the path easier to read. The last name may be a reference to an attribute or an element, as defined in the Australian CDA Schema. The cardinalities of the items map through from the SCS. It is possible to specify an index after the name, such as 'participation[inf_prov]' in Example 1. The presence of the index means there are two or more mappings to the same participation class that differ only in the inner detail. The indexes show which of the multiple mappings is the parent of the inner detail. Note that each of the indexed participations may exist more than once (as specified by the SCS group cardinality). To determine the mapping for these kinds of elements, a document reader must look at the content inside the element. It is possible for one SCS data component to map to more than one CDA Schema element as in Example 2. Any fixed attribute values are represented as a separate line of the mapping such as those shown in Example 2. The path may end with a pattern designator, such as <Address>. This indicates that the mapping involves a number of sub-elements of the named element following the pattern as shown in the name (which is a link to the appropriate pattern in this document).	The name of the vocabulary.	Helpful additional information about the mapping.

How to interpret the following example mapping:

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: ClinicalDocument		
Subject of Care	Identifies the person about whom the health information contained in this PCEHR Prescription and Dispense View has been captured.	1..1	recordTarget/**patientRole**		
n/a	n/a	1..1	recordTarget/patientRole/**id**	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	Required CDA element. If there are any entitlements for Subject of Care this value **SHALL** be the same as: ClinicalDocument/ component/ structuredBody/ component[admin_obs]/ section/ entry/ act/ participant/ participantRole/ **id** where participantRole/ @classCode = "PAT".
Subject of Care > Participant > **Person**	An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient).	1..1	n/a		Not mapped directly, encompassed implicitly in recordTarget/ patientRole/ patient.
Subject of Care > Participant > Person > **Person Name**	The appellation by which an individual may be identified separately from any other within a social context.	1..*	recordTarget/patientRole/patient/**<Person Name>**		See common pattern: Person Name.

The Subject of Care (Patient) section is part of the context section of the SCS (as opposed to being part of the content section of the SCS). Although it is located in the context section of the SCS, it contains data components that map to the CDA body as well as data components that map to the CDA header. The information specifying the location of the elements is in the shaded context header row located above each group of mapping rows. The context remains the same until a new context header row starts.

The first row of the mapping (after the context header row), 'Subject of Care', is a CDA Header Element and has a context of 'ClinicalDocument' (the root element of a CDA document). Adding together the context and the mapping using '/' gives a full path of:

1. ClinicalDocument/recordTarget/patientRole

Due to the fact that 'Subject of Care' is part of the context section of the SCS (as opposed to a content element), information about it and its child elements can be located in the SCS document by finding the data component 'Subject of Care' in the table of contents under the context section and navigating to the relevant page.

If the data component were part of the content section of the SCS, information about it could be located by finding the data component (or its parent) in the table of contents under the content section of the SCS.

2. The next row in the mapping (n/a) is a row that is not defined in the SCS but which is required by CDA. The CDA schema data element is recordTarget/patientRole/id. This is a technical identifier that is used for system purposes such as matching the Entitlement details back to the Subject of Care (patient). This identifier must be a UUID.

3. The next row in the mapping table (Subject of Care > Participant > Person) is defined in the SCS but is not mapped directly to the CDA because it is already encompassed implicitly by CDA in recordTarget/patientRole/patient.

Moving to the next row in the table (Subject of Care > Participant > Person > **Person Name**) and concatenating the context and the mapping, we get:

4. ClinicalDocument/recordTarget/patientRole/patient/**<Person Name>**

<PersonName> holds a link to the common pattern section where a new table lays out the mapping for the Person Name common pattern.

Moving down the table to the context row '**CDA Header Data Elements**', any data components after this row (until the occurrence of a new context row) map to the CDA body. Because there is no equivalent concept in CDA, an Australian CDA extension has been added in order to represent Entitlement. This extension is indicated by the presence of the 'ext:' prefix. For the data component 'Entitlement', adding together the context and the mapping using '/' gives the following paths for the CDA body level 3 data elements ([index] is dependent on context, the Entitlement CDA elements **SHALL** be deemed as CDA Header Data Elements for conformance assessment, See *4 Administrative Observations* for details):

5. ClinicalDocument/component/structuredBody/component[index]/section/**ext:coverage2/@typeCode="COVBY"**

6. ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/**ext:entitlement**

7. ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**@classCode="COV"**

8. ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**@moodCode="EVN"**

9. ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/**ext:entitlement/ext:participant/@typeCode="BEN"**

10. ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/ext:participant/**ext:participantRole/@classCode="PAT"**

11. ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/ext:participant/ext:participantRole/**ext:id**

This id is also a technical identifier and must hold the same value as the ClinicalDocument/recordTarget/patientRole/id mentioned above in comment 1.

The order of the SCS data components is not always the same as the order of the CDA elements. In addition, the CDA elements need to be in the order specified in the Australian CDA Schema.

The "id" element is not specified in the SCS and should be filled with a UUID. This element may be used to reference the act from other places in the CDA document.

The next row in the table (Subject of Care > Participant > Entitlement > Entitlement Number) maps to the id element:

12. ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**ext:id**

The next row in the table (Subject of Care > Participant > Entitlement > Entitlement Type) maps to the code element:

13. ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**ext:code**

The next row in the table (Subject of Care > Participant > Entitlement > Entitlement Validity Duration) maps to the effectiveTime element:

14. ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**ext:effectiveTime**

See comments in the example below.

Example 2.1. Mapping Interpretation

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->
<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >

      …

   <!-- Begin Subject of Care - Header Part -->
   <recordTarget>
      <!-- 1 Corresponds to:
            ‘//recordTarget/patientRole’
         in the mapping. -->
      <patientRole>
         <!-- 2 Corresponds to:
                  '//recordTarget/patientRole/id'
```

```
            in the mapping -->
         <id root="04A103C4-7924-11DF-A383-FC69DFD72085"/>

         …

         <telecom value="tel:0499999999" use="H"/>
         <!-- 3 -->
         <patient>
            <!-- 4 Corresponds to:
                 '//recordTarget/patientRole/patient/<Person Name>'
                in the mapping -->
            <name use="L">
               <prefix>Ms</prefix>
               <given>Sally</given>
               <family>Grant</family>
            </name>

            …

         </patient>
      </patientRole>
   </recordTarget>
   <!-- End Subject of Care - Header Part -->

…

   <!-- Begin CDA Body -->
   <component>
      <structuredBody>

         <!-- Begin section -->
         <component>
            <section>

               …

               <!-- Begin Subject of Care Entitlement -->
               <!— 5 Corresponds to:
                     '//ext:coverage2'
                  in the mapping. -->
               <ext:coverage2 typeCode="COVBY">
                  <!-- 6, 7, 8 Corresponds to:
                        '//ext:coverage2/ext:entitlement',
                        '//ext:coverage2/ext:entitlement/@classCode="COV"',
                        '//ext:coverage2/ext:entitlement/@moodCode="EVN"'
                     in the mapping -->
                  <ext:Entitlement classCode="COV" moodCode="EVN">
                     <!-- 12 Corresponds to:
                           '//ext:coverage2/ext:entitlement/ext:id'
                        in the mapping -->
                     <ext:id root="1.2.36.174030967.0.5" extension="1234567892"
                        assigningAuthorityName="Department of Human Services"/>
                     <!-- 13 Corresponds to:
                        '//ext:coverage2/ext:entitlement/ext:code'
                     in the mapping -->
                     <ext:code code="1"
       codeSystem="1.2.36.1.2001.1001.101.104.16047"
       codeSystemName="NCTIS Entitlement Type Values"
       displayName="Medicare Benefits" />
                     <!-- 14 Corresponds to:
                           '//ext:coverage2/ext:entitlement/ext:effectiveTime'
                        in the mapping -->
                     <ext:effectiveTime>
                        <low value="200701010101"/>
                        <high value="202701010101"/>
```

```
                    </ext:effectiveTime>
                    <!-- 9 Corresponds to:
                          '//ext:coverage2/ext:entitlement/ext:participant/@typeCode="BEN"'
                       in the mapping -->
                    <ext:participant typeCode="BEN">
                       <!-- 10 Corresponds to:
                             '//ext:coverage2/ext:entitlement/ext:participant/ext:participantRole/@classCode="PAT"'
                          in the mapping -->
                       <ext:participantRole classCode="PAT">
                          <!-- 11 Corresponds to:
                                '//ext:coverage2/ext:entitlement/ext:participant/ext:participantRole/ext:id'
                             in the mapping -->
                          <!-- Same as recordTarget/patientRole/id -->
                          <ext:id root="04A103C4-7924-11DF-A383-FC69DFD72085"/>
                       </ext:participantRole>
                    </ext:participant>
                 </ext:Entitlement>
              </ext:coverage2>
              <!-- End Entitlement -->

              …

           </section>
        </component>
        <!-- End section -->

     </structuredBody>
  </component>
  <!-- End CDA Body -->
</ClinicalDocument>
```

2.3 CDA Extensions

The SCS is based on Australian requirements, either as expressed in existing Australian Standards, or based upon extensive consultation with major stakeholders. Not all of these requirements are supported by HL7 Clinical Document Architecture Release 2 (CDA).

CDA provides a mechanism for handling this. Implementation guides are allowed to define extensions, provided some key rules are followed:

- Extensions must have a namespace other than the standard HL7v3 namespace.
- The extension cannot alter the intent of the standard CDA document. For example, an extension cannot be used to indicate that an observation does not apply where the CDA document requires it.
- HL7 encourages users to get their requirements formalised in a subsequent version of the standard so as to maximise the use of shared semantics.

Accordingly, a number of extensions to CDA have been defined in this *Implementation Guide*. To maintain consistency, the same development paradigm has been used as CDA, and all the extensions have been submitted to HL7 for inclusion into a future release of CDA (Release 3 currently under development).

Version 3.0 of these extensions are incorporated in the namespace <http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0> as shown in the CDA example output throughout this document. Future versions of CDA Extensions will be versioned as per the following example:

<http://ns.electronichealth.net.au/Ci/Cda/Extensions/4.0>

2.4 W3C XML Schema

This document refers to an accompanying CDA W3C XML Schema (referred to in this document as the Australian CDA Schema). This schema differs from the base HL7 CDA W3C XML Schema (referred to in this document as the HL7 CDA Schema) as mentioned below:

- Australian CDA extensions have been added to the Australian CDA Schema.

CDA documents which include extensions will fail to validate against the HL7 CDA Schema – this is a known limitation.

PCEHR Prescription and Dispense View that conform to this specification **SHALL** validate against the Australian CDA Schema that accompanies this specification, and **SHALL** validate against the HL7 CDA Schema once the extensions have been removed. Note that merely passing schema validation does not ensure conformance; for more information, refer to Conformance.

2.5 Schematron

Many of the rules this document makes about CDA documents cannot be captured in the W3C XML Schema language (XSD) as XSD does not provide a mechanism to state that the value or presence of one attribute is dependent on the values or presence of other attributes (co-occurrence constraints).

Schematron is a rule-based validation language for making assertions about the presence or absence of patterns in XML trees. The rules defined by this document may be captured as Schematron rules. As of this release, the matching Schematron assertions have not yet been developed: NEHTA is considering the distribution of these rules in association with future releases of this guide.

2.6 Implementation Strategies

There are many platform specific implementation options for readers pursuing the implementation of a CDA document according to this guide. Examples of these implementation options include:

- Read or write CDA documents directly using a Document Object Model (DOM) and/or 3rd Generation Language (3GL) code.
- Transform an existing XML format to and from a CDA document.
- Use a toolkit to generate a set of classes from HL7 CDA Schema or the Australian CDA Schema provided with this implementation guide, to read or write documents.
- Use existing libraries, possibly open source, which can read and write CDA documents.

The best approach for any given implementation is strongly dictated by existing architecture, technology and legacy constraints of the implementation project or existing system.

3 PCEHR Prescription and Dispense View Data Hierarchy

The data hierarchy below provides a logical representation of the data structure of the PPDV SCS data components.

The data hierarchy is a logical representation of the data components of a PCEHR Prescription and Dispense View, and is not intended to represent how the data contents are represented in a CDA document.

	PCEHR PRESCRIPTION AND DISPENSE VIEW					
CONTEXT						
	SUBJECT OF CARE					1..1
	DOCUMENT AUTHOR					1..1
	DateTime Authored					1..1
	Earliest Date for Filtering (DateTime Health Event Started)					0..1
	Latest Date for Filtering (DateTime Health Event Ended)					0..1
	PCEHR Prescription and Dispense View Instance Identifier					0..1
	Structured Document Identifier					1..1
CONTENT						
	EXCLUSION STATEMENT					0..1
		General Statement				1..1
	Prescribing and Dispensing Reports (SUMMARIES OF MEDICATION ENTRIES)					0..1
		MEDICATION ENTRIES WITH SUMMARY				1..*
			SUMMARY OF MEDICATION ENTRIES			1..1
				Therapeutic Good Identification		1..1
				DateTime Prescription Written (DateTime Earliest Prescription Written)		0..1
				DateTime of Earliest Dispense Event		0..1
				DateTime of Latest Dispense Event		0..1
				Total Number of Known Supplies		0..1
				Maximum Number of Permitted Supplies		0..1
				MEDICATION ENTRY		1..*

					Dispense Item (MEDICATION ACTION)		0..1
						Therapeutic Good Identification	1..1
						Therapeutic Good Strength (Additional Therapeutic Good Detail)	0..1
						Therapeutic Good Generic Name (Additional Therapeutic Good Detail)	0..1
						Additional Dispensed Item Description (Additional Therapeutic Good Detail)	0..1
						Label Instruction (Medication Action Instructions)	0..1
						Formula	0..1
						Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)	0..1
						Form	1..1
						Quantity Dispensed (AMOUNT OF MEDICATION)	0..1
						Quantity Description	1..1
						Comment (Medication Action Comment)	0..1
						Brand Substitution Occurred	0..1
						Number of this Dispense	0..1
						Maximum Number of Repeats	0..1
						PBS Manufacturer Code (Administrative Manufacturer Code)	0..1
						Unique Pharmacy Prescription Number (Administrative System Identifier)	0..1
						DateTime of Dispense Event (Medication Action DateTime)	1..1
						Dispense Item Identifier (Medication Action Instance Identifier)	1..1
						Dispense Record Link (LINK)	1..1
						Link Nature	1..1
						Link Role	1..1
						Link Target	1..1
						Prescription Item Link (LINK)	0..1
						Link Nature	1..1

						Link Role		1..1
						Link Target		1..1
				Prescription Item (MEDICATION INSTRUCTION)				0..1
					Therapeutic Good Identification			1..1
					Therapeutic Good Strength (Additional Therapeutic Good Detail)			0..1
					Therapeutic Good Generic Name (Additional Therapeutic Good Detail)			0..1
					Directions			0..1
					Formula			0..1
					Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)			0..1
						Form		1..1
					Clinical Indication			0..1
					Administration Details (MEDICATION ADMINISTRATION)			0..1
						Route		1..1
					Comment (Medication Instruction Comment)			0..1
					DISPENSING			1..1
						Quantity to Dispense (AMOUNT OF MEDICATION)		1..1
							Quantity Description	1..1
						Maximum Number of Repeats (Number of Repeats)		0..1
						Minimum Interval Between Repeats		0..1
						Brand Substitution Permitted		0..1
					DateTime Prescription Written (DateTime Medication Instruction Written)			1..1
					PBS Manufacturer Code (Administrative Manufacturer Code)			0..1
					DateTime Prescription Expires (DateTime Medication Instruction Expires)			1..1
					Prescription Item Identifier (Medication Instruction Instance Identifier)			1..1
					Prescription Record Link (LINK)			1..1

							Link Nature	1..1
							Link Role	1..1
							Link Target	1..1

4 Administrative Observations

The PPDV SCS contains a number of data elements that are logically part of the SCS context, but for which there are no equivalent data elements in the CDA header. These data elements are considered to be "Administrative Observations" about the encounter, the patient or some other participant. Administrative Observations is a CDA section that is created to hold these data components in preference to creating extensions for them.

CDA R-MIM Representation

Figure 4.1, “Administrative Observations” shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The Administrative Observations section is composed of a Section class related to its context ClinicalDocument.structuredBody through a component relationship.

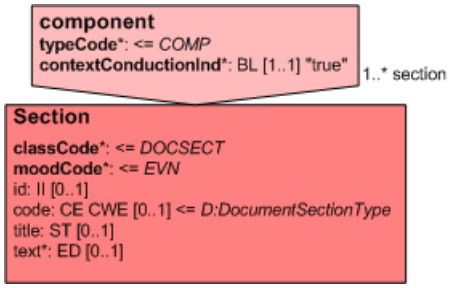

Figure 4.1. Administrative Observations

CDA Mapping

At most one instance of Administrative Observation section **SHOULD** to be present in a CDA document. The cardinality of this section comes from its linking context Data Elements (Ex: CDA context Data Element(s) mapped to Administrative Observation Section). If any of the linking context Data Elements is mandatory, then this section **SHALL** be marked as a mandatory section.

This section **SHALL NOT** be populated if there is no entries/text to go in it.

This section **SHALL** contain a code if provided .

All Data Elements (only with an exception of narrative text.) within this section **SHALL** be deemed as **CDA Header Data Elements** for conformance assessment.

The <text> Data Element is 'Optional' and **SHALL** be treated as a Level 2 CDA Data Element.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: ClinicalDocument/component/structuredBody/		
n/a	n/a	Cardinality comes from linking context Data Elements	**component/section[admin_obs]**		
		0..1	component/section[admin_obs]/**id**	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	
		1..1	component/section[admin_obs]/**code**		
			component/section[admin_obs]/code/**@code="102.16080"**		
			component/section[admin_obs]/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component/section[admin_obs]/code/**@codeSystemName="NCTIS Data Components"**		
			component/section[admin_obs]/code/**@displayName="Administrative Observations"**		
			component[admin_obs]/section/**title="Administrative Observations"**		
		0..1	component[admin_obs]/section/**text**		See Appendix A, *CDA Narratives*

Example 4.1. Administrative Observations XML Fragment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema
shall be considered to take precedence -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
   <!-- Begin CDA Header -->

   …

   <!-- End CDA Header -->

   <!-- Begin CDA Body -->

   …

   <component>
      <structuredBody>

         …

         <!-- Begin Administrative Observations section -->
   <component><!-- [admin_obs] -->
    <section>
     <id root="88CDBCA4-EFD1-11DF-8DE4-E4CDDFD72085"/>
     <code code="102.16080"
       codeSystem="1.2.36.1.2001.1001.101"
       codeSystemName="NCTIS Data Components"
       displayName="Administrative Observations"/>
     <title>Administrative Observations</title>

     <!-- Narrative text for Administrative Observations -->
     <text/>

     …

    </section>
   </component><!-- [admin_obs] -->
   <!-- End Administrative Observations section -->

      </structuredBody>
   </component>
   <!-- End CDA Header -->
</ClinicalDocument>
```

5 CDA Header

This chapter contains elements that are not specified in the PPDV SCS specification. These elements include CDA specific header elements (both required and optional) and data elements described in the Endpoint Specification (EPS). The CDA header elements are specified in the CDA Schema Data Element column and where they map to Endpoint specification elements is indicated in the EPS Element column.

All the definitions in this chapter are sourced from "HL7 Clinical Document Architecture, Release 2" [HL7CDAR2].

5.1 ClinicalDocument

Identification

Name	ClinicalDocument
Definition	The ClinicalDocument class is the entry point into the CDA R-MIM, and corresponds to the <ClinicalDocument> XML element that is the root element of a CDA document.

Relationships

Children

Name	Occurrence
Custodian	1..1

CDA R-MIM Representation

Figure 5.1, “ClinicalDocument”

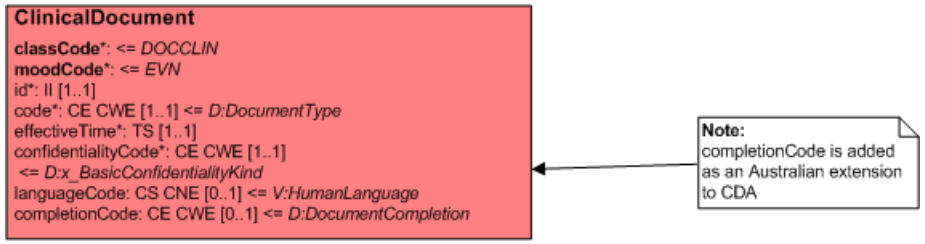

Figure 5.1. ClinicalDocument

CDA Mapping

CDA Schema Data Element	Definition	Card	Vocab	EPS Element	Comments
Context: /					
ClinicalDocument	The ClinicalDocument class is the entry point into the CDA R-MIM, and corresponds to the <ClinicalDocument> XML element that is the root element of a CDA document.	1..1			
ClinicalDocument/**typeId**	A technology-neutral explicit reference to the CDA Release Two specification.	1..1			
ClinicalDocument/typeId/**@extension="POCD_HD000040"**		1..1			The unique identifier for the CDA Release Two Hierarchical Description.
ClinicalDocument/typeId/**@root="2.16.840.1.113883.1.3"**		1..1			The OID for HL7 Registered models.
ClinicalDocument/**templateId**		1..*			One or more template identifiers that indicate constraints on the CDA document that this document conforms to. One of the identifiers must be the templateId that identifies this specification (see immediately below). Additional template identifiers may be required by other specifications, such as the CDA Rendering Specification. Systems are not required to recognise any other template identifiers than the one below in order to understand the document as a [type] but these identifiers may influence how the document must be handled.
ClinicalDocument/templateId/**@root="1.2.36.1.2001.1001.100.1002.179"**		1..1		docType	The healthcare context-specific name of the published PCEHR Prescription and Dispense View CDA Implementation Guide.
ClinicalDocument/templateId/**@extension="1.0"**		1..1			The identifier of the version that was used to create the document instance.
ClinicalDocument/**id**	Represents the unique instance identifier of a clinical document.	1..1		docId	See common pattern: id.

CDA Schema Data Element	Definition	Card	Vocab	EPS Element	Comments
ClinicalDocument/**code**	The code specifying the particular kind of document (e.g. History and Physical, Discharge Summary, Progress Note).	1..1			See common pattern: code.
ClinicalDocument/code/**@code="100.16789"**					A collection of reports about prescribing and dispensing events for a subject of care.
ClinicalDocument/code/**@codeSystem="1.2.36.1.2001.1001.101"**					
ClinicalDocument/code/**@codeSystemName="NCTIS Data Components"**					
ClinicalDocument/code/**@displayName="PCEHR Prescription and Dispense View"**					
ClinicalDocument/**effectiveTime**	Signifies the document creation time, when the document first came into being. Where the CDA document is a transform from an original document in some other format, the ClinicalDocument.effectiveTime is the time the original document is created.	1..1		creationTime	See common pattern: time.
ClinicalDocument/**confidentialityCode/@nullFlavor="NA"**	Codes that identify how sensitive a piece of information is and/or that indicate how the information may be made available or disclosed.	1..1			
ClinicalDocument/**languageCode**		0..1	[RFC3066] – Tags for the Identification of Languages		<Language Code> – <DIALECT> The <Language Code> **SHALL** be "en". The <DIALECT> **SHOULD** be 'AU'
ClinicalDocument/**ext:completionCode**	The lifecycle status of a document.	1..1	NCTIS: Admin Codes - Document Status	docStatus	See Australian CDA extension: ClinicalDocument.completionCode

Example

Example 5.1. ClinicalDocument Body XML Fragment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
      xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
      xmlns:xs="http://www.w3.org/2001/XMLSchema"
      xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
 <typeId extension="POCD_HD000040" root="2.16.840.1.113883.1.3"/>
 <templateId root="1.2.36.1.2001.1001.100.1002.179" extension="1.0"/>
 <id root="8BC3406A-B93F-11DE-8A2B-6A1C56D89593"/>
 <code code="100.16789"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="PCEHR Prescription and Dispense View"/>
 <effectiveTime value="200910201235+1000"/>
 <confidentialityCode nullFlavor="NA"/>
 <languageCode code="en-AU"/>
 <ext:completionCode code="F" codeSystem="1.2.36.1.2001.1001.101.104.20104" codeSystemName="NCTIS Document Status Values" displayName="Final"/>

 <!-- Begin CDA Header -->

   ...

   <!-- End CDA Header -->

 <!-- Begin CDA Body -->

 ...

 <!-- End CDA Body -->
</ClinicalDocument>
```

5.1.1 Custodian

Identification

Name	Custodian
Definition	Represents the organization that is in charge of maintaining the document. The custodian is the steward that is entrusted with the care of the document. Every CDA document has exactly one custodian.

Relationships

Parent

Name	Occurrences (child within parent)
ClinicalDocument	1..1

CDA R-MIM Representation

Figure 5.2, “Custodian”shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The CUSTODIAN data group maps to the CDA Header element custodian. The custodian participation class represents the organization that is in charge of maintaining the document. The role is AssignedCustodian and is represented by the CustodianOrganization entity.

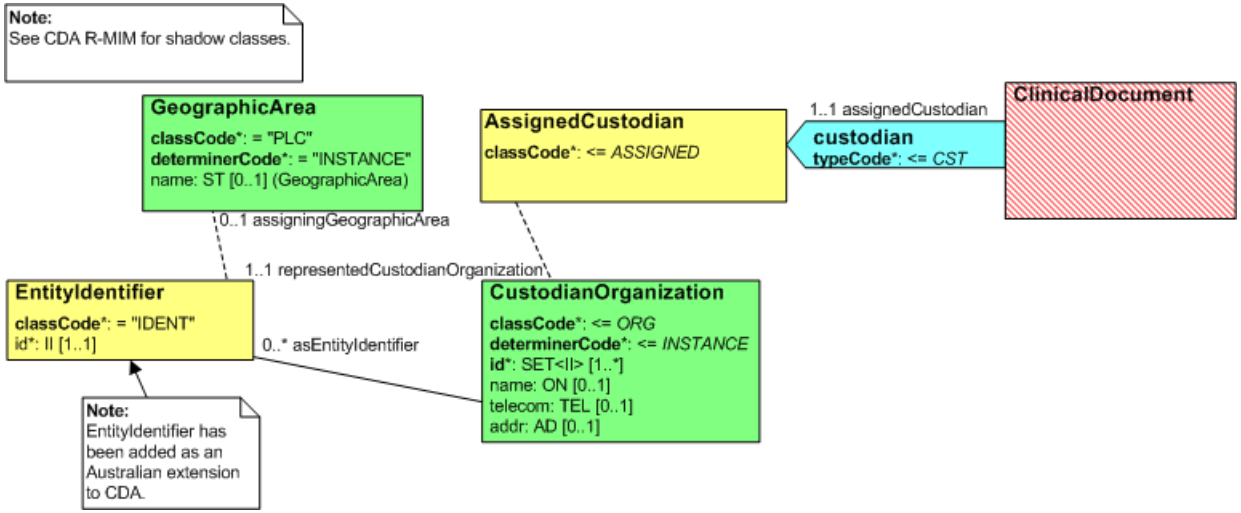

Figure 5.2. Custodian

CDA Mapping

CDA Schema Data Element	Definition	Card	Vocab	Comments
Context: ClinicalDocument/				
custodian	Represents the organization that is in charge of maintaining the document. The custodian is the steward that is entrusted with the care of the document. Every CDA document has exactly one custodian.	1..1		
custodian/**assignedCustodian**	A custodian is a scoping organization in the role of an assigned custodian.	1..1		
custodian/assignedCustodian/**representedCustodianOrganization**	The steward organization (CustodianOrganization class) is an entity scoping the role of AssignedCustodian.	1..1		
custodian/assignedCustodian/representedCustodianOrganization/**id**	A unique identifier for the scoping entity (representedCustodianOrganization) in this role.	1..*	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	See <id> for available attributes.
custodian/assignedCustodian/representedCustodianOrganization/**<Entity Identifier>**	The entity identifier of the custodian organization.	0..*	The value of one Entity Identifier SHALL be a PAIO.	See common pattern: Entity Identifier.
custodian/assignedCustodian/representedCustodianOrganization/**name**	The name of the steward organization.	0..1		
custodian/assignedCustodian/representedCustodianOrganization/**<Electronic Communication Detail>**	The telecom of the steward organization.	0..1		See common pattern: Electronic Communication Detail.
custodian/assignedCustodian/representedCustodianOrganization/**<Address>**	The address of the steward organization	0..1		See common pattern: Address.

Example

Example 5.2. Custodian Body XML Fragment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >

   …

   <!-- Begin CDA Header -->

   …

    <!-- Begin Custodian -->
 <custodian>
  <assignedCustodian>
   <representedCustodianOrganization>
    <id root="072EC7BC-78EC-11DF-B9AC-D524DFD72085"/>

    <!-- Organisation Name -->
    <name>Oz Health Clinic</name>

    <!-- Electronic Communication Detail -->
    <telecom use="WP" value="tel:0712341234"/>

    <!-- Address -->
    <addr use="H">
     <streetAddressLine>99 Clinician Street</streetAddressLine>
     <city>Nehtaville</city>
     <state>QLD</state>
     <postalCode>5555</postalCode>
     <additionalLocator>32568931</additionalLocator>
    </addr>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
     <ext:id assigningAuthorityName="PAI-O" root="1.2.36.1.2001.1007.1.8003640001000036"/>
     <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
     </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>
   </representedCustodianOrganization>
  </assignedCustodian>
 </custodian>
 <!-- End Custodian -->

   …

   <!-- End CDA Header -->

   <!-- Begin CDA Body -->
   <component>
      <structuredBody>
```

```
      …

      </structuredBody>
   </component>
   <!-- End CDA Body -->
</ClinicalDocument>
```

6 Context Data Specification - CDA Mapping

6.1 PCEHR PRESCRIPTION AND DISPENSE VIEW

Identification

Name	PCEHR PRESCRIPTION AND DISPENSE VIEW
Metadata Type	Structured Document
Identifier	SD-16789

Relationships

Children Not Included in Mapping for This Section (Context Data Components)

Data Type	Name	Occurrence
	SUBJECT OF CARE	1..1
	DOCUMENT AUTHOR	1..1

CDA R-MIM Representation

Figure 6.1, “CDA Header Model for PCEHR Prescription and Dispense View Context” shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

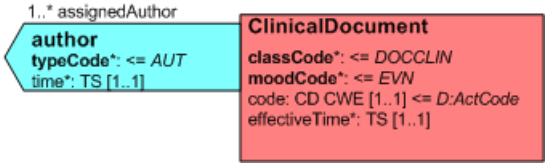

Figure 6.1. CDA Header Model for PCEHR Prescription and Dispense View Context

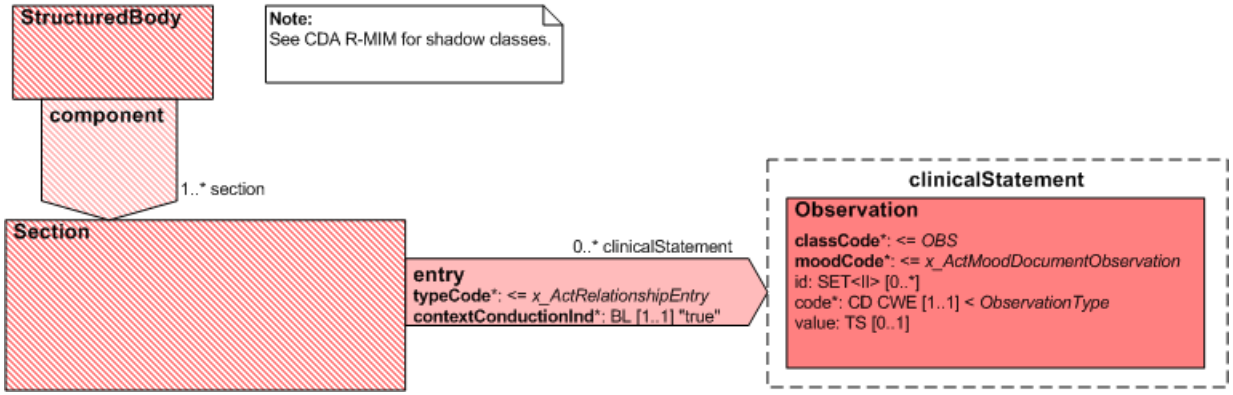

Figure 6.2. CDA Body Model for PCEHR Prescription and Dispense View Context

CDA Mapping

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements					
PCEHR Prescription and Dispense View	A collection of reports about prescribing and dispensing events for a subject of care.	1..1	ClinicalDocument/**code**		
			ClinicalDocument/code/**@code="100.16789"**		
			ClinicalDocument/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			ClinicalDocument/code/**@codeSystemName="NCTIS Data Components"**		
			ClinicalDocument/code/**@displayName="PCEHR Prescription and Dispense View"**		
			ClinicalDocument/**effectiveTime**		Document creation time.
PCEHR Prescription and Dispense View > ***Subject of Care***	See: SUBJECT OF CARE				
PCEHR Prescription and Dispense View > ***Document Author***	See: DOCUMENT AUTHOR				
PCEHR Prescription and Dispense View > **DateTime Authored**	The date, or date and time, that authoring of the PCEHR Prescription and Dispense View document was completed.	1..1	ClinicalDocument/**author/time/@value**		See <time> for available attributes.
CDA Header Data Elements			Context: ClinicalDocument/component/structuredBody/component[admin_obs]/section (See *4 Administrative Observations*)		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Earliest Date for Filtering (DateTime Health Event Started)	The date, or date and time, on or after which all source documents were authored.	0..1	**entry[earliest_date]**		Though this Data Element has been mapped as **CDA Body Data Elements** this entry **SHALL** be asserted as CDA Level 1 Data Elements.
			entry[earliest_date]/**observation**		
			entry[earliest_date]/observation/**@classCode="OBS"**		
			entry[earliest_date]/observation/**@moodCode="EVN"**		
			entry[earliest_date]/observation/**code**		
			entry[earliest_date]/observation/code/**@code="103.15507"**		
			entry[earliest_date]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[earliest_date]/observation/code/**@codeSystemName="NCTIS Data Components"**		
			entry[earliest_date]/observation/code/**@displayName="Earliest Date for Filtering"**		
			entry[earliest_date]/observation/**id**	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	See <id> for available attributes.
			entry[earliest_date]/observation/**value:TS**		Usage: date or date/time+tz
			entry[earliest_date]/observation/value/**@value**		Implementation specific nullFlavor="NI" **MAY** be allowed.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Latest Date for Filtering (DateTime Health Event Ended)	The date, or date and time, on or before which all source documents were authored.	0..1	**entry[latest_date]**		Though this Data Element has been mapped as **CDA Body Data Elements** this entry **SHALL** be asserted as CDA Level 1 Data Elements.
			entry[latest_date]/**observation**		
			entry[latest_date]/observation/**@classCode="OBS"**		
			entry[latest_date]/observation/**@moodCode="EVN"**		
			entry[latest_date]/observation/**code**		
			entry[latest_date]/observation/code/**@code="103.15510"**		
			entry[latest_date]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[latest_date]/observation/code/**@codeSystemName="NCTIS Data Components"**		
			entry[latest_date]/observation/code/**@displayName="Latest Date for Filtering"**		
			entry[latest_date]/observation/**id**	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	See <id> for available attributes.
			entry[latest_date]/observation/**value:TS**		Usage: date or date/time+tz
			entry[latest_date]/observation/value/**@value**		Implementation specific nullFlavor="NI" **MAY** be allowed.
CDA Header Data Elements					
PCEHR Prescription and Dispense View > **PCEHR Prescription and Dispense View Instance Identifier**	A globally unique identifier for each instance of a PCEHR Prescription and Dispense View document.	0..1	ClinicalDocument/**id**		See <id> for available attributes.
PCEHR Prescription and Dispense View > **Structured Document Identifier**	The NEHTA OID for the PCEHR Prescription and Dispense View concept represented by this Structured Document.	1..1	ClinicalDocument/**code**	This is a fixed value for all instances of a NPDR Prescribing/Dispensing Summary View composition.	See <code> for available attributes.

For CDA Header mappings and model which are not explicitly included in the SCS, see ClinicalDocument.

Example 6.1. PCEHR Prescription and Dispense View Context XML Fragment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<ClinicalDocument xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
 xsi:schemaLocation="CDA-eDS-V3_0.xsd"
  xmlns="urn:hl7-org:v3"
  xmlns:xs="http://www.w3.org/2001/XMLSchema"
  xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0">

 …
 <id root="8BC3406A-B93F-11DE-8A2B-6A1C56D89593"/>
 <code code="100.16789"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="PCEHR Prescription and Dispense View "/>
   …

   <!-- Begin CDA Header -->

   …

 <!-- Begin Document Author -->
 <author>
  ...
  <!-- DateTime Authored -->
  <time value="201110201235+1000" />
  ...
 </author>
 <!-- End Document Author -->

   …

   <!-- End CDA Header -->

   <!-- Begin CDA Body -->
  <component>
  <structuredBody>

              …
              <!-- Begin Section Administrative Observations -->
   <component>
    <!-- [admin_obs] -->
    <section>
      …
     <!-- Begin Earliest Date for Filtering (DateTime Health Event Started) -->
     <entry>
      <observation classCode="OBS" moodCode="EVN">
       <id root="8f854d40-352b-11e2-81c1-0800200c9a66"/>
       <code code="103.15507" codeSystem="1.2.36.1.2001.1001.101"
        codeSystemName="NCTIS Data Components"
        displayName="Earliest Date for Filtering"/>
       <value xsi:type="TS" value="20110101"/>
      </observation>
     </entry>
     <!-- End Earliest Date for Filtering (DateTime Health Event Started) -->

     <!-- Begin Latest Date for Filtering (DateTime Health Event Ended) -->
     <entry>
      <observation classCode="OBS" moodCode="EVN">
       <id root="a76a9770-352c-11e2-81c1-0800200c9a66"/>
```

```
        <code code="103.15510" codeSystem="1.2.36.1.2001.1001.101"
         codeSystemName="NCTIS Data Components"
         displayName="Latest Date for Filtering"/>
        <value xsi:type="TS" value="20120101"/>
       </observation>
      </entry>
      <!-- End Latest Date for Filtering (DateTime Health Event Ended) -->
                …
                </section>
    </component>
    <!-- End Section Administrative Observations -->
                …
   </structuredBody>
  </component>

    <!-- End CDA Body -->
</ClinicalDocument>
```

6.1.1 SUBJECT OF CARE

Identification

Name	SUBJECT OF CARE
Metadata Type	Data Group
Identifier	DG-10296

Relationships

Parent

Data Type	Name	Occurrences (child within parent)
	PCEHR PRESCRIPTION AND DISPENSE VIEW	1..1

CDA R-MIM Representation

Figure 6.3, “Subject of Care - Header Data Elements” and Figure 6.4, “Subject of Care - Body Data Elements” show a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to both CDA Header and CDA Body elements.

The SUBJECT OF CARE data group maps mostly to CDA Header elements. The recordTarget participation class represents the medical record to which this document belongs. The recordTarget is associated to the Patient class by the PatientRole class. In order to represent the Date of Death of the Subject of Care, Patient.deceasedTime has been added as an Australian CDA extension.

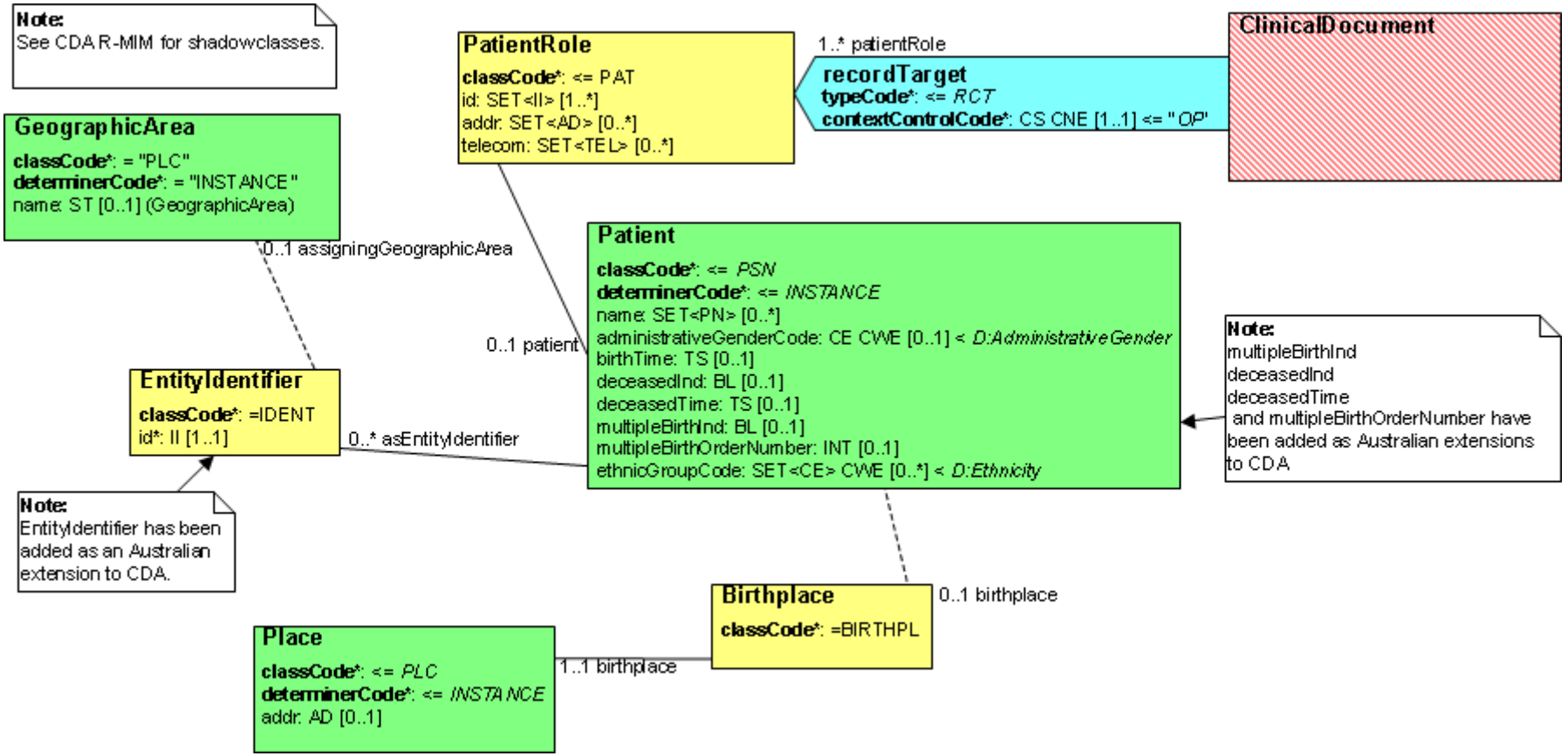

Figure 6.3. Subject of Care - Header Data Elements

Note

Several data elements contained in the SUBJECT OF CARE data group could not be mapped to CDA Header elements. These data elements – have been mapped to Observations in the Administrative Observations section (see 4 *Administrative Observations*).

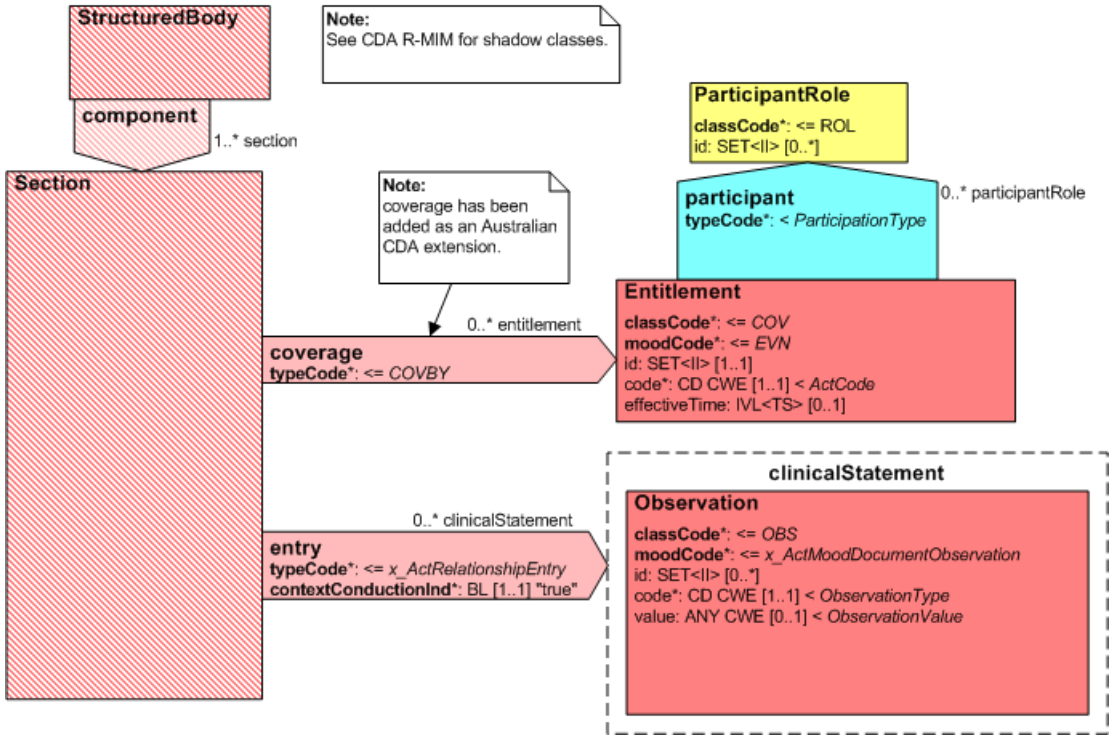

Figure 6.4. Subject of Care - Body Data Elements

CDA Mapping

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: ClinicalDocument/		
Subject of Care	Identifies the person about whom the health information contained in this PCEHR Prescription and Dispense View has been captured.	1..1	recordTarget/**patientRole**		
n/a	n/a	1..1	recordTarget/patientRole/**id**	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	Required CDA element. If there are any entitlements for Subject of Care this value **MUST** be the same as: ClinicalDocument/ component/ structuredBody/ component[admin_obs]/ section/ entry/ act/ participant/ participantRole/ **id** where participantRole/ @classCode = "PAT".
Subject of Care > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	n/a	Participation Type **SHALL** have an implementation-specific fixed value equivalent to "Subject of Care".	Not mapped directly, encompassed implicitly in recordTarget/ typeCode = "RCT" (optional, fixed value).
Subject of Care >**Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	n/a	Role **SHALL** have an implementation-specific fixed value equivalent to "Patient".	Not mapped directly, encompassed implicitly in recordTarget/ patientRole/ classCode = "PAT" .
Subject of Care > **Participant**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	recordTarget/patientRole/**patient**		
Subject of Care > Participant > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..*	recordTarget/patientRole/patient/**<Entity Identifier>**	The value of one Entity Identifier **SHALL** be an Australian IHI.	See common pattern: Entity Identifier. The Subject of Care's Medicare card number is recorded in Entitlement, not Entity Identifier.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Subject of Care > Participant > **Address**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	recordTarget/patientRole/**<Address>**	AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.	See common pattern: Address.
Subject of Care > Participant > **Electronic Communication Detail**	The electronic communication details of entities.	0..*	recordTarget/patientRole/**<Electronic Communication Detail>**		See common pattern: Electronic Communication Detail.
Subject of Care > Participant > **Person or Organisation or Device**	Represents a choice to be made at run-time between PERSON, ORGANISATION and DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON.	This logical NEHTA data component has no mapping to CDA. The cardinality of this component propagates to its children.
Subject of Care > Participant > Person or Organisation or Device > **Person**	An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient).	1..1	n/a		Not mapped directly, encompassed implicitly in recordTarget/ patientRole/ patient.
Subject of Care > Participant > Person or Organisation or Device > Person > **Person Name**	The appellation by which an individual may be identified separately from any other within a social context.	1..*	recordTarget/patientRole/patient/**<Person Name>**		See common pattern: Person Name.
Subject of Care > Participant > Person or Organisation or Device > Person > **Demographic Data**	Additional characteristics of a person that may be useful for identification or other clinical purposes.	1..1	n/a		This logical NEHTA data component has no mapping to CDA. The cardinality of this component propagates to its children.
Subject of Care > Participant > Person or Organisation or Device > Person > Demographic Data > **Sex**	The biological distinction between male and female. Where there is inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.	1..1	recordTarget/patientRole/patient/**administrativeGenderCode**	AS 5017-2006 Health Care Client Identifier Sex	
Subject of Care > Participant > Person or Organisation or Device > Person > Demographic Data > **Date of Birth Detail**	Details of the accuracy, origin and value of a person's date of birth.	1..1	n/a		This logical NEHTA data component has no mapping to CDA. The cardinality of this component propagates to its children.
Subject of Care > Participant > Person or Organisation or Device > Person > Demographic Data > Date of Birth Detail > **Date of Birth**	The date of birth of the person.	1..1	recordTarget/patientRole/patient/**birthTime**		See <time> for available attributes.
CDA Header Data Elements			Context: ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*)		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Subject of Care > Participant > Person or Organisation or Device > Person > Demographic Data > Date of Birth Detail > **Date of Birth is Calculated From Age**	Indicates whether or not a person's date of birth has been derived from the value in the Age data element.	0..1	**entry[calc_age]**		
			entry[calc_age]/**observation**		
			entry[calc_age]/observation/**@classCode="OBS"**		
			entry[calc_age]/observation/**@moodCode="EVN"**		
			entry[calc_age]/observation/**code**		
			entry[calc_age]/observation/code/**@code="103.16233"**		
			entry[calc_age]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[calc_age]/observation/code/**@codeSystemName="NCTIS Data Components"**		
			entry[calc_age]/observation/code/**@displayName="Date of Birth is Calculated From Age"**		
			entry[calc_age]/observation/**id**	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	See <id> for available attributes.
			entry[calc_age]/observation/**value:BL**		If the date of birth has been calculated from age this is true, otherwise it is false.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Subject of Care > Participant > Person or Organisation or Device > Person > Demographic Data > Date of Birth Detail > **Date of Birth Accuracy Indicator**	The level of certainty or estimation of a person's date of birth.	0..1	**entry[dob_acc]**		
			entry[dob_acc]/**observation**		
			entry[dob_acc]/observation/**@classCode="OBS"**		
			entry[dob_acc]/observation/**@moodCode="EVN"**		
			entry[dob_acc]/observation/**code**		
			entry[dob_acc]/observation/code/**@code="102.16234"**		
			entry[dob_acc]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[dob_acc]/observation/code/**@codeSystemName="NCTIS Data Components"**		
			entry[dob_acc]/observation/code/**@displayName="Date of Birth Accuracy Indicator"**		
			entry[dob_acc]/observation/**id**	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	See <id> for available attributes.
			entry[dob_acc]/observation/**value:CS**	AS 5017-2006 Health Care Client Identifier Date Accuracy Indicator	
Subject of Care > Participant > Person or Organisation or Device > Person > Demographic Data > Date of Birth Detail > Date of Birth Accuracy Indicator > **Date of Birth Day Accuracy Indicator**	The accuracy of the day component of a person's date of birth.	1..1	n/a		Encompassed in the mapping for Date of Birth Accuracy Indicator (above).
Subject of Care > Participant > Person or Organisation or Device > Person > Demographic Data > Date of Birth Detail > Date of Birth Accuracy Indicator > **Date of Birth Month Accuracy Indicator**	The accuracy of the month component of a person's date of birth.	1..1	n/a		Encompassed in the mapping for Date of Birth Accuracy Indicator (above).
Subject of Care > Participant > Person or Organisation or Device > Person > Demographic Data > Date of Birth Detail > Date of Birth Accuracy Indicator > **Date of Birth Year Accuracy Indicator**	The accuracy of the year component of a person's date of birth.	1..1	n/a		Encompassed in the mapping for Date of Birth Accuracy Indicator (above).

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Subject of Care > Participant > Person or Organisation or Device > Person > Demographic Data > **Age Detail**	Details of the accuracy and value of a person's age.	1..1	n/a		This logical NEHTA data component has no mapping to CDA. The cardinality of this component propagates to its children.
Subject of Care > Participant > Person or Organisation or Device > Person > Demographic Data > Age Detail > **Age**	The age of a person/subject of care at the time.	1..1	**entry[age]**		
			entry[age]/**observation**		
			entry[age]/observation/**@classCode="OBS"**		
			entry[age]/observation/**@moodCode="EVN"**		
			entry[age]/observation/**code**		
			entry[age]/observation/code/**@code="103.20109"**		
			entry[age]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[age]/observation/code/**@codeSystemName="NCTIS Data Components"**		
			entry[age]/observation/code/**@displayName="Age"**		
			entry[age]/observation/**id**	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	See <id> for available attributes.
			entry[age]/observation/**value:PQ**		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Subject of Care > Participant > Person or Organisation or Device > Person > Demographic Data > Age Detail > **Age Accuracy Indicator**	The accuracy of a person's age.	0..1	**entry[age_acc]**		
			entry[age_acc]/**observation**		
			entry[age_acc]/observation/**@classCode="OBS"**		
			entry[age_acc]/observation/**@moodCode="EVN"**		
			entry[age_acc]/observation/**code**		
			entry[age_acc]/observation/code/**@code="103.16279"**		
			entry[age_acc]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[age_acc]/observation/code/**@codeSystemName="NCTIS Data Components"**		
			entry[age_acc]/observation/code/**@displayName="Age Accuracy Indicator"**		
			entry[age_acc]/observation/**id**	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	See <id> for available attributes.
			entry[age_acc]/observation/**value:BL**		If the age is considered to be accurate this is true, otherwise it is false.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Subject of Care > Participant > Person or Organisation or Device > Person > Demographic Data > **Birth Plurality**	An indicator of multiple birth, showing the total number of births resulting from a single pregnancy.	0..1	**entry[brth_plr]**		
			entry[brth_plr]/**observation**		
			entry[brth_plr]/observation/**@classCode="OBS"**		
			entry[brth_plr]/observation/**@moodCode="EVN"**		
			entry[brth_plr]/observation/**code**		
			entry[brth_plr]/observation/code/**@code="103.16249"**		
			entry[brth_plr]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[brth_plr]/observation/code/**@codeSystemName="NCTIS Data Components"**		
			entry[brth_plr]/observation/code/**@displayName="Birth Plurality"**		
			entry[brth_plr]/observation/**id**	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	See <id> for available attributes.
			entry[brth_plr]/observation/**value:INT**		
Subject of Care > Participant > Person or Organisation or Device > Person > Demographic Data > **Birth Order**	The sequential order of each baby of a multiple birth regardless of live or still birth.	0..1	recordTarget/patientRole/patient/**ext:multipleBirthInd**		See Australian CDA extension: Multiple Birth.
			recordTarget/patientRole/patient/**ext:multipleBirthOrderNumber**		
Subject of Care > Participant > Person or Organisation or Device > Person > Demographic Data > **Indigenous Status**	Indigenous Status is a measure of whether a person identifies as being of Aboriginal or Torres Strait Islander origin.	0..1	recordTarget/patientRole/patient/**ethnicGroupCode**	METeOR 291036: Indigenous Status	
CDA Header Data Elements			Context: ClinicalDocument/component/structuredBody/component[admin_obs]/section/		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Subject of Care > Participant > **Entitlement**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..*	**ext:coverage2/@typeCode="COVBY"**		See Australian CDA extension: Entitlement.
			ext:coverage2/**ext:entitlement**		
			ext:coverage2/ext:entitlement/**@classCode="COV"**		
			ext:coverage2/ext:entitlement/**@moodCode="EVN"**		
			ext:coverage2/ext:entitlement/**ext:participant/@typeCode="BEN"**		
			ext:coverage2/ext:entitlement/ext:participant/**ext:participantRole/@classCode="PAT"**		
			ext:coverage2/ext:entitlement/ext:participant/ext:participantRole/**ext:id**	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	**SHALL** hold the same value as ClinicalDocument/ recordTarget/ patientRole/ **id**.
Subject of Care > Participant > Entitlement > **Entitlement Number**	A number or code issued for the purpose of identifying the entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	1..1	ext:coverage2/ext:entitlement/**ext:id**		
Subject of Care > Participant > Entitlement > **Entitlement Type**	The description of the scope of an entitlement.	1..1	ext:coverage2/ext:entitlement/**ext:code**		See <code> for available attributes.
Subject of Care > Participant > Entitlement > **Entitlement Validity Duration**	The time interval for which an entitlement is valid.	0..1	ext:coverage2/ext:entitlement/**ext:effectiveTime**		See <time> for available attributes.

Example 6.2. Subject of Care XML Fragment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >

      …

   <!-- Begin Subject of Care - Header Part -->
 <recordTarget>
  <patientRole>
   <!-- This system generated id is used for matching patient details such as Entitlement, Date of Birth Details and Age Details -->
   <id root="7AA0BAAC-0CD0-11E0-9516-4350DFD72085"/>

   <!-- Address -->
   <addr use="H">
    <streetAddressLine>1 Patient Street</streetAddressLine>
    <city>Nehtaville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568931</additionalLocator>
    <country>Australia</country>
   </addr>

   <!-- Electronic Communication Detail -->
   <telecom use="H" value="tel:0499999999"/>

   <!-- Participant -->
   <patient>

    <!-- Person Name -->
    <name use="L">
     <prefix>Ms</prefix>
     <given>Sally</given>
     <family>Grant</family>
    </name>

    <!-- Sex -->
    <administrativeGenderCode code="F"
     codeSystem="2.16.840.1.113883.13.68"
     codeSystemName="AS 5017-2006 Health Care Client Identifier Sex"
                    displayName="Female" />

    <!-- Date of Birth -->
    <birthTime value="19480607"/>

    <!-- Indigenous Status -->
    <ethnicGroupCode code="4" codeSystem="2.16.840.1.113883.3.879" codeSystemName="METeOR Indigenous Status"
     displayName="Neither Aboriginal nor Torres Strait Islander origin" />

    <!-- Multiple Birth Indicator -->
    <ext:multipleBirthInd value="true"/>
    <ext:multipleBirthOrderNumber value="2"/>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
     <ext:id assigningAuthorityName="IHI" root="1.2.36.1.2001.1003.0.8003608833357361"/>
```

```
    <ext:assigningGeographicArea classCode="PLC">
     <ext:name>National Identifier</ext:name>
    </ext:assigningGeographicArea>
   </ext:asEntityIdentifier>
  </patient>
 </patientRole>
</recordTarget>
<!-- End Patient - Header Part -->

…

  <!-- Begin CDA Body -->
  <component>
     <structuredBody>

        …

        <!-- Begin Section Administrative Observations -->
  <component><!-- [admin_obs] -->
   <section>
    <code code="102.16080"
      codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components"
      displayName="Administrative Observations"/>

    <title>Administrative Observations</title>

    <!-- Narrative text -->
    <text>
     <table>
      <tbody>
       <tr>
        <th>Date of Birth is Calculated From Age</th>
        <td>True</td>
       </tr>
       <tr>
        <th>Date of Birth Accuracy Indicator</th>
        <td>AAA</td>
       </tr>
       <tr>
        <th>Age</th>
        <td>54</td>
       </tr>
       <tr>
        <th>Age Accuracy Indicator</th>
        <td>True</td>
       </tr>
       <tr>
        <th>Birth Plurality</th>
        <td>3</td>
       </tr>
       <tr>
        <th>Australian Medicare Number</th>
        <td>123456789</td>
       </tr>

       ...

      </tbody>
     </table>
    </text>

    <!-- Begin Subject of Care – Body -->
    <!-- Begin Date of Birth is Calculated From Age -->
    <entry><!-- [calc_age] -->
```

```
 <observation classCode="OBS" moodCode="EVN">
  <id root="DA10C13E-EFD0-11DF-91AF-B5CCDFD72085"/>
  <code code="103.16233"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Date of Birth is Calculated From Age"/>
  <value value="true" xsi:type="BL"/>
 </observation>
</entry><!-- [calc_age] -->
<!-- End Date of Birth is Calculated From Age -->

<!-- Begin Date of Birth Accuracy Indicator-->
<entry><!-- [dob_acc] -->
 <observation classCode="OBS" moodCode="EVN">
  <id root="D253216C-EFD0-11DF-A686-ADCCDFD72085"/>
  <code code="102.16234"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Date of Birth Accuracy Indicator"/>
  <value code="AAA" xsi:type="CS"/>
 </observation>
</entry><!-- [dob_acc] -->
<!-- End Date of Birth Accuracy Indicator-->

<!-- Begin Age -->
<entry><!-- [age] -->
 <observation classCode="OBS" moodCode="EVN">
  <id root="CCF0D55C-EFD0-11DF-BEA2-A6CCDFD72085"/>
  <code code="103.20109"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Age"/>
  <value xsi:type="PQ" value="54" unit="a"/>
 </observation>
</entry><!-- [age] -->
<!-- End Age -->

<!-- Age Accuracy Indicator -->
<entry><!-- [age_acc] -->
 <observation classCode="OBS" moodCode="EVN">
  <id root="C629C9F4-EFD0-11DF-AA9E-96CCDFD72085"/>
  <code code="103.16279"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Age Accuracy Indicator"/>
  <value value="true" xsi:type="BL"/>
 </observation>
</entry><!-- [age_acc] -->

<!-- Birth Plurality -->
<entry><!-- [birth_plr] -->
 <observation classCode="OBS" moodCode="EVN">
  <id root="C1EE2646-EFD0-11DF-8D9C-95CCDFD72085"/>
  <code code="103.16249"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Birth Plurality"/>
  <value value="3" xsi:type="INT"/>
 </observation>
</entry><!-- [birth_plr] -->

 <!-- Begin Entitlement -->
 <ext:coverage2 typeCode="COVBY">
  <ext:entitlement classCode="COV" moodCode="EVN">
                          <ext:id assigningAuthorityName="Australian Medicare number" extension="12345678921" root="1.2.36.1.5001.1.0.7" />
```

```
        <ext:code code="1" codeSystem="1.2.36.1.2001.1001.101.104.16047" codeSystemName="NCTIS Entitlement Type Values" displayName="Medicare Benefits"/>
        <ext:effectiveTime>
         <high value="20110101"/>
        </ext:effectiveTime>
        <ext:participant typeCode="BEN">
         <ext:participantRole classCode="PAT">
          <ext:id root="7AA0BAAC-0CD0-11E0-9516-4350DFD72085" />
         </ext:participantRole>
        </ext:participant>
       </ext:entitlement>
      </ext:coverage2>
      <!-- End Entitlement -->

    <!-- End Patient – Body -->

    ...

   </section>

  </component>
  <!-- End Section Administrative Observations -->

  ...

     </structuredBody>
  </component>
  <!-- End CDA Body -->
</ClinicalDocument>
```

6.1.2 DOCUMENT AUTHOR

Identification

Name	DOCUMENT AUTHOR
Metadata Type	Data Group
Identifier	DG-10296

Relationships

Parent

Data Type	Name	Occurrences (child within parent)
	PCEHR PRESCRIPTION AND DISPENSE VIEW	1..1

CDA R-MIM Representation

Figure 6.5, “Document Author” shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The DOCUMENT AUTHOR data group is related to its context of ClinicalDocument by the author participation class. An author is a device in the role of assignedAuthor (AssignedAuthor class). The entity playing the role is assignedAuthorChoice (AuthoringDevice class). The entity identifier of the participant is mapped to the EntityIdentifier class (Australian CDA extension) and is associated to the assignedAuthorChoice.

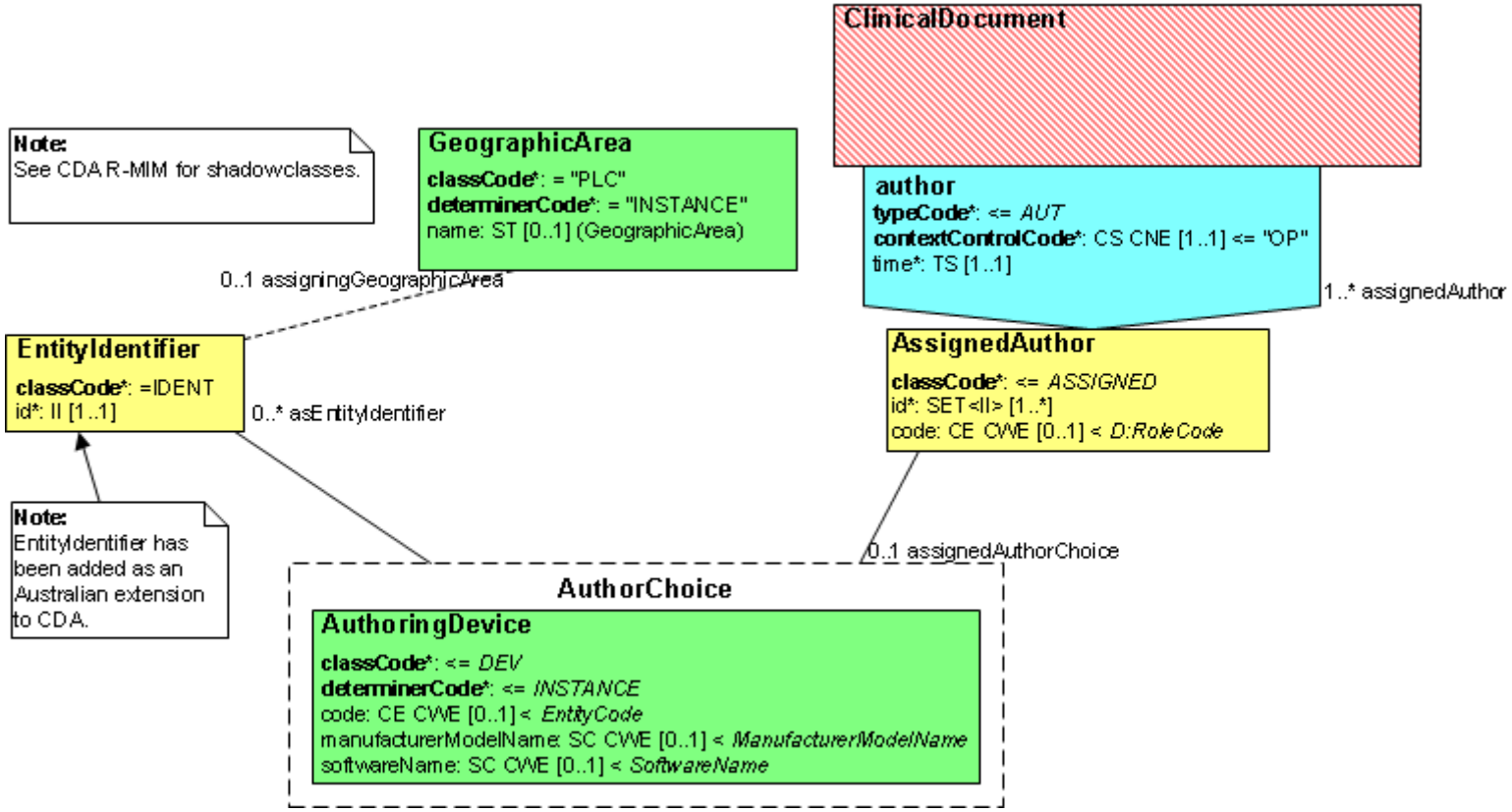

Figure 6.5. Document Author

CDA Mapping

Note

CDA mapping for 'Document Author' when 'Document Author > Participant > Person or Organisation or Device' instantiated as **'PERSON' (Non-healthcare Provider)**.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: ClinicalDocument		
Document Author	The device which composed the PCEHR Prescription and Dispense View.	1..1	**author**		
Document Author > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	n/a	Participation Type **SHALL** have an implementation-specific fixed value equivalent to "Document Author".	Not mapped directly, encompassed implicitly in author/typeCode="AUT" (optional, fixed value).
Document Author > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	author/**assignedAuthor/code**	Role SHALL have an implementation-specific fixed value equivalent to "Not Applicable"	n/a
n/a	n/a	1..1	author/assignedAuthor/**id**	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	Required CDA element.
Document Author > **Participant**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	author/assignedAuthor/**assignedAuthoringDevice**		
Document Author > Participant > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..*	author/assignedAuthor/assignedAuthoringDevice/**<Entity Identifier>**	The value of one Entity Identifier SHALL be a PAI-D	See common pattern: Entity Identifier.
Document Author > Participant > **Person or Organisation or Device**	Represents a choice to be made at run-time between PERSON, ORGANISATION and DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a DEVICE.	This logical NEHTA data component has no mapping to CDA. The cardinality of this component propagates to its children.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Document Author > Participant > Person or Organisation or Device > **Device**	Describes a device or software module of interest to, or involved in, the business of healthcare service provision.	1..1	n/a		Not mapped directly, encompassed implicitly in author/assignedAuthor/assignedAuthoringDevice.
Document Author > Participant > Person or Organisation or Device > Device > **Device Name**	The full name of the device.	1..1	author/assignedAuthor/assignedAuthoringDevice/**softwareName**		

Example 6.3. Document Author XML Fragment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >

    <!-- Begin CDA Header -->

  …
  <!-- Begin Document Author -->
  <author>

   <!-- DateTime Authored -->
   <time value="201110201235+1000" />

   <assignedAuthor>

    <!-- ID is used for system purposes such as matching -->
    <id root="7FCB0EC4-0CD0-11E0-9DFC-8F50D8572085" />

    <!-- The author code is not applicable  -->
    <code nullFlavor='NA'/>

    <!-- Participant -->
    <assignedAuthoringDevice>

     <!-- Device Name -->
     <softwareName>Software Name</softwareName>

     <!-- Entity Identifier -->
     <ext:asEntityIdentifier classCode="IDENT">
      <ext:id assigningAuthorityName="PAI-D" root="1.2.36.1.2001.1007.20.8003640003000026" />
     </ext:asEntityIdentifier>

    </assignedAuthoringDevice>

   </assignedAuthor>
  </author>
  <!-- End Document Author -->
     …
   <!-- End CDA Header -->

   <!-- Begin CDA Header -->
   <component>
      <structuredBody>

      …

      </structuredBody>
   </component>
   <!-- End CDA Header -->

</ClinicalDocument>
```

7 Content Data Specification - CDA Mapping

7.1 PCEHR PRESCRIPTION AND DISPENSE VIEW

Identification

Name	PCEHR PRESCRIPTION AND DISPENSE VIEW
Metadata Type	Structured Document
Identifier	SD-16789

Relationships:

Children Not Included in Mapping for This Section (Content Data Components)

Data Type	Name	Occurrence
	EXCLUSION STATEMENT	0..1
	Prescribing and Dispensing Reports (SUMMARIES OF MEDICATION ENTRIES)	0..1

CDA R-MIM Representation

Figure 7.1, “PCEHR Prescription and Dispense View” shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The PCEHR Prescription and Dispense View is composed of a ClinicalDocument, which is the entry point into the CDA R-MIM. The ClinicalDocument is associated with the bodyChoice through the component relationship. The structuredBody class represents a CDA document body that is comprised of one or more document sections.

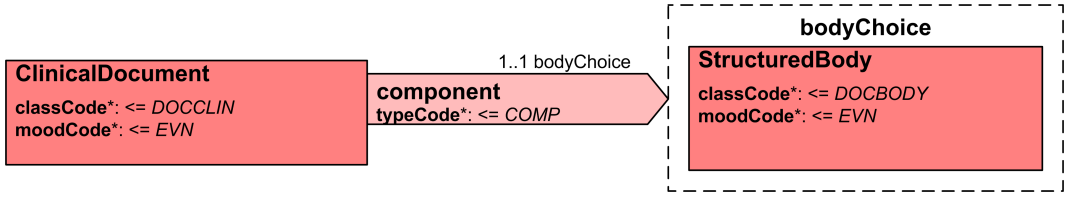

Figure 7.1. PCEHR Prescription and Dispense View

CDA Mapping

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements					
PCEHR Prescription and Dispense View	A collection of reports about prescribing and dispensing events for a subject of care.	1..1	**ClinicalDocument**		
CDA Body Level 2 Data Elements					
PCEHR Prescription and Dispense View (Body)	See above.	1..1	ClinicalDocument/**component/structuredBody**		Each instance of this composition **SHALL** have one instance of EXCLUSION STATEMENT or one instance of 'Prescribing and Dispensing Reports' but not instances of both.

Example 7.1. PCEHR Prescription and Dispense View Body XML Fragment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >

   …

   <!-- Begin CDA Header -->

   …

   <!-- End CDA Header -->

   <!-- Begin CDA Body -->
   <component>
      <structuredBody>

      …

      </structuredBody>
   </component>
   <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.1 EXCLUSION STATEMENT

Identification

Name	EXCLUSION STATEMENT
Metadata Type	Data Group
Identifier	DG-16134

Relationships

Parent

Data Type	Name	Occurrences (child within parent)
	PCEHR PRESCRIPTION AND DISPENSE VIEW	0..1

CDA R-MIM Representation

Figure 7.2, “EXCLUSION STATEMENT” shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The EXCLUSION STATEMENT data group is represented by an observation class and is related to its containing section by an entry relationship.

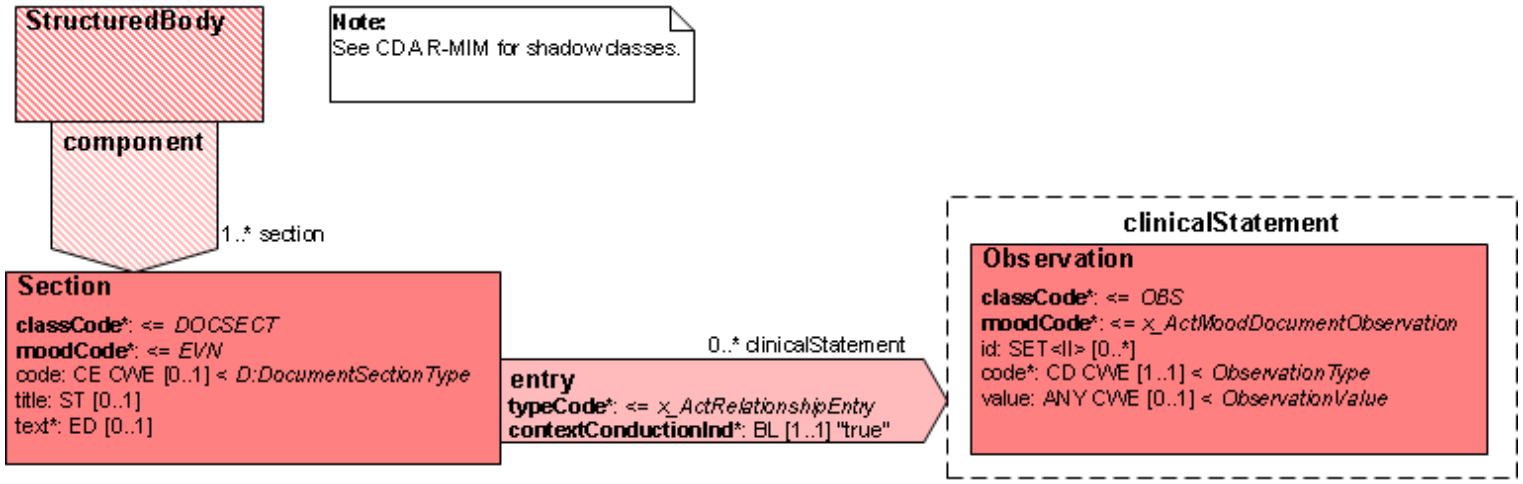

Figure 7.2. EXCLUSION STATEMENT

CDA Mapping

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: ClinicalDocument/component/structuredBody		
EXCLUSION STATEMENT	An explicit statement about the absence of reports of prescribing and dispensing.	0..1	**component[npdv_exc_statement]/section**		
			component[npdv_exc_statement]/section/**code**		
			component[npdv_exc_statement]/section/code/**@code="102.16134.179.1.1"**		
			component[npdv_exc_statement]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[npdv_exc_statement]/section/code/**@codeSystemName="NCTIS Data Components"**		
			component[npdv_exc_statement]/section/code/**@displayName="Exclusion Statement"**		
			component[npdv_exc_statement]/section/**title**	The title **SHALL** be an implementation specific value as specified in the PCEHR Prescription and Dispense View - CDA Rendering Guide	
			component[npdv_exc_statement]/section/**text**		See Appendix A, *CDA Narratives*
CDA Body Level 3 Data Elements			Context: ClinicalDocument/component/structuredBody/component[npdv_exc_statement]/section		
General Statement	A general statement about the absence or exclusion of data values.	1..1	entry[gnl_stat]/**observation**		
			entry[gnl_stat]/observation/**@classCode="OBS"**		
			entry[gnl_stat]/observation/**@moodCode="EVN"**		
			entry[gnl_stat]/observation/**id**	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	See <id> for available attributes.
			entry[gnl_stat]/observation/**code**		
			entry[gnl_stat]/observation/code/**@code="103.16135.179.1.1"**		
			entry[gnl_stat]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[gnl_stat]/observation/code/**@codeSystemName="NCTIS Data Components"**		
			entry[gnl_stat]/observation/code/**@displayName="General Statement"**		
			entry[gnl_stat]/observation/**value:ST**		

Example 7.2. EXCLUSION STATEMENT XML Fragment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
   <!-- Begin CDA Header -->

   …

   <!-- End CDA Header -->

 <!-- Begin CDA Body -->
 <component>
    <structuredBody>

     ...

      <!-- Begin PCEHR Prescription and Dispense View Exclusion Statement (EXCLUSION STATEMENT) -->
   <component>
    <section>
     <code code="102.16134.179.1.1" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components"
      displayName="Exclusion Statement" />
     <title>Overview</title>
     <text>No Information Available</text>

     <!-- Begin Exclusion Statement - General Statement -->
     <entry>
      <observation classCode="OBS" moodCode="EVN">
       <!-- ID is used for system purposes such as matching -->
       <id root="D1645208-09A6-11E1-8B51-296A4824019B"/>
       <code code="103.16135.179.1.1" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="General Statement" />
       <value xsi:type="ST">No Information Available</value>
      </observation>
     </entry>
     <!-- End Exclusion Statement - General Statement -->

    </section>
   </component>
   <!-- End PCEHR Prescription and Dispense View Exclusion Statement (EXCLUSION STATEMENT) -->

    ...

    </structuredBody>
 <component>
   <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.2 Prescribing and Dispensing Reports (SUMMARIES OF MEDICATION ENTRIES)

Identification

Name	Prescribing and Dispensing Reports (SUMMARIES OF MEDICATION ENTRIES)
Metadata Type	Section
Identifier	S-16794

Relationships

Parent

Data Type	Name	Occurrences (child within parent)
	PCEHR PRESCRIPTION AND DISPENSE VIEW	0..1

Child

Data Type	Name	Occurrence
	MEDICATION ENTRIES WITH SUMMARY	1..*

CDA R-MIM Representation

Figure 7.3, “Prescribing and Dispensing Reports (SUMMARIES OF MEDICATION ENTRIES)” shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The Prescribing and Dispensing Reports (SUMMARIES OF MEDICATION ENTRIES) data group is represented by an observation class and is related to its containing section by an entry relationship.

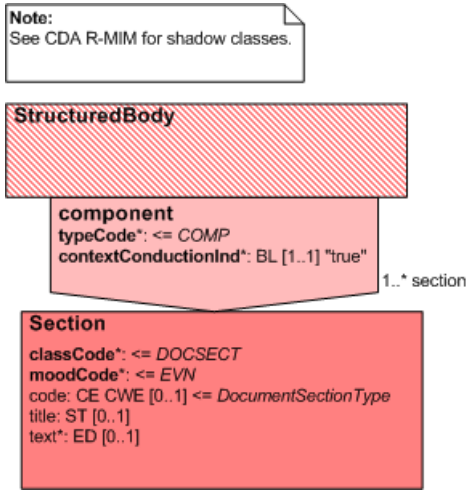

Figure 7.3. Prescribing and Dispensing Reports (SUMMARIES OF MEDICATION ENTRIES)

CDA Mapping

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: ClinicalDocument/component/structuredBody/		
Prescribing and Dispensing Reports (SUMMARIES OF MEDICATION ENTRIES)	Reports of prescribing and dispensing.	0..1	**component[pdv_pres_and_disp_reports]/section**		
			component[pdv_pres_and_disp_reports]/section/**code**		
			component[pdv_pres_and_disp_reports]/section/code/**@code="101.16794"**		
			component[pdv_pres_and_disp_reports]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[pdv_pres_and_disp_reports]/section/code/**@codeSystemName="NCTIS Data Components"**		
			component[pdv_pres_and_disp_reports]/section/code/**@displayName="Prescribing and Dispensing Reports"**		
			component[pdv_pres_and_disp_reports]/section/**title**	The title **SHALL** be an implementation specific value as specified in the PCEHR Prescription and Dispense View - CDA Rendering Guide	
			component[pdv_pres_and_disp_reports]/section/**text**		See Appendix A, *CDA Narratives*
SUMMARY OF MEDICATION ENTRIES > **MEDICATION ENTRIES WITH SUMMARY**	A collection of information about prescriptions and dispense events together with a summary.	1..*	See: MEDICATION ENTRIES WITH SUMMARY		

Example 7.3. Prescribing and Dispensing Reports (SUMMARIES OF MEDICATION ENTRIES) XML Fragment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
   <!-- Begin CDA Header -->

   …

   <!-- End CDA Header -->

 <!-- Begin CDA Body -->
 <component>
    <structuredBody>

     ...

      <!-- Begin Prescribing and Dispensing Reports (SUMMARY OF MEDICATION ENTRIES) -->
   <component>
    <section>
     <code code="101.16794" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components"
      displayName="Prescribing and Dispensing Reports" />
     <title>Prescribing and Dispensing Reports (SUMMARY OF MEDICATION ENTRIES)</title>
     <text>Summary of Medication Entries narrative text goes here...</text>

     ...

    </section>
   </component>
   <!-- End Prescribing and Dispensing Reports (SUMMARY OF MEDICATION ENTRIES) -->

    ...

    </structuredBody>
 <component>
   <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.2.1 MEDICATION ENTRIES WITH SUMMARY

Identification

Name	MEDICATION ENTRIES WITH SUMMARY
Metadata Type	Section
Identifier	S-16795

Relationships

Parent

Data Type	Name	Occurrences (child within parent)
	Prescribing and Dispensing Reports (SUMMARIES OF MEDICATION ENTRIES)	1..*

Children

Data Type	Name	Occurrence
	SUMMARY OF MEDICATION ENTRIES	1..1
	MEDICATION ENTRY	1..*

CDA R-MIM Representation

Figure 7.4, “MEDICATION ENTRIES WITH SUMMARY” shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The MEDICATION ENTRIES WITH SUMMARY data group is represented by an observation class and is related to its containing section by an entry relationship.

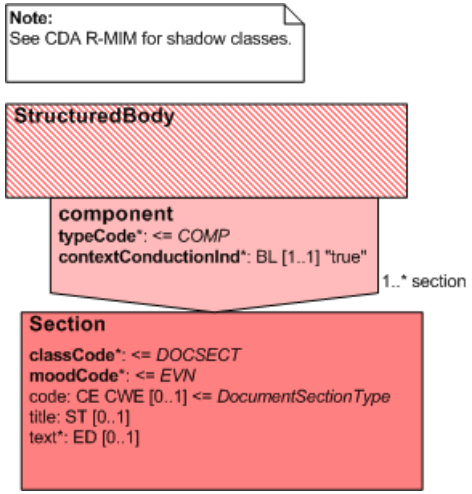

Figure 7.4. MEDICATION ENTRIES WITH SUMMARY

CDA Mapping

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: ClinicalDocument/component/structuredBody/component[pdv_pres_and_disp_reports]/section/		
MEDICATION ENTRIES WITH SUMMARY	A collection of information about prescriptions and dispense events together with a summary.	1..*	*component[sme_med_ent_with_summary]/section/*		
			component[sme_med_ent_with_summary]/section/**code**		
			component[sme_med_ent_with_summary]/section/code/**@code="101.16795"**		
			component[sme_med_ent_with_summary]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[sme_med_ent_with_summary]/section/code/**@codeSystemName="NCTIS Data Components"**		
			component[sme_med_ent_with_summary]/section/code/**@displayName="MEDICATION ENTRIES WITH SUMMARY"**		
			component[sme_med_ent_with_summary]/section/**title**	The title **SHALL** be an implementation specific value as specified in the PCEHR Prescription and Dispense View - CDA Rendering Guide	
MEDICATION ENTRIES WITH SUMMARY > **SUMMARY OF MEDICATION ENTRIES**	Summary of information contained in a set of medication entries.	1..1	See: SUMMARY OF MEDICATION ENTRIES		
MEDICATION ENTRY > **SUMMARY OF MEDICATION ENTRIES**	A collection of information about prescriptions and dispense events.	1..*	See: MEDICATION ENTRY		There **SHALL** be at most one instance of MEDICATION ENTRY which is instantiated as a Prescription Item (MEDICATION INSTRUCTION)

Example 7.4. MEDICATION ENTRIES WITH SUMMARY XML Fragment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
   <!-- Begin CDA Header -->

   …

   <!-- End CDA Header -->

 <!-- Begin CDA Body -->
 <component>
    <structuredBody>

     ...

      <!-- Begin MEDICATION ENTRIES WITH SUMMARY -->
   <component>
    <section>
     <code code="101.16795" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components"
      displayName="Medication Entries with Summary" />
     <title>Medication Entries with Summary</title>
     <!-- Begin SUMMARY OF MEDICATION ENTRIES -->
     <component>
      <section>
       <code code="102.16798" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Medication Entries with Summary" />
       <title>Medication Entries with Summary</title>
       ...
      </section>
   </component>
   <!-- End SUMMARY OF MEDICATION ENTRIES  -->
     ...

    </section>
   </component>
   <!-- End MEDICATION ENTRIES WITH SUMMARY -->

    ...

    </structuredBody>
 <component>
   <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.2.1.1 SUMMARY OF MEDICATION ENTRIES

Identification

Name	SUMMARY OF MEDICATION ENTRIES
Metadata Type	Data Group
Identifier	DG-16798

Relationships

Parent

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

CDA R-MIM Representation

Figure 7.5, “SUMMARY OF MEDICATION ENTRIES” shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The Data Elements of SUMMARY OF MEDICATION ENTRIES data group are represented by observation classes, which are grouped together by an organizer class that is related to its containing section by an entry class.

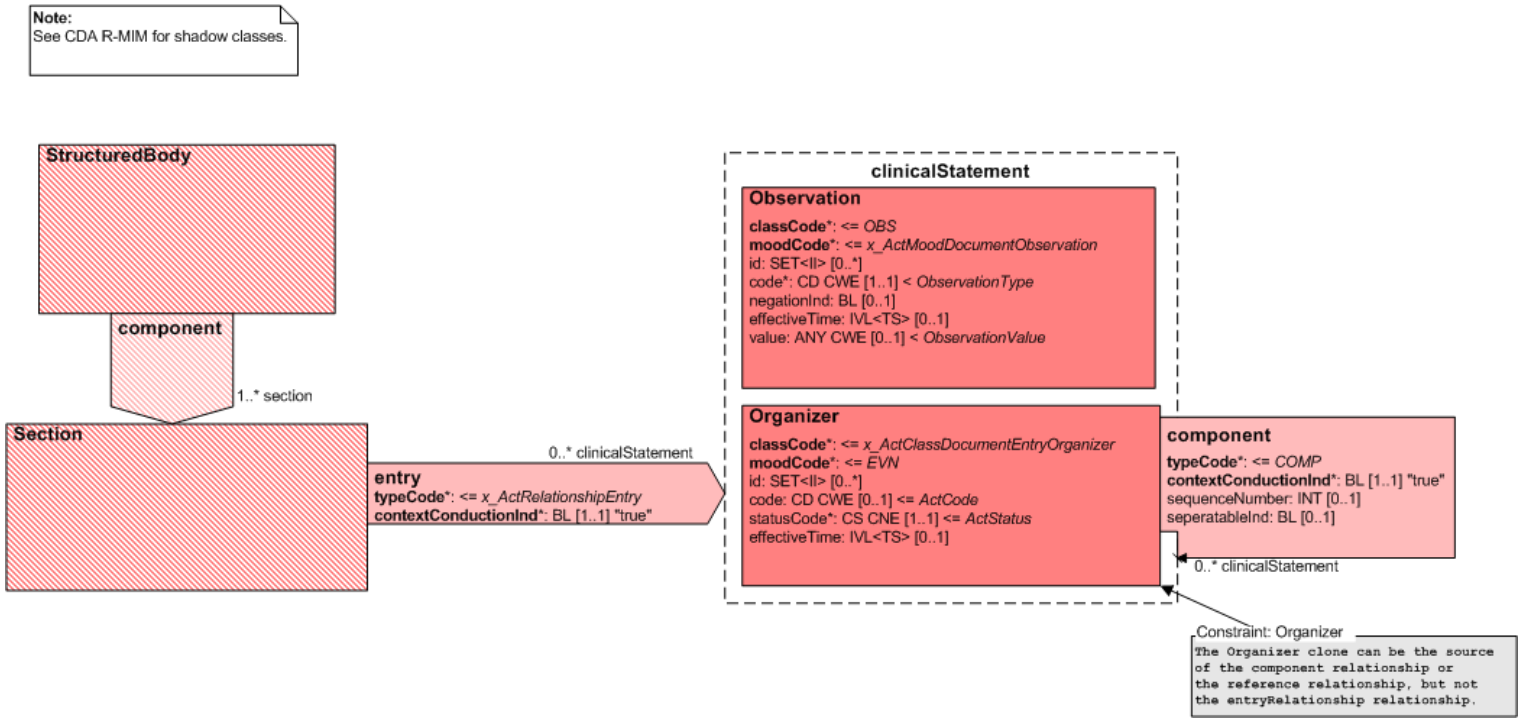

Figure 7.5. SUMMARY OF MEDICATION ENTRIES

CDA Mapping

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: ClinicalDocument/component/structuredBody/component[pdv_pres_and_disp_reports]/section/component[sme_med_ent_with_summary]/section/		
SUMMARY OF MEDICATION ENTRIES	Summary of information contained in a set of medication entries.	1..1	**entry/organizer**		
			entry/organizer/**@classCode="CLUSTER"**		
			entry/organizer/**@moodCode="EVN"**		
			entry/organizer/**statusCode="completed"**		
			entry/organizer/**code**		
			entry/organizer/code/**@code="102.16798"**		
			entry/organizer/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry/organizer/code/**@codeSystemName="NCTIS Data Components"**		
			entry/organizer/code/**@displayName="SUMMARY OF MEDICATION ENTRIES"**		
			Context: ClinicalDocument/component/structuredBody/component[pdv_pres_and_disp_reports]/section/component[sme_med_ent_with_summary]/section/entry/organizer/		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SUMMARY OF MEDICATION ENTRIES > **Therapeutic Good Identification**	The medicine, vaccine or other therapeutic good being ordered, administered to or used by the subject of care.	1..1	**component[npdv_ther_good_id]/observation**		
			component[npdv_ther_good_id]/observation/**@classCode="OBS"**		
			component[npdv_ther_good_id]/observation/**@moodCode="EVN"**		
			component[npdv_ther_good_id]/observation/**code**		
			component[npdv_ther_good_id]/observation/code/**@code="103.10194"**		
			component[npdv_ther_good_id]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[npdv_ther_good_id]/observation/code/**@codeSystemName="NCTIS Data Components"**		
			component[npdv_ther_good_id]/observation/code/**@displayName="Therapeutic Good Identification"**		
			component[npdv_ther_good_id]/observation/**value:CD**		
			component[npdv_ther_good_id]/observation/value		See <code> for available attributes.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
				Where the Therapeutic Good Identification can be identified by an Australian Medicines Terminology (AMT) concept, this **SHOULD** be represented by the AMT ConceptID and Preferred Term. The permissible values are the members of the following AMT reference sets • 929360081000036101 Medicinal product pack reference set • 929360071000036103 Medicinal product unit of use reference set • 929360041000036105 Trade product pack reference set • 929360031000036100 Trade product unit of use reference set • 929360051000036108 Containered trade product pack reference set For items without an AMT code the value from 'PBS Item Code' **SHOULD** be used. When a suitable 'AMT' code becomes available or system/user has chosen value from AMT code, they **SHOULD** be used and the usage of 'PBS Item Code' **SHOULD** be deprec-	

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
				ated.	
SUMMARY OF MEDICATION ENTRIES > **DateTime Prescription Written (DateTime Earliest Prescription Written)**	The date and, optionally, time when the earliest prescription in a set was written.	0..1	**component[npdv_time_pres_written]/observation**		
			component[npdv_time_pres_written]/observation/**@classCode="OBS"**		
			component[npdv_time_pres_written]/observation/**@moodCode="EVN"**		
			component[npdv_time_pres_written]/observation/**code**		
			component[npdv_time_pres_written]/observation/code/**@code="103.16799"**		
			component[npdv_time_pres_written]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[npdv_time_pres_written]/observation/code/**@codeSystemName="NCTIS Data Components"**		
			component[npdv_time_pres_written]/observation/code/**@displayName="DateTime Prescription Written"**		
			component[npdv_time_pres_written]/observation/**value:TS**		
			component[npdv_time_pres_written]/observation/value/**@value**		This is a simple Date with an optional time value. See <time> for available attributes.
SUMMARY OF MEDICATION ENTRIES > **DateTime of Earliest Dispense Event**	The date and, optionally, time when the earliest dispense event in a set occurred.	0..1	**component[npdv_time_earliest_dispense_event]/observation**		
			component[npdv_time_earliest_dispense_event]/observation/**@classCode="OBS"**		
			component[npdv_time_earliest_dispense_event]/observation/**@moodCode="EVN"**		
			component[npdv_time_earliest_dispense_event]/observation/**code**		
			component[npdv_time_earliest_dispense_event]/observation/code/**@code="103.16801"**		
			component[npdv_time_earliest_dispense_event]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[npdv_time_earliest_dispense_event]/observation/code/**@codeSystemName="NCTIS Data Components"**		
			component[npdv_time_earliest_dispense_event]/observation/code/**@displayName="DateTime of Earliest Dispense Event"**		
			component[npdv_time_earliest_dispense_event]/observation/**value:TS**		
			component[npdv_time_earliest_dispense_event]/observation/value/**@value**		This is a simple Date with an optional time value. See <time> for available attributes.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SUMMARY OF MEDICATION ENTRIES > **DateTime of Latest Dispense Event**	The date and, optionally, time when the latest dispense event in a set occurred.	0..1	**component[npdv_time_last_dispense_event]/observation**		
			component[npdv_time_last_dispense_event]/observation/**@classCode="OBS"**		
			component[npdv_time_last_dispense_event]/observation/**@moodCode="EVN"**		
			component[npdv_time_last_dispense_event]/observation/**code**		
			component[npdv_time_last_dispense_event]/observation/code/**@code="103.16802"**		
			component[npdv_time_last_dispense_event]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[npdv_time_last_dispense_event]/observation/code/**@codeSystemName="NCTIS Data Components"**		
			component[npdv_time_last_dispense_event]/observation/code/**@displayName="DateTime of Latest Dispense Event"**		
			component[npdv_time_last_dispense_event]/observation/**value:TS**		
			component[npdv_time_last_dispense_event]/observation/value/**@value**		This is a simple Date with an optional time value. See <time> for available attributes.
SUMMARY OF MEDICATION ENTRIES > **Total Number of Known Supplies**	The total number of times a therapeutic good was supplied in accordance with a set of dispense records.	0..1	**component[npdv_nbr_known_supplies]/observation**		
			component[npdv_nbr_known_supplies]/observation/**@classCode="OBS"**		
			component[npdv_nbr_known_supplies]/observation/**@moodCode="EVN"**		
			component[npdv_nbr_known_supplies]/observation/**code**		
			component[npdv_nbr_known_supplies]/observation/code/**@code="103.16804"**		
			component[npdv_nbr_known_supplies]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[npdv_nbr_known_supplies]/observation/code/**@codeSystemName="NCTIS Data Components"**		
			component[npdv_nbr_known_supplies]/observation/code/**@displayName="Total Number of Known Supplies"**		
			component[npdv_nbr_known_supplies]/observation/**value:INT**		
			component[npdv_nbr_known_supplies]/observation/value/**@value**		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SUMMARY OF MEDICATION ENTRIES > **Maximum Number of Permitted Supplies**	The maximum number of times a therapeutic good may be supplied in accordance with a set of prescriptions.	0..1	**component[npdv_max_nbr_of_supplies]/observation**		
			component[npdv_max_nbr_of_supplies]/observation/**@classCode="OBS"**		
			component[npdv_max_nbr_of_supplies]/observation/**@moodCode="EVN"**		
			component[npdv_max_nbr_of_supplies]/observation/**code**		
			component[npdv_max_nbr_of_supplies]/observation/code/**@code="103.16805"**		
			component[npdv_max_nbr_of_supplies]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[npdv_max_nbr_of_supplies]/observation/code/**@codeSystemName="NCTIS Data Components"**		
			component[npdv_max_nbr_of_supplies]/observation/code/**@displayName="Maximum Number of Permitted Supplies"**		
			component[npdv_max_nbr_of_supplies]/observation/**value:INT**		
			component[npdv_max_nbr_of_supplies]/observation/value/**@value**		

Example 7.5. SUMMARY OF MEDICATION ENTRIES XML Fragment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
   <!-- Begin CDA Header -->

   …

   <!-- End CDA Header -->

 <!-- Begin CDA Body -->
 <component>
    <structuredBody>

     ...

   <component>
    <section>
     <code code="101.16794" codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components"
      displayName="Prescribing and Dispensing Reports"/>
     <title>Prescribing and Dispensing Reports (SUMMARY OF MEDICATION
      ENTRIES)</title>
     <!-- Begin MEDICATION ENTRIES WITH SUMMARY -->
     <component>
      <section>
       <code code="101.16795" codeSystem="1.2.36.1.2001.1001.101"
        codeSystemName="NCTIS Data Components"
        displayName="Medication Entries with Summary"/>
       <title>Medication Entries with Summary</title>
       <text>Medication Entries with Summary narrative text goes here...</text>
       <!-- Begin SUMMARY OF MEDICATION ENTRIES -->

       <entry>
        <organizer classCode="CLUSTER" moodCode="EVN">
         <code code="102.16798" codeSystem="1.2.36.1.2001.1001.101"
          codeSystemName="NCTIS Data Components"
          displayName="Summary of Medication Entries"/>
         <statusCode code="completed"/>

         <!-- Therapeutic Good Identification -->
         <component>
          <observation classCode="OBS" moodCode="EVN">
           <code code="103.10194"
            codeSystem="1.2.36.1.2001.1001.101"
            codeSystemName="NCTIS Data Components"
            displayName="Therapeutic Good Identification"/>
           <value xsi:type="CD">
            <originalText>Panadeine Forte 500mg/30mg Tablets 20
            (Paracetamol/Codeine Phosphate)</originalText>
           </value>
          </observation>
         </component>

         <!-- DateTime Earliest Prescription Written -->
         <component>
```

```
          <observation classCode="OBS" moodCode="EVN">
           <code code="103.16799"
            codeSystem="1.2.36.1.2001.1001.101"
            codeSystemName="NCTIS Data Components"
            displayName="DateTime Earliest Prescription Written"/>
           <value xsi:type="TS" value="201201011459"/>
          </observation>
         </component>

         <!-- DateTime of Earliest Dispense Event -->
         <component>
          <observation classCode="OBS" moodCode="EVN">
           <code code="103.16801"
            codeSystem="1.2.36.1.2001.1001.101"
            codeSystemName="NCTIS Data Components"
            displayName="DateTime of Earliest Dispense Event"/>
           <value xsi:type="TS" value="201201011459"/>
          </observation>
         </component>

         <!-- DateTime of Latest Dispense Event -->
         <component>
          <observation classCode="OBS" moodCode="EVN">
           <code code="103.16802"
            codeSystem="1.2.36.1.2001.1001.101"
            codeSystemName="NCTIS Data Components"
            displayName="DateTime of Latest Dispense Event"/>
           <value xsi:type="TS" value="201201011459"/>
          </observation>
         </component>

         <!-- Total Number of Known Supplies -->
         <component>
          <observation classCode="OBS" moodCode="EVN">
           <code code="103.16804"
            codeSystem="1.2.36.1.2001.1001.101"
            codeSystemName="NCTIS Data Components"
            displayName="Total Number of Known Supplies"/>
           <value xsi:type="INT" value="3"/>
          </observation>
         </component>

         <!-- Maximum Number of Permitted Supplies -->
         <component>
          <observation classCode="OBS" moodCode="EVN">
           <code code="103.16804"
            codeSystem="1.2.36.1.2001.1001.101"
            codeSystemName="NCTIS Data Components"
            displayName="Maximum Number of Permitted Supplies"/>
           <value xsi:type="INT" value="5"/>
          </observation>
         </component>

        </organizer>
       </entry>
       <!-- End MEDICATION ENTRIES WITH SUMMARY -->
      </section>
     </component>

    ...
     <!-- End Prescribing and Dispensing Reports (SUMMARY OF MEDICATION ENTRIES) -->
    </section>
   </component>
   </structuredBody>
<component>
```

```
   <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.2.1.2 MEDICATION ENTRY

Identification

Name	MEDICATION ENTRY
Metadata Type	Choice
Identifier	C-16796

Relationships

Parent

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

Children

Data Type	Name	Occurrence
	Dispense Item (MEDICATION ACTION)	0..1
	Prescription Item (MEDICATION INSTRUCTION)	0..1

CDA Mapping

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: ClinicalDocument/component/structuredBody/component[pdv_pres_and_disp_reports]/section/component[sme_med_ent_with_summary]/section/		
MEDICATION ENTRY	A run-time choice to be made between a 'Prescription Entry' and a 'Dispense Entry'.	1..*	n/a		Exactly one 'Prescription Item (MEDICATION INSTRUCTION)' OR exactly one 'Dispense Item (MEDICATION ACTION)' SHALL be present per instance of the parent choice ('MEDICATION ENTRY').
MEDICATION ENTRY > **Dispense Item (MEDICATION ACTION)**	Details of the dispensing and supply of a therapeutic good, including its use by a subject of care and related information.	0..1	See: Dispense Item (MEDICATION ACTION)		
MEDICATION ENTRY > **Prescription Item (MEDICATION INSTRUCTION)**	Details of a therapeutic good with its use by a subject of care and related information.	0..1	See: Prescription Item (MEDICATION INSTRUCTION)		

7.1.2.1.2.1 Dispense Item (MEDICATION ACTION)

Identification

Name	Dispense Item (MEDICATION ACTION)
Metadata Type	Data Group
Identifier	DG-16210

Relationships

Parent

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

Children

Data Type	Name	Occurrence
	Dispense Record Link (LINK)	1..1
	Prescription Item Link (LINK)	0..1

CDA R-MIM Representation

Figure 7.6, “Dispense Item” shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

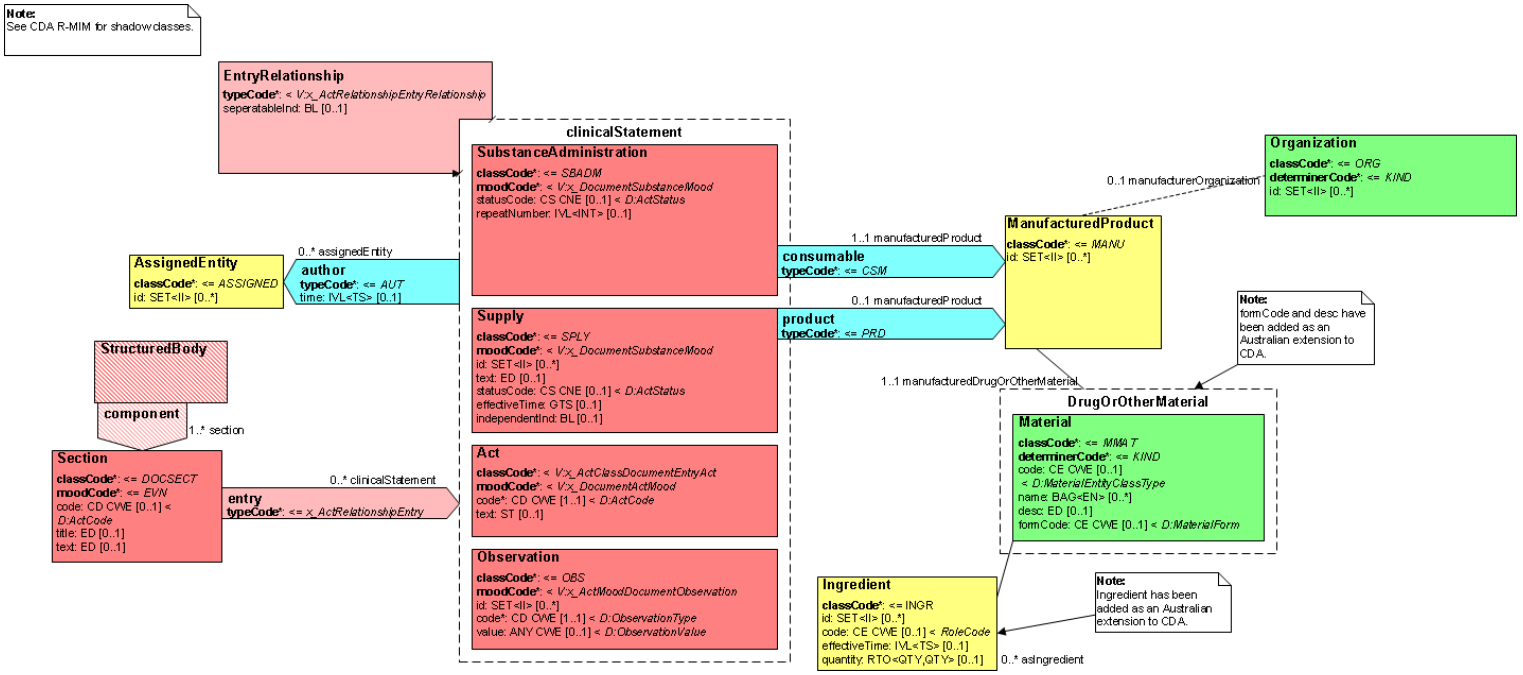

Figure 7.6. Dispense Item

CDA Mapping

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: ClinicalDocument/component/structuredBody/component[pdv_pres_and_disp_reports]/section/component[sme_med_ent_with_summary]/section/		
Dispense Item (MEDICATION ACTION)	Details of the dispensing and supply of a therapeutic good, including its use by a subject of care and related information.	0..1	**component[disp_item]/section/code**		
			component[disp_item]/section/code/**@code="102.16210"**		
			component[disp_item]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[disp_item]/section/code/**@codeSystemName="NCTIS Data Components"**		
			component[disp_item]/section/code/**@displayName="Dispense Item"**		
			component[disp_item]/section/**title="Dispense Item"**		
			component[disp_item]/section/**text**		See Appendix A, *CDA Narratives*
CDA Body Level 3 Data Elements			Context: ClinicalDocument/component/structuredBody/component[pdv_pres_and_disp_reports]/section/component[sme_med_ent_with_summary]/section/component[disp_item]/section/		
		1..1	**entry[sbadm]**		
			entry[sbadm]/**substanceAdministration**		
			entry[sbadm]/substanceAdministration/**@classCode="SBADM"**		
			entry[sbadm]/substanceAdministration/**@moodCode="RQO"**		
			entry[sbadm]/substanceAdministration/**entryRelationship[sply]**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/**@typeCode="COMP"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/**supply**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/**@moodCode="EVN"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/**independentInd**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/independentInd/**@value="false"**		
			entry[sbadm]/substanceAdministration/**statusCode/@code**	'active' or 'completed'	‘active’ if there are more repeats to be dispensed. ‘completed’ if the last repeat has been dispensed
			entry[sbadm]/substanceAdministration/**consumable/manufacturedProduct/manufacturedMaterial**		Included for CDA conformance only

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Dispense Item (MEDICATION ACTION) > **Therapeutic Good Identification**	The medicine, vaccine or other therapeutic good which was the focus of the action.	1..1	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/**product/manufacturedProduct/manufacturedMaterial/code**		See <code> for available attributes.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
				Where the Therapeutic Good Identification can be identified by an Australian Medicines Terminology (AMT) concept, this **SHOULD** be represented by the AMT ConceptID and Preferred Term. The permissible values are the members of the following AMT reference sets • 929360081000036101 Medicinal product pack reference set • 929360071000036103 Medicinal product unit of use reference set • 929360041000036105 Trade product pack reference set • 929360031000036100 Trade product unit of use reference set • 929360051000036108 Containered trade product pack reference set For items without an AMT code the value from 'PBS Item Code' **SHOULD** be used. When a suitable 'AMT' code becomes available or system/user has chosen value from AMT code, they **SHOULD**	

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
				be used and the usage of 'PBS Item Code' **SHOULD** be deprecated. If a text description is provided, this **SHOULD** include the name of the medication (brand name or generic name equivalent), strength and dose form, where appropriate. Note: If Therapeutic Good Identification contains a PBS Item Code, use the PBS Manufacturer Code data element to record the Manufacturer Code.	
Dispense Item (MEDICATION ACTION) > **Therapeutic Good Strength (Additional Therapeutic Good Detail)**	Information concerning the strength of the Therapeutic Good.	0..1	entry[sbadm]/substanceAdministration/**entryRelationship[strength]**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/**@typeCode='COMP'**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/**act**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/**@classCode="INFRM"**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/**@moodCode="EVN"**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/**code**		See <code> for available attributes.
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/**@code="103.16769.171.1.1"**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/**@codeSystemName="NCTIS Data Components"**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/**@displayName="Therapeutic Good Strength"**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/**text**	This **SHALL NOT** contradict the value of Therapeutic Good Identification	

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Dispense Item (MEDICATION ACTION) > **Therapeutic Good Generic Name (Additional Therapeutic Good Detail)**	The generic name of the Therapeutic Good.	0..1	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/product/manufacturedProduct/manufacturedMaterial/**name**	This **SHALL NOT** contradict the value of Therapeutic Good Identification	
Dispense Item (MEDICATION ACTION) > **Additional Dispensed Item Description (Additional Therapeutic Good Detail)**	Extra information about the therapeutic good.	0..1	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/product/manufacturedProduct/manufacturedMaterial/**ext:desc**	This **SHALL NOT** contradict the value of Therapeutic Good Identification	
Dispense Item (MEDICATION ACTION) > **Label Instruction (Medication Action Instructions)**	Any instructions given to the subject of care or carer at the time of the dispense event.	0..1	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/**entryRelationship[label]**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[label]/**@typeCode="COMP"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[label]/**act**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[label]/act/**@classCode="INFRM"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[label]/act/**@moodCode="EVN"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[label]/act/**code**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[label]/act/code/**@code="103.16109"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[label]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[label]/act/code/**@codesystemName="NCTIS Data Components"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[label]/act/code/**@displayName="Label Instruction"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[label]/act/**text:ST**		
Dispense Item (MEDICATION ACTION) > **Formula**	The recipe for compounding a medicine.	0..1	entry[sbadm]/substanceAdministration/**entryRelationship[form]**		
			entry[sbadm]/substanceAdministration/entryRelationship[form]/**@typeCode="COMP"**		
			entry[sbadm]/substanceAdministration/entryRelationship[form]/**act**		
			entry[sbadm]/substanceAdministration/entryRelationship[form]/act/**@classCode="INFRM"**		
			entry[sbadm]/substanceAdministration/entryRelationship[form]/act/**@moodCode="EVN"**		
			entry[sbadm]/substanceAdministration/entryRelationship[form]/act/**code**	10 *Vocabularies/Code Sets*	See <code> for available attributes.
			entry[sbadm]/substanceAdministration/entryRelationship[form]/act/**text**		
Dispense Item (MEDICATION ACTION) > **Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)**	Detailed information about the ingredient(s) including form and strength.	0..1	n/a		This logical NEHTA data component has no mapping to CDA.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Dispense Item (MEDICATION ACTION) > Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION) > **Form**	The formulation or presentation of the overall substance.	1..1	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/product/manufacturedProduct/manufacturedMaterial/**ext:formCode**	Medication Form Reference Set SNOMED CT-AU Concept Id: 32570621000036105	Values might include: Tablets, Capsules, Sachets, etc... See <code> for available attributes.
Dispense Item (MEDICATION ACTION) > **Quantity Dispensed (AMOUNT OF MEDICATION)**	The quantity of medicine, vaccine or other therapeutic good which was dispensed.	0..1	n/a		This logical NEHTA data component has no mapping to CDA.
Dispense Item (MEDICATION ACTION) > Quantity Dispensed (AMOUNT OF MEDICATION) > **Quantity Description**	Free text description of the amount which may consist of the quantity and dose unit.	1..1	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/**entryRelationship[qty_desc]**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/**@typeCode="COMP"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/**act**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/**@classCode="INFRM"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/**@moodCode="EVN"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/**code**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/code/**@code='246205007'**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/code/**@codeSystem='2.16.840.1.113883.6.96'**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/code/**@codeSystemName='SNOMED CT-AU'**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/code/**@displayName='Quantity'**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/**text**		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Dispense Item (MEDICATION ACTION) > **Comment (Medication Action Comment)**	Any additional information that may be needed to ensure the continuity of supply, proper use, or appropriate medication management.	0..1	entry[sbadm]/substanceAdministration/**entryRelationship[cmts]**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/**@typeCode="COMP"**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/**act**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/**@classCode="INFRM"**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/**@moodCode="EVN"**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/**code**	Additional Comments 10 *Vocabularies/Code Sets*	
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/code/**@code="103.16044"**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/code/**@codeSystemName="NCTIS Data Components"**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/code/**@displayName="Additional Comments"**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/**text**		
Dispense Item (MEDICATION ACTION) > **Brand Substitution Occurred**	A different brand of the same medicine, vaccine or other therapeutic good was substituted for the one nominated in the order.	0..1	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/**entryRelationship[brand]**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[brand]/**@typeCode="COMP"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[brand]/**observation**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[brand]/observation/**@classCode="OBS"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[brand]/observation/**@moodCode="EVN"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[brand]/observation/**code**	Brand Substitution Occurred 10 *Vocabularies/Code Sets*	See <code> for available attributes.
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[brand]/observation/**value:BL**		
Dispense Item (MEDICATION ACTION) > **Number of this Dispense**	A numeric value that represents the dispense number or sequence number that has been reached for a therapeutic good prescribed with repeats. This count includes the first dispense. It has the value 1 when there are no repeats.	0..1	entry[sbadm]/substanceAdministration/entryRelationship[sply]/**sequenceNumber**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/sequenceNumber/**@value**		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Dispense Item (MEDICATION ACTION) > **Maximum Number of Repeats**	The number of times the supply of the prescribed item may be repeated under the terms of the prescription.	0..1	entry[sbadm]/substanceAdministration/**repeatNumber**		
			entry[sbadm]/substanceAdministration/repeatNumber/**high**		
			entry[sbadm]/substanceAdministration/repeatNumber/high/**@value**		
Dispense Item (MEDICATION ACTION) > **PBS Manufacturer Code (Administrative Manufacturer Code)**	Administrative code used to identify the manufacturer of the pharmaceutical item supplied.	0..1	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/product/manufacturedProduct/**manufacturerOrganization**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/product/manufacturedProduct/manufacturerOrganization/**id**	Australian PBS Manufacturer Code 10 *Vocabularies/Code Sets*	This **SHALL NOT** have a value if the value of Therapeutic Good Identification encodes the manufacturer If Therapeutic Good Identification contains an AMT code as the primary code, this **SHALL** be empty. If Therapeutic Good Identification contains a PBS Item Code as the primary code, this **SHOULD** contain a PBS Manufacturer Code.
Dispense Item (MEDICATION ACTION) > **Unique Pharmacy Prescription Number (Administrative System Identifier)**	A sequential number assigned by a pharmacy to identify, for Medicare, a dispense event by that pharmacy.	0..1	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply//**entryRelationship[pharm_pres_num]**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[pharm_pres_num]/**@typeCode="COMP"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[pharm_pres_num]/**act**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[pharm_pres_num]/act/**@classCode="ACT"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[pharm_pres_num]/act/**@moodCode="EVN"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[pharm_pres_num]/act/**code**	Unique Pharmacy Prescription Number 10 *Vocabularies/Code Sets*	
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[pharm_pres_num]/act/**text**		
Dispense Item (MEDICATION ACTION) > **DateTime of Dispense Event (Medication Action DateTime)**	The point in time at which the Medication Action is completed.	1..1	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/**effectiveTime**		See <time> for available attributes.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Dispense Item (MEDICATION ACTION) > **Dispense Item Identifier (Medication Action Instance Identifier)**	A globally unique identifier for each instance of Medication Action.	1..1	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/**id**		See <id> for available attributes.
Dispense Item (MEDICATION ACTION) > **Dispense Record Link (LINK)**	A link to the source document for this Medication Action.	1..1	See: Dispense Record Link (LINK)		
Dispense Item (MEDICATION ACTION) > **Prescription Item Link (LINK)**	A link to the Prescription Item which authorised the dispensing of the therapeutic good which this Dispense Event describes.	0..1	See: Prescription Item Link (LINK)		

Example 7.6. Dispense Item (MEDICATION ACTION) XML Fragment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >

 <!-- Begin CDA Header -->

 …

 <!-- End CDA Header -->

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
    …
   <!-- Begin Prescribing and Dispensing Reports (SUMMARY OF MEDICATION ENTRIES) -->
   <component>
    <section>
     …
            <!-- Begin MEDICATION ENTRIES WITH SUMMARY -->
     <component>
      <section>
           …
       <!-- Begin Dispense Item section -->
       <component>
        <section>
          <code code="101.16210"
           codeSystem="1.2.36.1.2001.1001.101"
           codeSystemName="NCTIS Data Components"
           displayName="Dispense Item"/>


          <title>Dispense Item</title>
          <!-- Begin Dispense Item Narrative -->
          <text>
           <list>
            <caption>Subject of Care Entitlement</caption>
            <item>
             <caption>Entitlement Type</caption> Medicare Pharmaceutical Benefits </item>
            <item>
             <caption>Entitlement Number</caption> 1234567892 </item>
            <item>
             <caption>Entitlement Validity Duration</caption>
             <list>
              <item>
               <caption>From</caption> 1 January, 2007 </item>
              <item>
               <caption>Until</caption> 1 January, 2007 </item>
             </list>
            </item>
           </list>

           <list>
            <caption>Dispensing Organisation Entitlement</caption>
            <item>
             <caption>Entitlement Type</caption> Approval to Supply Medications under the
```

```
   PBS </item>
  <item>
   <caption>Entitlement Number</caption> 987654321 </item>
  <item>
   <caption>Entitlement Validity Duration</caption>
   <list>
    <item>
     <caption>From</caption> 1 January, 2007 </item>
    <item>
     <caption>Until</caption> 1 January, 2027 </item>
   </list>
  </item>
 </list>

 <list>
  <item>
   <caption>Dispense Item</caption>
   <list>
    <item>
     <caption>Therapeutic Good Identification</caption>Prodeine Forte</item>
    <item>
     <caption>Therapeutic Good Strength</caption> 500mg + 30mg tablet </item>
    <item>
     <caption>Therapeutic Good Generic Name</caption> Paracetamol 500mg + codeine phosphate 30mg tablet </item>
    <item>
     <caption>Additional Dispensed Item Description</caption>Prodeine Forte, 30mg, 20 tablets.</item>
    <item>
     <caption>Quantity Description</caption>20 tablets</item>
    <item>
     <caption>Additional Dispensed Item Description</caption>Prodeine Forte, 30mg, 20 tablets.</item>
    <item>
     <caption>Unique Pharmacy Prescription Number</caption>1234556</item>
    <item>
     <caption>Supply</caption>
     <list>
      <item>
       <caption>Number of this dispense</caption> 2 </item>
      <item>Item successfully dispensed</item>
      <item>Brand substitution occurred</item>
      <item>
       <caption>Label instruction</caption> Store below 30°C </item>
     </list>
    </item>
    <item>
     <caption>Additional Comments</caption> Phoned doctor to clarify
     medication. </item>
   </list>
  </item>
 </list>
</text>
<!-- End Dispense Item Narrative -->



<!-- Begin Dispense Item entry-->
<entry><!-- [item] -->

 <substanceAdministration classCode="SBADM" moodCode="RQO">

  <!-- Prescription Item Identifier -->
  <id root="1.2.36.1.2001.1005.36" extension="080C5AC2-C835-11DE-81C9-B16456D89593"/>

  <!-- Maximum number of repeats -->
  <repeatNumber>
   <high value="2"/>
```

```
</repeatNumber>

<!-- Included for CDA Conformance only -->
<consumable>
 <manufacturedProduct>
  <manufacturedMaterial>

  </manufacturedMaterial>

 </manufacturedProduct>
</consumable>

<!-- Begin: Strength [strength] -->
<entryRelationship typeCode="COMP"><!-- [form] -->
 <act classCode="INFRM" moodCode="EVN">
  <code code="103.16769.171.1.1"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Therapeutic Good Strength"/>
  <text>500mg + 30mg</text>
 </act>
</entryRelationship>
<!-- End: Strength [strength] -->

<!--  Begin Formula-->
<entryRelationship typeCode="COMP"><!-- [form] -->
 <act classCode="INFRM" moodCode="EVN">
  <id root="0C704162-EFC8-11DF-8D6E-2EBFDFD72085"/>
  <code code="103.16272"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Formula"/>
  <text>BORIC ACID, OLIVE OIL AND ZINC OXIDE (BOZ) Ointment:
   Boric Acid 1% in Paraffin Ointment B.P. 25
   Olive Oil 25
   Zinc Oxide Ointment to 100</text>
 </act>
</entryRelationship><!-- [form] -->
<!--  End Formula -->

<!-- (Medication Action Comment)-->
<entryRelationship typeCode="COMP"><!-- [cmts] -->
 <act classCode="INFRM" moodCode="EVN">
  <id root="12AC380C-D1E1-11DE-B505-09BE56D89593"/>
  <code code="103.16044"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Additional Comments"/>
  <text>Phoned doctor to clarify medication.</text>
 </act>
</entryRelationship><!-- [cmts] -->

<!-- Begin Supply/ Dispense Information. [sply] -->
<entryRelationship typeCode="COMP"><!-- [sply] -->

 <!-- Number of this dispense -->
 <sequenceNumber value="2"/>

 <supply classCode="SPLY" moodCode="EVN">

  <!-- Dispense Item Identifier -->
  <id root="5DBAE0AE-79E4-11DF-B5A5-0BDCDED72085"/>

  <!-- A code specifying the state of the Dispense -->
  <statusCode code="completed"/>
```

```
<!-- Begin DateTime of Dispense Event -->
<effectiveTime value="201001061149"/>
<!-- End DateTime of Dispense Event -->

<!-- Signals that the supply cannot stand alone without its containing substanceAdministration -->
<independentInd value="false"/>

<!-- Therapeutic Good Identification -->
<product>
 <manufacturedProduct>
  <manufacturedMaterial>
   <code code="6647011000036101"
   codeSystem="1.2.36.1.2001.1004.100">
   <originalText>Prodeine Forte</originalText>
   </code>

   <!-- Begin Therapeutic Good Generic Name -->
   <name>Paracetamol 500mg + codeine phosphate 30 mg
   tablet</name>
   <!-- End Therapeutic Good Generic Name -->

   <!-- Begin Additional Dispensed Item Description -->
   <ext:desc>Prodeine Forte, 30mg, 20
   tablets.</ext:desc>
   <!-- End Additional Dispensed Item Description -->

   <!-- Begin Form -->
   <ext:formCode code="385057009"
   codeSystem="2.16.840.1.113883.6.96"
   codeSystemName="SNOMED CT"
   displayName="Film-coated tablet"/>
   <!-- End Form -->

  </manufacturedMaterial>

  <!-- Begin PBS Manufacturer Code (Administrative Manufacturer Code) -->
  <manufacturerOrganization classCode="ORG" determinerCode="INSTANCE">
   <id root="1.2.36.1.2001.1005.23" extension="AB"  />
  </manufacturerOrganization>
  <!-- End PBS Manufacturer Code (Administrative Manufacturer Code) -->

 </manufacturedProduct>
</product>

<!-- Begin Label instruction -->
<entryRelationship typeCode="COMP">
 <act classCode="INFRM" moodCode="EVN">
  <code code="103.16109"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Label Instruction"/>
  <text xsi:type="ST">Store below 30°C</text>
 </act>
</entryRelationship>
<!-- End Label instruction -->

<!-- Begin Brand substitution occurred -->
<entryRelationship typeCode="COMP">
 <observation classCode="OBS" moodCode="EVN">
  <id root="3B5D4176-79E6-11DF-88FB-26DEDED72085"/>
  <code code="103.16064"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Brand substitution occured"/>
```

```
                <value value="true" xsi:type="BL"/>
               </observation>
              </entryRelationship>
              <!-- Begin Brand substitution occurred -->

              <!-- Begin Quantity Description -->
              <entryRelationship typeCode="COMP">
               <act classCode="INFRM" moodCode="EVN">
                <code code="246205007" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT-AU" displayName="Quantity"/>
                <text>20 tablets</text>
               </act>
              </entryRelationship>
              <!-- End Quantity Description -->

              <!-- Begin Unique Pharmacy Prescription Number -->
              <entryRelationship typeCode="COMP">
               <act classCode="ACT" moodCode="EVN">
                <code code="103.16786" codeSystem="1.2.36.1.2001.1001.101"
                 codeSystemName="NCTIS Data Components" displayName="Unique Pharmacy Prescription Number"/>
                <text>1234556</text>
               </act>
              </entryRelationship>
              <!-- End Unique Pharmacy Prescription Number -->

             </supply>
            </entryRelationship>
            <!-- Begin Supply/ Dispense Information  [sply] -->
           </substanceAdministration>


          </entry><!-- [item] -->
          <!-- End Dispense item entry -->
         </section>
        </component>
        <!-- End Dispense Item section -->
       …
      </section>
     </component>
     <!-- End MEDICATION ENTRIES WITH SUMMARY -->
    </section>
   </component>
   <!-- End Prescribing and Dispensing Reports (SUMMARY OF MEDICATION ENTRIES) -->

  </structuredBody>
 </component>
 <!-- End CDA Body -->

</ClinicalDocument>
```

7.1.2.1.2.1.1 Dispense Record Link (LINK)

Identification

Name	Dispense Record Link (LINK)
Metadata Type	Data Group
Identifier	DG-16692

Relationships

Parent

Data Type	Name	Occurrences (child within parent)
	Dispense Item (MEDICATION ACTION)	1..1

CDA R-MIM Representation

Figure 7.7, “Dispense Record Link (LINK)” shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

Each Dispense Record Link (LINK) data group modelled as an externalDocument which is related to its containing section.entry by a reference entry.

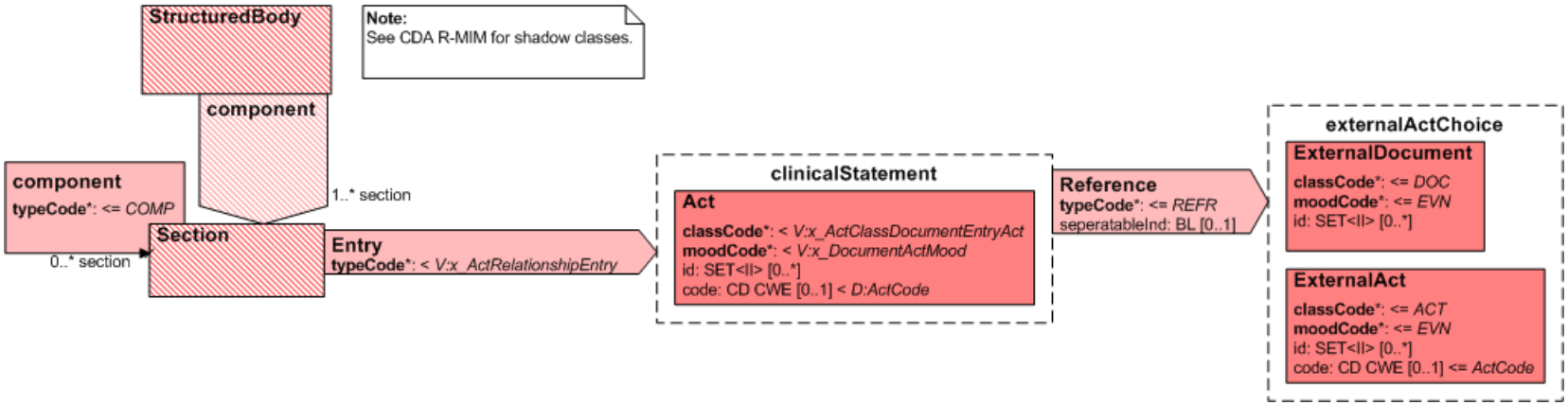

Figure 7.7. Dispense Record Link (LINK)

CDA Mapping

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: ClinicalDocument/component/structuredBody/component[pdv_pres_and_disp_reports]/section/component[sme_med_ent_with_summary]/section/component[dispense_item]/section/		
Dispense Record Link (LINK)	A link to the source document for this Medication Action.	1..1	**entry**		
			entry/**act**		
			entry/act**@classCode="ACT"**		
			entry/act**@moodCode="EVN"**		
			entry/act/**id**	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	See <id> for available attributes.
			entry/act/**code**		
			entry/act/code/**@code="102.16692.179.1.1"**		
			entry/act/code/**@codesystem="1.2.36.1.2001.1001.101"**		
			entry/act/code/**@codeSystemName="NCTIS Data Components"**		
			entry/act/code/**@displayName="Dispense Record Link"**		
			entry/act/**reference[document]**		
			entry/act/reference[document]/**seperatableInd/@value="true"**		
			entry/act/**text**		
			entry/act/text/**reference/@value**		This reference/@value **SHALL** begin with a '#' and SHALL point to its corresponding <linkHtml> narrative. See PCEHR URN Scheme for details.
Dispense Record Link (LINK) > **Link Nature**	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.	1..1	n/a		This logical NEHTA data component has no mapping to CDA.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Dispense Record Link (LINK) > **Link Role**	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.	1..1	entry[dispense_item_link]/act/reference[document]/**@typeCode="REFR"**		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Dispense Record Link (LINK) > **Link Target**	The logical "to" object in the link relation, as per the linguistic sense of the Link Nature data element (and, if present, the Link Role data element).	1..1	entry[dispense_item_link]/act/reference[document]/**externalDocument**		
			entry[dispense_item_link]/act/reference[document]/externalDocument/**@classCode="DOC"**		
			entry[dispense_item_link]/act/reference[document]/externalDocument/**@moodCode="EVN"**		
			entry[dispense_item_link]/act/reference[document]/externalDocument/**id**		The 'id' shall be the identifier of the external document and **SHALL** be included in the corresponding CDA narrative inside a <linkHtml href=" pcehr:URN/> Document </linkHtml> element. Note: The external document 'id' and repository 'id' shall be included together as a pcehr:URN See PCEHR URN Scheme for details.
			entry[dispense_item_link]/act/reference[document]/externalDocument/**templateId**	PCEHR Dispense Record NCTIS: CDA Template OIDS	The docType or the 'ClinicalDocument/templateId/@root and ClinicalDocument/templateId/@extension' of the target CDA document.
			entry[dispense_item_link]/act/**reference[repository]**		
			entry[dispense_item_link]/act/reference[document]/**seperatableInd/@value="true"**		
			entry[dispense_item_link]/act/reference[repository]/**@typeCode="REFR"**		
			entry[dispense_item_link]/act/reference[repository]/**externalAct**		
			entry[dispense_item_link]/act/reference[repository]/externalAct/**@classCode="ACT"**		
			entry[dispense_item_link]/act/reference[repository]/externalAct/**@moodCode="EVN"**		
			entry[dispense_item_link]/act/reference[repository]/externalAct/**id**		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
					The 'id' **SHALL** be the identifier of the PCEHR repository and **SHALL** be included in the corresponding CDA narrative inside a <linkHtml href=" pcehr:URN/> Document </linkHtml> element. Note: The external document 'id' and repository 'id' shall be included together as a pcehr:URN See PCEHR URN Scheme for details.
			entry[dispense_item_link]/act/reference[repository]/externalAct/**code**		
			entry[dispense_item_link]/act/reference[repository]/externalAct/code**code="10"**		
			entry[dispense_item_link]/act/reference[repository]/externalAct/code/**@codeSystem="1.2.36.1.2001.1007"**		
			entry[dispense_item_link]/act/reference[repository]/externalAct/code**@codeSystemName="PCEHR Identifiers"**		
			entry[dispense_item_link]/act/reference[repository]/externalAct/code**@displayName="PCEHR Assigned Identifier - Repository"**		

Example 7.7. Dispense Record Link (LINK) XML Fragment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
   <!-- Begin CDA Header -->

   …

   <!-- End CDA Header -->

 <!-- Begin CDA Body -->
 <component>
    <structuredBody>

    …
      <!-- Begin Prescribing and Dispensing Reports -->
   <component>
    <section>

       <!-- Begin MEDICATION ENTRIES WITH SUMMARY  -->
     <component>
      <section>

     <!-- Begin MEDICATION ENTRIES  -->
     <component>
      <section>

     <!--  Begin Dispense Item (MEDICATION ACTION)  -->
     <component>
      <section>
        ...
       <text>
        <!-- Add narrative text here -->
        <!-- Link to the external document  -->
        <content>
         <linkHtml href="pcehr:1.2.36.1.2001.1007.10.8003640002000001/2.25.203427086955788632508418985946785767155" ID="dispenseRecordLink">PCEHR Dispense</linkHtml>
        </content>
        <!-- Add narrative text here -->
       </text>
       ...

        <!-- Begin Dispense Record Link-->
        <entry>
         <act classCode="ACT" moodCode="EVN">
          <!-- Technical Identifier to uniquely identify this act -->
          <id root="9b0a6820-3f45-11e2-a25f-0800200c9a66"/>
          <code code="102.16692.179.1.1"
           codeSystem="1.2.36.1.2001.1001.101"
           codeSystemName="NCTIS Data Components"
           displayName="Dispense Record Link"/>
          <text>
           <reference value="#dispenseRecordLink"/>
          </text>
          <reference typeCode="REFR">
           <seperatableInd value="true"/>
           <externalDocument classCode="DOC" moodCode="EVN">
```

```
            <!-- templateId of the PCEHR Prescription document. -->
            <templateId extension="1.0"
            root="1.2.36.1.2001.1001.101.100.1002.171"/>

            <!-- The identifier of the document -->
            <id root="14741d8a-3ddd-45a0-a391-1fc1af6945a0"
            extension="a12323"/>
            </externalDocument>
           </reference>
           <reference typeCode="REFR">
            <seperatableInd value="true"/>
            <externalAct classCode="ACT" moodCode="EVN">
             <id root="1.2.36.1.2001.1007.10.8003640002000035"/>
             <code code="10"
              codeSystem="1.2.36.1.2001.1007" codeSystemName="PCEHR Identifiers" displayName="PCEHR Assigned Identifier - Repository"/>
            </externalAct>
           </reference>
          </act>
         </entry>
         <!-- End Dispense Record Link-->
        ...
       </section>
     </component>
     <!--  End Dispense Item (MEDICATION ACTION)  -->
    </section>
   </component>
   <!-- End MEDICATION ENTRIES -->
       </section>
     </component>
     <!-- End MEDICATION ENTRIES WITH SUMMARY -->
    </section>
   </component>
   <!-- End Prescribing and Dispensing Reports -->
    </structuredBody>
 <component>
   <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.2.1.2.1.2 Prescription Item Link (LINK)

Identification

Name	Prescription Item Link (LINK)
Metadata Type	Data Group
Identifier	DG-16692

Relationships

Parent

Data Type	Name	Occurrences (child within parent)
	Dispense Item (MEDICATION ACTION)	0..1

CDA R-MIM Representation

Figure 7.8, “Prescription Item Link (LINK)” shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

Each Prescription Item Link (LINK) data group modelled as an externalDocument which is related to its containing section.entry by a reference entry.

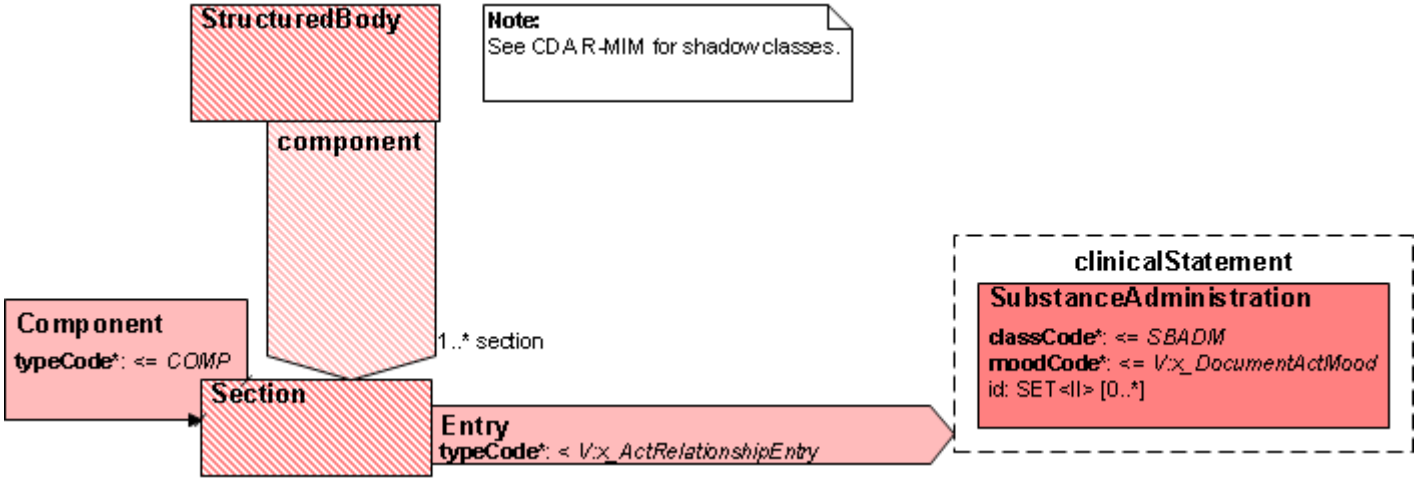

Figure 7.8. Prescription Item Link (LINK)

CDA Mapping

Note

NS = 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.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: ClinicalDocument/component/structuredBody/component[pdv_pres_and_disp_reports]/section/component[sme_med_ent_with_summary]/section/component[dispense_item]/section/		
Prescription Item Link (LINK)	A link to the Prescription Item which authorised the dispensing of the therapeutic good which this Dispense Event describes.	0..1	n/a		
Prescription Item Link (LINK) > **Link Nature**	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.	1..1	n/a		This logical NEHTA data component has no mapping to CDA.
Prescription Item Link (LINK) > **Link Role**	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.	1..1	n/a		This logical NEHTA data component has no mapping to CDA.
Prescription Item Link (LINK) > **Link Target**	The Prescription Item Identifier of the Prescription Item which authorised the dispensing of the therapeutic good which this Dispense Event describes.	1..1	entry[sbadm]/substanceAdministration/**id**		The 'Link Target' **SHALL** be included in the corresponding CDA narrative inside a <linkHTML href=" pcehr:URN/> Document </linkHTML> element. See PCEHR URN Scheme for details.

[1] http://www.hl7.org/oid/index.cfm?ref=footer

Example 7.8. Prescription Item Link (LINK) XML Fragment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
   <!-- Begin CDA Header -->

   …

   <!-- End CDA Header -->

 <!-- Begin CDA Body -->
 <component>
    <structuredBody>

    …
    <!-- Begin Prescribing and Dispensing Reports (SUMMARY OF MEDICATION ENTRIES) -->
   <component>
    <section>
                …
                <!-- Begin MEDICATION ENTRIES WITH SUMMARY -->
     <component>
      <section>
       …
       <!-- Begin Dispense Item (MEDICATION ACTION) -->
       <component>
        <section>
         …
         <entry>
          <substanceAdministration classCode="SBADM" moodCode="RQO">

           <!-- Prescription Item Identifier -->
           <id root="1.2.36.1.2001.1005.36" extension="080C5AC2-C835-11DE-81C9-B16456D89593"/>
          …

          </substanceAdministration>
         </entry>
         …
        </section>
       </component>
       <!-- End Dispense Item (MEDICATION ACTION) -->
      </section>
     </component>
     <!-- End MEDICATION ENTRIES WITH SUMMARY -->
    </section>
   </component>
   <!-- End Prescribing and Dispensing Reports (SUMMARY OF MEDICATION ENTRIES) -->

    </structuredBody>
 <component>
   <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.2.1.2.2 Prescription Item (MEDICATION INSTRUCTION)

Identification

Name	Prescription Item (MEDICATION INSTRUCTION)
Metadata Type	Data Group
Identifier	DG-16211

Relationships

Parent

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

Children

Data Type	Name	Occurrence
	Prescription Record Link (LINK)	1..1

CDA R-MIM Representation

Figure 7.9, “Prescription Item (MEDICATION INSTRUCTION)” shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

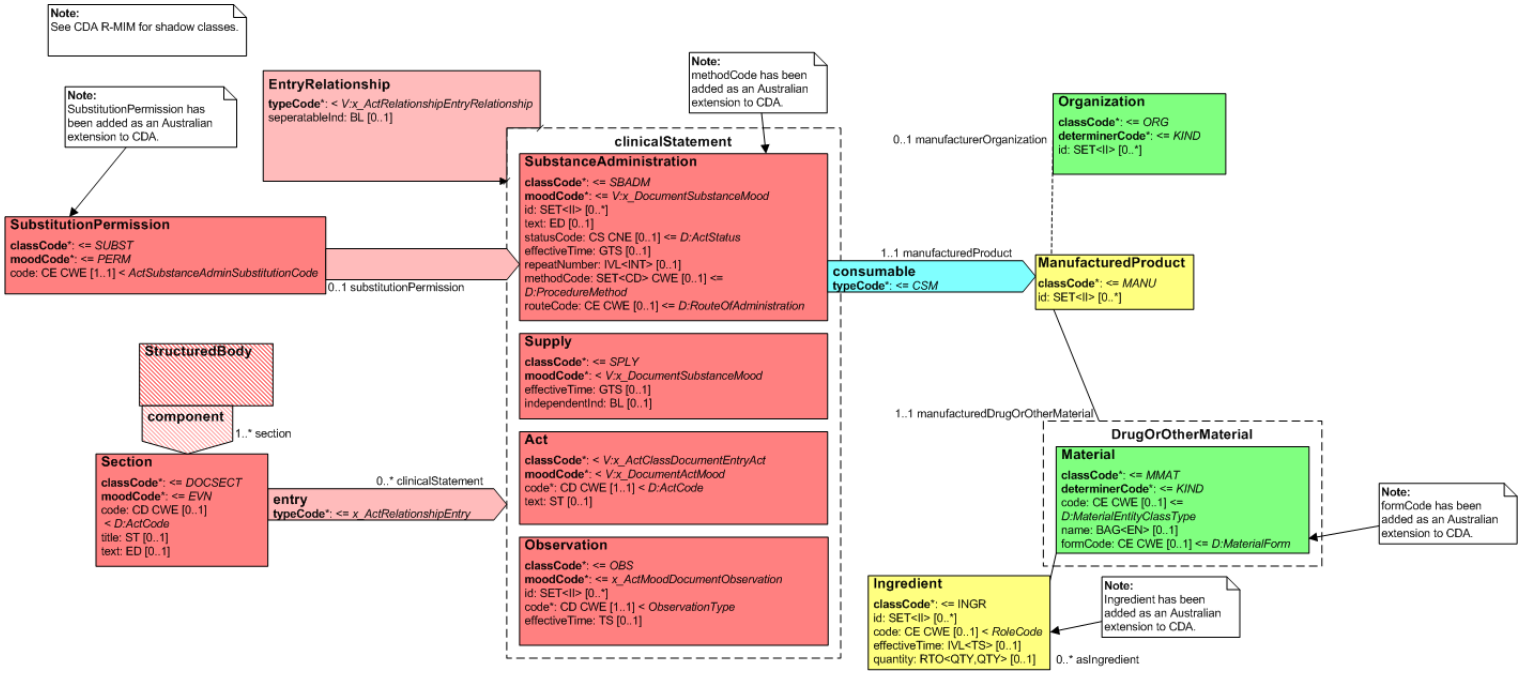

Figure 7.9. Prescription Item (MEDICATION INSTRUCTION)

CDA Mapping

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: ClinicalDocument/component/structuredBody/component[pdv_pres_and_disp_reports]/section/component[sme_med_ent_with_summary]/		
Prescription Item (MEDICATION INSTRUCTION)	Details of a therapeutic good with its use by a subject of care and related information.	1..1	**component[pres_item]/section**		When instantiated as 'Prescription Item (MEDICATION INSTRUCTION)' the cardinality *shall* be '[1..1]'.
			component[pres_item]/section/**code**		
			component[pres_item]/section/code/**@code="102.16211"**		
			component[pres_item]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[pres_item]/section/code/**@codeSystemName="NCTIS Data Components"**		
			component[pres_item]/section/code/**@displayName="Prescription Item"**		
			component[pres_item]/section/**title="Prescription Item"**		
			component[pres_item]/section/**text**		See Appendix A, *CDA Narratives*
CDA Body Level 3 Data Elements			Context: ClinicalDocument/component/structuredBody/component[pdv_pres_and_disp_reports]/section/component[sme_med_ent_with_summary]/section/component[pres_item]/section/		
		1..1	**entry[sbadm]**		
			entry[sbadm]/**substanceAdministration**		
			entry[sbadm]/substanceAdministration/**@moodCode="RQO"**		
			entry[sbadm]/substanceAdministration/**@classCode="SBADM"**		
			entry[sbadm]/substanceAdministration/**statusCode/@code="active"**		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Prescription Item (MEDICATION INSTRUCTION) > **Therapeutic Good Identification**	The medicine, vaccine or other therapeutic good being ordered, administered to or used by the subject of care.	1..1	entry[sbadm]/substanceAdministration/**consumable/manufacturedProduct/manufacturedMaterial/code**		See <code> for available attributes.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
				Where the Therapeutic Good Identification can be identified by an Australian Medicines Terminology (AMT) concept, this **SHOULD** be represented by the AMT ConceptID and Preferred Term. The permissible values are the members of the following AMT reference sets • 929360081000036101 Medicinal product pack reference set • 929360071000036103 Medicinal product unit of use reference set • 929360041000036105 Trade product pack reference set • 929360031000036100 Trade product unit of use reference set • 929360051000036108 Containered trade product pack reference set For items without an AMT code the value from 'PBS Item Code' **SHOULD** be used. When a suitable 'AMT' code becomes available or system/user has chosen value from AMT code, they **SHOULD**	

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
				be used and the usage of 'PBS Item Code' **SHOULD** be deprecated. If a text description is provided, this **SHOULD** include the name of the medication (brand name or generic name equivalent), strength and dose form, where appropriate. Note: If Therapeutic Good Identification contains a PBS Item Code, use the PBS Manufacturer Code data element to record the Manufacturer Code.	
Prescription Item (MEDICATION INSTRUCTION) > **Therapeutic Good Strength (Additional Therapeutic Good Detail)**	Information concerning the strength of the Therapeutic Good.	0..1	entry[sbadm]/substanceAdministration/**entryRelationship[strength]**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/**@typeCode='COMP'**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/**act**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/**@classCode="INFRM"**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/**@moodCode="RQO"**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/**code**		See <code> for available attributes.
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/**@code="103.16769.170.1.1"**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/**@codeSystemName="NCTIS Data Components"**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/**@displayName="Therapeutic Good Strength"**		
			entry[sbadm]/substanceAdministration/entryRelationship[strength]/act/**text**	This **SHALL NOT** contradict the value of Therapeutic Good Identification	

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Prescription Item (MEDICATION INSTRUCTION) > **Therapeutic Good Generic Name (Additional Therapeutic Good Detail)**	The generic name of the Therapeutic Good.	0..1	entry[sbadm]/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/**name**	This **SHALL NOT** contradict the value of Therapeutic Good Identification	
Prescription Item (MEDICATION INSTRUCTION) > **Directions**	A complete narrative description of how much, when and how to use the medicine, vaccine or other therapeutic good.	0..1	entry[sbadm]/substanceAdministration/**text**		
Prescription Item (MEDICATION INSTRUCTION) > **Formula**	The recipe for compounding a medicine.	0..1	entry[sbadm]/substanceAdministration/**entryRelationship[form]**		
			entry[sbadm]/substanceAdministration/entryRelationship[form]/**@typeCode="COMP"**		
			entry[sbadm]/substanceAdministration/entryRelationship[form]/**act**		
			entry[sbadm]/substanceAdministration/entryRelationship[form]/act/**@classCode="INFRM"**		
			entry[sbadm]/substanceAdministration/entryRelationship[form]/act/**@moodCode="RQO"**		
			entry[sbadm]/substanceAdministration/entryRelationship[form]/act/**code**	10 *Vocabularies/Code Sets*	See <code> for available attributes.
			entry[sbadm]/substanceAdministration/entryRelationship[form]/act/**text**		
Prescription Item (MEDICATION INSTRUCTION) > **Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)**	Detailed information about the ingredient(s) including form and strength.	0..1	n/a		This logical NEHTA data component has no mapping to CDA.
Prescription Item (MEDICATION INSTRUCTION) > Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION) > **Form**	The formulation or presentation of the overall substance.	1..1	entry[sbadm]/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/**ext:formCode**	Medication Form Reference Set SNOMED CT-AU Concept Id: 32570621000036105	Values might include: Tablets, Capsules, Sachets, etc... See <code> for available attributes.
Prescription Item (MEDICATION INSTRUCTION) > **Clinical Indication**	A reason for ordering the medicine, vaccine or other therapeutic good.	0..1	entry[sbadm]/substanceAdministration/**entryRelationship[reason]**		
			entry[sbadm]/substanceAdministration/entryRelationship[reason]/**@typeCode="RSON"**		
			entry[sbadm]/substanceAdministration/entryRelationship[reason]/**act**		
			entry[sbadm]/substanceAdministration/entryRelationship[reason]/act/**@classCode="INFRM"**		
			entry[sbadm]/substanceAdministration/entryRelationship[reason]/act/**@moodCode="RQO"**		
			entry[sbadm]/substanceAdministration/entryRelationship[reason]/act/**code**		
			entry[sbadm]/substanceAdministration/entryRelationship[reason]/act/code/**@code="103.10141"**		
			entry[sbadm]/substanceAdministration/entryRelationship[reason]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[sbadm]/substanceAdministration/entryRelationship[reason]/act/code/**@codeSystemName="NCTIS Data Components"**		
			entry[sbadm]/substanceAdministration/entryRelationship[reason]/act/code/**@displayName="Reason for Therapeutic Good"**		
			entry[sbadm]/substanceAdministration/entryRelationship[reason]/act/**text**		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Prescription Item (MEDICATION INSTRUCTION) > **Administration Details (MEDICATION ADMINISTRATION)**	Details of the administration of the medicine, vaccine or other therapeutic good.	0..1	n/a		This logical NEHTA data component has no mapping to CDA. The cardinality of this component propagates to its children.
Prescription Item (MEDICATION INSTRUCTION) > Administration Details (MEDICATION ADMINISTRATION); **Route**	The route by which the medication is administered.	1..1	entry[sbadm]/substanceAdministration/**routeCode**	Route of Administration Reference Set SNOMED CT-AU Concept Id: 32570601000036100	See <code> for available attributes.
Prescription Item (MEDICATION INSTRUCTION) > **Comment (Medication Instruction Comment)**	Any additional information that may be needed to ensure the continuity of supply, rationale for current dose and timing, or safe and appropriate use.	0..1	entry[sbadm]/substanceAdministration/**entryRelationship[cmts]**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/**@typeCode="COMP"**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/**act**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/**@classCode="INFRM"**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/**@moodCode="EVN"**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/**code**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/code/**@code="103.16044"**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/code/**@codeSystemName="NCTIS Data Components"**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/code/**@displayName="Additional comments"**		
			entry[sbadm]/substanceAdministration/entryRelationship[cmts]/act/**text**		
Prescription Item (MEDICATION INSTRUCTION) > **DISPENSING**	Information for the dispenser.	1..1	entry[sbadm]/substanceAdministration/**entryRelationship[sply]**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/**@typeCode="COMP"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/**supply**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/**@moodCode="RQO"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/**@classCode="SPLY"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/**independentInd/@value="false"**		
Prescription Item (MEDICATION INSTRUCTION) > DISPENSING > **Quantity to Dispense (AMOUNT OF MEDICATION)**	The amount of medicine, vaccine or other therapeutic good to be dispensed.	1..1	n/a		This logical NEHTA data component has no mapping to CDA.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Prescription Item (MEDICATION INSTRUCTION) > DISPENSING > Quantity to Dispense (AMOUNT OF MEDICATION) > **Quantity Description**	Free text description of the amount which may consist of the quantity and dose unit.	1..1	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/**entryRelationship[qty_desc]**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/**@typeCode="COMP"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/**act**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/**@classCode="INFRM"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/**@moodCode="INT"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/**code**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/code/**@code='246205007'**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/code/**@codeSystem='2.16.840.1.113883.6.96'**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/code/**@codeSystemName='SNOMED CT-AU'**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/code/**@displayName='Quantity'**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/entryRelationship[qty_desc]/act/**text**		
Prescription Item (MEDICATION INSTRUCTION) > DISPENSING > **Maximum Number of Repeats (Number of Repeats)**	The number of times the expressed quantity of medicine, vaccine or other therapeutic good may be refilled or redispensed without a new prescription.	0..1	entry[sbadm]/substanceAdministration/**repeatNumber**		
			entry[sbadm]/substanceAdministration/repeatNumber/**high**		
			entry[sbadm]/substanceAdministration/repeatNumber/high/**@value**		
Prescription Item (MEDICATION INSTRUCTION) > DISPENSING > **Minimum Interval Between Repeats**	The minimum time between repeat dispensing of the medicine, vaccine or therapeutic good.	0..1	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/**effectiveTime:PIVL_TS**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/effectiveTime/**period**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/effectiveTime/period/**@value**	Time interval	
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/effectiveTime/period/**@unit**	Unit of measure of time. i.e. "wk", "day". See [UCUM]: for full list.	

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Prescription Item (MEDICATION INSTRUCTION) > DISPENSING > **Brand Substitution Permitted**	Indicates whether or not the substitution of a prescribed medicine with a different brand name of the same medicine, vaccine or other therapeutic good, which has been determined as bioequivalent, is allowed when the medication is dispensed/supplied.	0..1	entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/**ext:subjectOf2**		If this entry is present Brand Substitution Permitted is true, if this entry is not present Brand Substitution Permitted is false See Australian CDA extension: BrandSubstituteAllowed.
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/ext:subjectOf2/**ext:substitutionPermission**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/ext:subjectOf2/ext:substitutionPermission/**@classCode="SUBST"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/ext:subjectOf2/ext:substitutionPermission/**@moodCode="PERM"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/ext:subjectOf2/ext:substitutionPermission/**ext:code**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/ext:subjectOf2/ext:substitutionPermission/ext:code/**@code="TE"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/ext:subjectOf2/ext:substitutionPermission/ext:code/**codeSystem="2.16.840.1.113883.5.1070"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/ext:subjectOf2/ext:substitutionPermission/ext:code/**codeSystemName="HL7:SubstanceAdminSubstitution"**		
			entry[sbadm]/substanceAdministration/entryRelationship[sply]/supply/ext:subjectOf2/ext:substitutionPermission/ext:code/**displayName="Therapeutic"**		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Prescription Item (MEDICATION INSTRUCTION) > **PBS Manufacturer Code (Administrative Manufacturer Code)**	Administrative code used to identify the manufacturer of the pharmaceutical item supplied.	0..1	entry[sbadm]/substanceAdministration/consumable/manufacturedProduct/**manufacturerOrganization**		
			entry[sbadm]/substanceAdministration/consumable/manufacturedProduct/manufacturerOrganization/**id**	Australian PBS Manufacturer Code 10 *Vocabularies/Code Sets*	This **SHALL NOT** have a value if the value of Therapeutic Good Identification encodes the manufacturer If Therapeutic Good Identification contains an AMT code as the primary code, this **SHALL** be empty. If Therapeutic Good Identification contains a PBS Item Code as the primary code, this **SHOULD** contain a PBS Manufacturer Code.
Prescription Item (MEDICATION INSTRUCTION) > **DateTime Prescription Written (DateTime Medication Instruction Written)**	The date (and optionally time) of the completion of the writing of the medication instruction.	1..1	**author/time/@value**		Usage: date or date/time+tz
			author/**assignedAuthor**		
			author/assignedAuthor/**@nullFlavor="NA"**		
			author/assignedAuthor/**id**		
			author/assignedAuthor/id/**@nullFlavor="NA"**		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Prescription Item (MEDICATION INSTRUCTION) > **DateTime Prescription Expires (DateTime Medication Instruction Expires)**	The date and, optionally, time after which the Medication Instruction is no longer effective or in force.	1..1	**entry**		
			entry[expiry]/**observation**		
			entry[expiry]/observation/**@classCode="OBS"**		
			entry[expiry]/observation/**@moodCode="EVN"**		
			entry[expiry]/observation/**id**	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	
			entry[expiry]/observation/**code**	10 *Vocabularies/Code Sets*	See <code> for available attributes.
			entry[expiry]/observation/**effectiveTime/@value**	The element can contains nullFlavor="NA" if the 'DateTime Prescription Expires' is not available.	
Prescription Item (MEDICATION INSTRUCTION) > **Prescription Item Identifier (Medication Instruction Instance Identifier)**	A globally unique object identifier for each instance of a Medication Instruction.	1..1	entry[sbadm]/substanceAdministration/**id**		See <id> for available attributes. The id/@root **SHALL** contain an implementation specific OID and id/@extension **SHALL** contain the Medication Instruction Identifier of the Prescription.
Prescription Item (MEDICATION INSTRUCTION) > **Prescription Record Link (LINK)**	A link to the source document for this Medication Instruction.	1..1	See: Prescription Record Link (LINK)		

Example 7.9. Prescription Item XML Fragment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/2.0"
 …
 >

 <!-- Begin CDA Header -->

 …

 <!-- End CDA Header -->

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>

  <!-- Begin Prescribing and Dispensing Reports (SUMMARY OF MEDICATION ENTRIES) -->
   <component>
    <section>

     <!-- Begin Prescription Item section -->
     <component>
      <section>
        <code code="102.16211" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Prescription Item"/>
        <!-- Begin Prescription Item Narrative -->
        <title>Prescription Item</title>
        <text>
         <list>
          <caption>Subject of Care Entitlement</caption>
          <item>
           <caption>Entitlement Type</caption> Medicare Benefits </item>
          <item>
           <caption>Entitlement Number</caption> 1234567892 </item>
          <item>
           <caption>Entitlement Validity Duration</caption>
           <list>
            <item>
             <caption>From</caption> 1 January, 2007 </item>
            <item>
             <caption>Until</caption> 1 January, 2027 </item>
           </list>
          </item>
         </list>

         <list>
          <caption>Prescriber Entitlement</caption>
          <item>
           <caption>Entitlement Type</caption> Medicare Prescriber Number </item>
          <item>
           <caption>Entitlement Number</caption> 987654321 </item>
          <item>
           <caption>Entitlement Validity Duration</caption>
           <list>
            <item>
             <caption>From</caption> 1 January, 2005 </item>
            <item>
             <caption>Until</caption> 1 January, 2025 </item>
```

```
   </list>
  </item>
 </list>

 <list>
  <caption>Prescription</caption>
  <item>
   <caption>DateTime Prescription Written</caption> 6 January, 2010 </item>
  <item>
   <caption>DateTime Prescription Expires</caption> 30 December, 2010
  </item>
   <item>
    <caption>Prescription Item</caption>
    <list>
     <item>
      <caption>Directions</caption> 1-2 tablets every 4-6 hours as needed for pain.</item>
     <item>
      <caption>Route</caption> Oral route </item>
     <item>
      <caption>Form</caption> Film-coated tablet </item>
     <item>
      <caption>Therapeutic Good Identification</caption> Panadeine Forte 500mg/30mg Tablets 20 (Paracetamol/Codeine Phosphate) </item>
     <item>
      <caption>Therapeutic Good Generic Name</caption> Paracetamol 500mg + codeine phosphate 30 mg tablet </item>
     <item>
      <caption>PBS Manufacturer Code</caption> AB </item>
     <item>
      <caption>Therapeutic Good Strength</caption> 500mg/30mg </item>

     <item>
      <caption>Dispensing Information</caption>
      <list>
       <item>
        <caption>Quantity to Dispense</caption> 20 </item>
       <item>
        <caption>Maximum number of repeats</caption> 2 </item>
       <item>
        <caption>Minimum interval between repeats</caption> 1 week </item>
       <item>Brand Substitute allowed</item>
      </list>
     </item>
     <item>
      <caption>Reason for Therapeutic Good</caption> Pain management. </item>
     <item>
      <caption>Additional Comments</caption> Patient requires an administration aid. </item>
    </list>
   </item>
 </list>
</text>
<!-- End Prescription Narrative -->

<!-- Begin DateTime Prescription Written -->
<author>
 <time value="20101230"/>
 <assignedAuthor nullFlavor="NA">
  <id nullFlavor="NA"/>
 </assignedAuthor>
</author>
<!-- End DateTime Prescription Written -->

<!-- Begin DateTime Prescription Expires -->
<entry>
 <observation classCode="OBS" moodCode="EVN">
  <id root="8579C552-EFC7-11DF-9F15-69BEDFD72085"/>
  <code code="103.10104" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="DateTime Prescription Expires"/>
```

```
  <effectiveTime value="20101230"/>
 </observation>
</entry>
<!-- End DateTime Prescription Expires -->
<!-- Begin Prescription Item entry -->
<entry>
 <!-- [sbadmn] -->
 <substanceAdministration classCode="SBADM" moodCode="RQO">
  <!-- Prescription Item Identifier-->
  <id root="1.2.36.1.2001.1005.36" extension="080C5AC2-C835-11DE-81C9-B16456D89593"/>

  <!--  Begin Directions -->
  <text>1-2 tablets every 4-6 hours as needed for pain</text>
  <!--  End Directions -->

  <statusCode code="active"/>

  <!-- Begin Maximum number of repeats -->
  <repeatNumber>
   <high value="2"/>
  </repeatNumber>
  <!-- End Maximum number of repeats -->


  <!-- Begin route -->
  <routeCode code="26643006" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Oral route"/>
  <!-- End route -->

  <consumable>
   <manufacturedProduct>
    <manufacturedMaterial>
     <!-- Begin Therapeutic Good Identification -->
     <code>
      <originalText>Panadeine Forte 500mg/30mg Tablets 20 (Paracetamol/Codeine Phosphate)</originalText>
     </code>
     <!-- End Therapeutic Good Identification -->

     <!-- Begin Therapeutic Good Generic Name -->
     <name>Paracetamol 500mg + codeine phosphate 30 mg tablet</name>
     <!-- End Therapeutic Good Generic Name -->

     <!-- Begin Form -->
     <ext:formCode code="385057009" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Film-coated tablet"/>
     <!-- End Form -->

    </manufacturedMaterial>
    <manufacturerOrganization classCode="ORG" determinerCode="INSTANCE">
     <id root="1.2.36.1.2001.1005.23" extension="AB"/>
    </manufacturerOrganization>
   </manufacturedProduct>
  </consumable>

  <!-- Begin Therapeutic Good Strength -->
  <entryRelationship typeCode="COMP">
   <act classCode="INFRM" moodCode="RQO">
    <code code="103.16769.170.1.1" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Therapeutic Good Strength"/>
    <text>500mg/30mg</text>
   </act>
  </entryRelationship>
  <!-- End Therapeutic Good Strength -->

  <!-- Begin Quantity Description -->
  <entryRelationship typeCode="COMP">
   <act classCode="INFRM" moodCode="INT">
    <code code="246205007" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT-AU" displayName="Quantity"/>
```

```
  <text>20</text>
 </act>
</entryRelationship>
<!-- End Quantity Description -->

<!--  Begin Formula-->
<!-- [form] -->
<entryRelationship typeCode="COMP">
 <act classCode="INFRM" moodCode="RQO">
  <code code="103.16272" codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components" displayName="Formula"/>
  <text>BORIC ACID, OLIVE OIL AND ZINC OXIDE (BOZ) Ointment: Boric
   Acid 1% in Paraffin Ointment B.P. 25 Olive Oil 25 Zinc Oxide
   Ointment to 100</text>
 </act>
</entryRelationship>
<!-- [form] -->
<!--  End Formula -->

<!-- Begin Clinical Indication -->
<!-- [reason] -->
<entryRelationship typeCode="RSON">
 <act classCode="INFRM" moodCode="RQO">
  <code code="103.10141" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Reason for Therapeutic Good"/>
  <text>Pain management.</text>
 </act>
</entryRelationship>
<!-- [reason] -->
<!-- End Clinical Indication -->

<!-- Begin Supply / DISPENSING -->
<entryRelationship typeCode="COMP">
 <!-- [sply] -->
 <supply classCode="SPLY" moodCode="RQO">

  <!-- Begin Minimum Interval Between Repeats -->
  <effectiveTime xsi:type="PIVL_TS">
   <period xsi:type="PQ" unit="wk" value="1"/>
  </effectiveTime>
  <!-- End Minimum Interval Between Repeats -->

  <!-- Signals that the supply cannot stand alone without its containing substanceAdministration -->
  <independentInd value="false"/>

  <!-- Begin Brand Substitute Permitted -->
  <ext:subjectOf2>
   <ext:substitutionPermission classCode="SUBST" moodCode="PERM">
    <ext:code code="TE" codeSystem="2.16.840.1.113883.5.1070" codeSystemName="HL7:SubstanceAdminSubstitution" displayName="Therapeutic"/>
   </ext:substitutionPermission>
  </ext:subjectOf2>
  <!-- End Brand Substitute Permitted -->

 </supply>
</entryRelationship>
<!-- End Supply / DISPENSING -->
<!-- Begin Comment (Medication Instruction Comment) -->
<entryRelationship typeCode="COMP">
 <!-- [cmts] -->
 <act classCode="INFRM" moodCode="EVN">
  <id root="12AC380C-D1E1-11DE-B505-09BE56D89593"/>
  <code code="103.16044" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Additional comments"/>
  <text>Patient requires an administration aid.</text>
 </act>
</entryRelationship>
<!-- [cmts] -->
```

```
          <!-- End Comment (Medication Instruction Comment) -->

         </substanceAdministration>
        </entry>
        <!-- [sbadmn] -->
        <!-- End Prescription Item entry -->
       </section>
      </component>
     <!-- End Prescription Item section -->

   </section>
  </component>
  <!-- End Prescribing and Dispensing Reports (SUMMARY OF MEDICATION ENTRIES) -->
   …

  </structuredBody>
 </component>
 <!-- End CDA Body -->

</ClinicalDocument>
```

7.1.2.1.2.2.1 Prescription Record Link (LINK)

Identification

Name	Prescription Record Link (LINK)
Metadata Type	Data Group
Identifier	DG-16692

Relationships

Parent

Data Type	Name	Occurrences (child within parent)
	Prescription Item (MEDICATION INSTRUCTION)	1..1

CDA R-MIM Representation

Figure 7.10, “Prescription Record Link (LINK)” shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

Each Prescription Record Link (LINK) data group modelled as an externalDocument which is related to its containing section.entry by a reference entry.

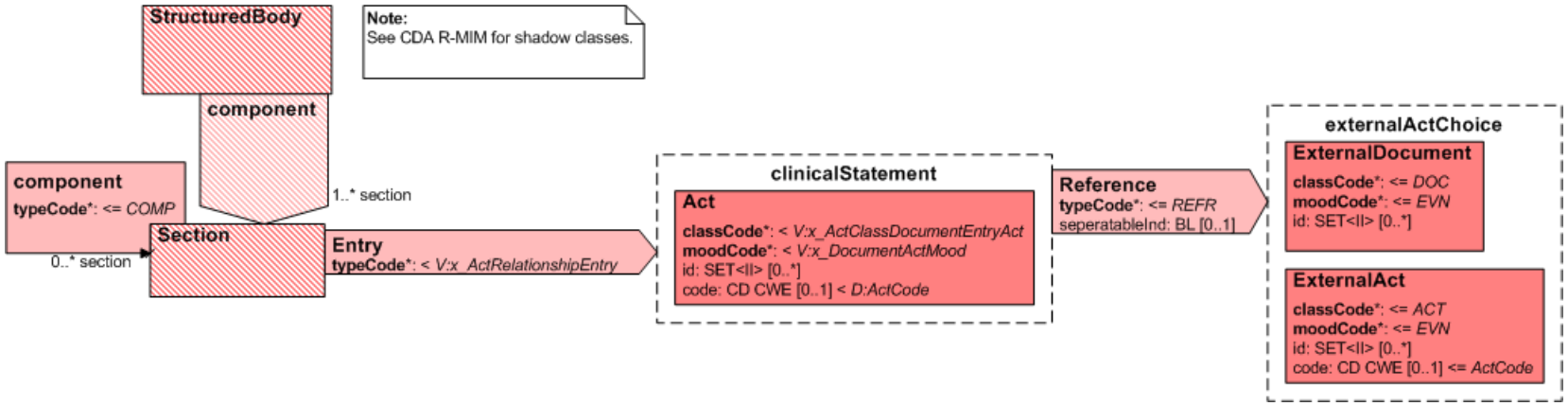

Figure 7.10. Prescription Record Link (LINK)

CDA Mapping

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: ClinicalDocument/component/structuredBody/component[pdv_pres_and_disp_reports]/section/component[sme_med_ent_with_summary]/section/component[pres_item]/section/		
Prescription Record Link (LINK)	A link to the source document for this Medication Instruction.	1..1	**entry[pres_record_link]**		
			entry[pres_record_link]/**act**		
			entry[pres_record_link]/act**@classCode="ACT"**		
			entry[pres_record_link]/act**@moodCode="EVN"**		
			entry[pres_record_link]/act/**id**	UUID This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID may be used.	See <id> for available attributes.
			entry[pres_record_link]/act/**code**		
			entry[pres_record_link]/act/code/**@code="102.16692.179.1.2"**		
			entry[pres_record_link]/act/code/**@codesystem="1.2.36.1.2001.1001.101"**		
			entry[pres_record_link]/act/code/**@codeSystemName="NCTIS Data Components"**		
			entry[pres_record_link]/act/code/**@displayName="Prescription Record Link"**		
			entry[pres_record_link]/act/**reference[document]**		
			entry[pres_record_link]/act/reference[document]/**seperatableInd/@value="true"**		
			entry[pres_record_link]/act/**text**		
			entry[pres_record_link]/act/text/**reference/@value**		This reference/@value **SHALL** begin with a '#' and SHALL point to its corresponding <linkHtml> narrative. See PCEHR URN Scheme for details.
Prescription Record Link (LINK) > **Link Nature**	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.	1..1	n/a		This logical NEHTA data component has no mapping to CDA.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Prescription Record Link (LINK) > **Link Role**	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.	1..1	entry[pres_record_link]/act/reference/**@typeCode="REFR"**		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Prescription Record Link (LINK) > **Link Target**	The logical "to" object in the link relation, as per the linguistic sense of the Link Nature data element (and, if present, the Link Role data element).	1..1	entry[pres_record_link]/act/reference/**externalDocument**		
			entry[pres_record_link]/act/reference/externalDocument/**@classCode="DOC"**		
			entry[pres_record_link]/act/reference/externalDocument/**@moodCode="EVN"**		
			entry[pres_record_link]/act/reference/externalDocument/**id**	The docId or the ClinicalDocument/id of the target document.	The 'Link Target' **SHALL** be included in the corresponding CDA narrative inside a <linkHTML href="pcehr:URN/> Document </linkHTML> element. See PCEHR URN Scheme for details.
			entry[pres_record_link]/act/reference/externalDocument/**templateId**	10 *Vocabularies/Code Sets*	The docType or the 'ClinicalDocument/templateId/@root and ClinicalDocument/templateId/@extension' of the target CDA document.
			entry[pres_record_link]/act/**reference[repository]**		
			entry[pres_record_link]/act/reference[document]/**seperatableInd/@value="true"**		
			entry[pres_record_link]/act/reference[repository]/**@typeCode="REFR"**		
			entry[pres_record_link]/act/reference[repository]/**externalAct**		
			entry[pres_record_link]/act/reference[repository]/externalAct/**@classCode="ACT"**		
			entry[pres_record_link]/act/reference[repository]/externalAct/**@moodCode="EVN"**		
			entry[pres_record_link]/act/reference[repository]/externalAct/**id**		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
					The 'id' **SHALL** be the identifier of the PCEHR repository and **SHALL** be included in the corresponding CDA narrative inside a <linkHtml href=" pcehr:URN/> Document </linkHtml> element. Note: The external document 'id' and repository 'id' shall be included together as a pcehr:URN See PCEHR URN Scheme for details.
			entry[pres_record_link]/act/reference[repository]/externalAct/**code**		
			entry[pres_record_link]/act/reference[repository]/externalAct/code**code="10"**		
			entry[pres_record_link]/act/reference[repository]/externalAct/code/**@codeSystem="1.2.36.1.2001.1007"**		
			entry[pres_record_link]/act/reference[repository]/externalAct/code**@codeSystemName="PCEHR Identifiers"**		
			entry[pres_record_link]/act/reference[repository]/externalAct/code**@displayName="PCEHR Assigned Identifier - Repository"**		

Example 7.10. Prescription Record Link (LINK) XML Fragment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
   <!-- Begin CDA Header -->

   …

   <!-- End CDA Header -->

 <!-- Begin CDA Body -->
 <component>
    <structuredBody>

    …
      <!-- Begin Prescribing and Dispensing Reports -->
   <component>
    <section>

       <!-- Begin MEDICATION ENTRIES WITH SUMMARY  -->
     <component>
      <section>

     <!-- Begin MEDICATION ENTRIES  -->
     <component>
      <section>

        <!-- Begin MEDICATION INSTRUCTION  -->
        <component>
         <section>
           ...
          <text>
           <!-- Add narrative text here -->
           <!-- Link to the external document  -->
           <content>
            <linkHtml href="pcehr:1.2.36.1.2001.1007.10.8003640002000001/2.25.138657451588237770141070928117650397714">PCEHR Prescription</linkHtml>
           </content>
           <!-- Add narrative text here -->
          </text>
          ...

          <!-- [sbadmn] -->
          <!-- Begin Prescription Record Link -->
          <entry>
           <act classCode="ACT" moodCode="EVN">
            <!-- Technical Identifier to uniquely identify this act -->
            <id root="c92e2510-3dac-11e2-a25f-0800200c9a66"/>
            <code code="102.16692.179.1.2" codeSystem="1.2.36.1.2001.1001.101"
             codeSystemName="NCTIS Data Components" displayName="Prescription Record Link"/>
            <reference typeCode="REFR">
             <seperatableInd value="true"/>
             <externalDocument classCode="DOC" moodCode="EVN">
              <!-- templateId of the PCEHR Prescription document. -->
              <templateId extension="1.0"
               root="1.2.36.1.2001.1001.101.100.1002.170"/>
              <!-- The identifier of the document -->
```

```
              <id root="6850742c-6898-4c7b-aeb5-15b5c5779a12"/>
             </externalDocument>
            </reference>
            <reference typeCode="REFR">
             <seperatableInd value="true"/>
             <externalAct classCode="ACT" moodCode="EVN">
              <id root="1.2.36.1.2001.1007.10.8003640002000035"/>
              <code code="10"
               codeSystem="1.2.36.1.2001.1007" codeSystemName="PCEHR Identifiers" displayName="PCEHR Assigned Identifier - Repository"/>
             </externalAct>
            </reference>
           </act>
          </entry>
          <!-- End Prescription Record Link-->
          <!-- End Prescription Item entry -->
          ...
         </section>
        </component>
        <!-- End MEDICATION INSTRUCTION -->
       </section>
     </component>
     <!-- End MEDICATION ENTRIES -->
       </section>
     </component>
     <!-- End MEDICATION ENTRIES WITH SUMMARY -->
    </section>
   </component>
   <!-- End Prescribing and Dispensing Reports -->
    </structuredBody>
 <component>
   <!-- End CDA Body -->
</ClinicalDocument>
```

8 Common Patterns

8.1 code

The <code> element pattern refines the kind of act being recorded. It is of data type CD CWE (Concept Descriptor, Coded With Extensibility). It may have:

- a null attribute (*nullFlavor*)
- *originalText*
- *code* and *codeSystem*
- *translation* (CD)
- any combination of the above.

A *displayName* is highly recommended.

Where used, the *code* attribute **SHALL** contain a code from the relevant vocabulary.

Where used, the *codeSystem* attribute **SHALL** contain the OID for the relevant vocabulary. Values for coding systems can be obtained from the HL7 OID registry accessible from the HL7 home web page at *www.hl7.org*[1].

Where used, the *displayName* attribute **SHALL** contain a human readable description of the code value.

The *codeSystemName* **MAY** be present, and, where used **SHALL** contain a human readable name for the coding system.

Where used, the *originalText* element **SHALL** be used to carry the full text associated with this code as selected, typed or seen by the author of this statement.

Codes can be obtained from a variety of sources. Additional vocabularies are also available from the HL7 Version 3 Vocabulary tables, available to HL7 members through the HL7 web site. In some cases, the vocabularies have been specified; in others, a particular code has been fixed or there is no vocabulary specified.

If a vocabulary is specified in this guide and no suitable code can be found the *originalText* element **SHALL** be used to carry the full text as selected, typed or seen by the author of this statement.

[1] http://www.hl7.org

If a vocabulary is specified in this guide and it is not possible to use this vocabulary, but an alternate vocabulary is in use, the *originalText* element **SHALL** be used to carry the full text as selected, typed or seen by the author of this statement. The *code* element **SHALL** be used to carry the relevant information from the alternate vocabulary and the alternate vocabulary shall be registered with HL7 and allocated an appropriate OID.

If an alternate vocabulary is in use and a translation into the specified code system is available, the *originalText* element **SHALL** be used to carry the full text as selected, typed or seen by the author of this statement. The *code* element **SHALL** be used to carry the relevant information from the alternate vocabulary and the alternate vocabulary must be registered with HL7 and allocated an appropriate OID. The *translation* element **SHALL** be used to indicate the translation code from the specified vocabulary.

Example 8.1. code

```
<!-- Specified code system in use -->
<code
   code="271807003"
   codeSystem="2.16.840.1.113883.6.96"
   codeSystemName="SNOMED CT-AU"
   codeSystemVersion="20101130"
   displayName="skin rash" />


<!-- Alternate code system in use and a translation into the specified code system is available -->
<code
   code='49390'
   codeSystem='2.16.840.1.113883.19.6.2'
   codeSystemName='ICD9CM'
   displayName='ASTHMA W/O STATUS ASTHMATICUS'>
   <originalText>Patient is Asthmatic</originalText>
   <translation
      code='195967001'
      codeSystem='2.16.840.1.113883.19.6.96'
      codeSystemName='SNOMED CT'
      displayName='Asthma'/>
</code>


<!-- Alternate code system in use and no translation into the specified code system is available -->
<code
   code='49390'
   codeSystem='2.16.840.1.113883.19.6.2'
   codeSystemName='ICD9CM'
   displayName='ASTHMA W/O STATUS ASTHMATICUS'>
   <originalText>Patient is Asthmatic</originalText>
</code>



<!-- No suitable code can be found or there is no code system in use -->
<code
    <originalText>Patient is Asthmatic</originalText>
</code>
```

8.2 id

The <id> element pattern is of data type II (Instance Identifier). The II data type may have:

- a null attribute (*nullFlavor*)
- a *root*
- a *root* and an *extension*
- a *root* and an *extension* and an *assigningAuthorityName*
- a *root* and an *assigningAuthorityName*
- a *root* and an *assigningAuthorityName* and a *displayable*
- a *root* and an *extension* and a *displayable*
- a *root* and an *extension* and an *assigningAuthorityName* and a *displayable*
- a *root* and a *displayable*

The root attribute is required and is a unique identifier that guarantees the global uniqueness of the instance identifier. The root alone may be the entire instance identifier. The root attribute shall be a UUID or OID.

The extension attribute may be present, and is a character string as a unique identifier within the scope of the identifier root.

In the case of Entity Identifier, assigningAuthorityName is recommended.

Identifiers appear in this implementation guide for two different reasons. The first is that the identifier has been identified in the business requirements as relevant to the business process. These identifiers are documented in the Structured Content Specifications which make clear the meaning of this identifier.

In addition, the implementation makes clear that identifiers may also be found on many other parts of the CDA content model. These identifiers are allowed to facilitate record matching across multiple versions of related documents, so that the same record can consistently be identified, in spite of variations in the information as the record passes through time or between systems. These identifiers have no meaning in the business specification. If senders provide one of these identifiers, it must always be the same identifier in all versions of the record, and it must be globally unique per the rules of the II data type.

Throughout the specification, these identifiers are labelled with the following text: "This is a technical identifier that is used for system purposes such as matching."

Example 8.2. id

```
<id root="2.16.840.1.113883.19" extension="123A45" />
<ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621234567890" />
```

8.3 time

The <time> element pattern is of data type TS (Point in Time) and can also be an interval between two times (IVL_TS), representing a period of time. Both forms may either have a nullFlavor attribute or child components following allowed patterns.

Any time that is more specific than a day SHALL include a time zone.

A simple timestamp (point in time) will only contain a value attribute containing the time value, expressed as a series of digits as long as required or available.

Example 8.3. Simple timestamp

```
<time value="20091030" />
```

This represents "October 30, 2009" to calendar day precision. In cases where the containing element is defined in the CDA schema as "ANY" data type, it is useful to provide an xsi:type attribute, set to the value "TS".

The period of time pattern is defined in terms of one or both of its lowest and highest values. The low and high elements are instances of the timestamp pattern described above. More complex time period concepts can be expressed by combining a high, low, or centre element with a width element.

Example 8.4. Low time

```
<period>
   <low value="20091030" />
</period>
```

This represents "a period after October 30, 2009". In cases where the containing element is defined in the CDA schema as "ANY" data type, it is useful to provide an xsi:type attribute, set to the value "IVL_TS", as in the next example.

Example 8.5. Interval timestamp 1

```
<period xsi:type="IVL_TS">
   <high value="200910301030+1000" />
</period>
```

This represents "a period before 10:30 a.m. UTC+10, October 30, 2009". A discretionary xsi:type attribute has been provided to explicitly cast the pattern to "IVL_TS".

Example 8.6. Interval timestamp 2

```
<period xsi:type="IVL_TS">
   <low value="2007" />
   <high value="2009" />
</period>
```

This represents "the calendar years between 2007 and 2009". The low element **SHALL** precede the high element. As per the previous example, a discretionary xsi:type attribute has been provided to explicitly cast the pattern to "IVL_TS".

Example 8.7. Width time

```
<period>
   <high value="20091017" />
   <width value="2" unit="wk" />
</period>
```

This expresses "two weeks before October 17th, 2009". A low value can be derived from this.

8.4 Entity Identifier

CDA Mapping

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Data Elements					
Entity Identifier	A number or code issued for the purpose of identifying an entity (person, organisation or organisation sub-unit) within a healthcare context.	The cardinality of the group comes from the linking parent and the cardinality of the children data elements comes from the R-MIM diagram.	**ext:asEntityIdentifier**		See Australian CDA extension: Entity-Identifier.
			ext:asEntityIdentifier/**@classCode="IDENT"**		
			ext:asEntityIdentifier/**ext:id**		
			ext:asEntityIdentifier/ext:id/**@root**	Attribute @root **SHALL** be used, **SHALL** be an OID and **SHALL NOT** be a UUID. Attribute @root **SHALL** be a globally unique object identifier (OID) that identifies the combination of geographic area, issuer and type. If no such OID exists, it **SHALL** be defined before any identifiers can be created.	
			ext:asEntityIdentifier/ext:id/**@extension**	Attribute @extension **MAY** be used and if it is used, **SHALL** be a unique identifier within the scope of the root that is populated directly from the designation.	
			ext:asEntityIdentifier/ext:id/**@assigningAuthorityName**	Attribute @assigningAuthorityName **SHOULD** be used and if it is used, is a human readable name for the namespace represented in the root that is populated with the issuer, or identifier type, or a concatenation of both as appropriate. This **SHOULD NOT** be used for machine readability purposes.	
			ext:asEntityIdentifier/**ext:code**		See <code> for available attributes.
			ext:asEntityIdentifier/**ext:assigningGeographicArea**		
			ext:asEntityIdentifier/ext:assigningGeographicArea/**@classCode="PLC"**		
			ext:asEntityIdentifier/ext:assigningGeographicArea/**ext:name**	Element ext:name **MAY** be used and if it is used, is the range and extent that the identifier applies to the object with which it is associated that is populated directly from the geographic area. This **SHOULD NOT** be used for machine readability purposes. For details see: AS 5017-2006: Health Care Client Identifier Geographic Area	

Example 8.8. Entity Identifier

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<!-- person -->
<xs:asEntityIdentifier classCode="IDENT">
 <xs:id root="1.2.36.1.2001.1003.0.8003608833357361" assigningAuthorityName="IHI" />
  <xs:assigningGeographicArea classCode="PLC">
       <xs:name>National Identifier</xs:name>
      </xs:assigningGeographicArea>
</xs:asEntityIdentifier>

<xs:asEntityIdentifier classCode="IDENT">
 <xs:id root="1.2.36.1.2001.1005.29.8003619900015717" extension="542181" assigningAuthorityName="Croydon GP Centre" />
   <xs:code code="MR" codeSystem="2.16.840.1.113883.12.203" codeSystemName="Identifier Type (HL7)" />
</xs:asEntityIdentifier>

<!-- organisation -->
<ext:asEntityIdentifier classCode="IDENT">
   <ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />
   <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
   </ext:assigningGeographicArea>
</ext:asEntityIdentifier>
```

8.5 Person Name

CDA Mapping

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Data Elements					
Person Name	The appellation by which an individual may be identified separately from any other within a social context.	Cardinality comes from linking parent.	**name**		
Person Name > **Name Title**	An honorific form of address commencing a name.	0..*	name/**prefix**		
Person Name > **Family Name**	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names.	1..1	name/**family**		
Person Name > **Given Name**	The person's identifying names within the family group or by which the person is uniquely socially identified.	0..*	name/**given**		
Person Name > **Name Suffix**	The additional term used following a person's name to identify that person.	0..*	name/**suffix**		
Person Name > **Preferred Name Indicator**	A flag to indicate that this is the name a person has selected for use.	0..1	name/**@use**		Space separated list of codes. true='L' false=blank
Person Name > **Person Name Usage**	The classification that enables differentiation between recorded names for a person.	0..1	name/**@use**	AS 5017-2006: Health Care Client Name Usage	Space separated list of codes.

Example 8.9. Person Name

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<!-- preferred name -->
<name use="L">
   <prefix>Ms</prefix>
   <given>Sally</given>
   <family>Grant</family>
</name>
```

8.6 Address

CDA Mapping

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Data Elements					
Address	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	Cardinality comes from linking parent.	**addr**		
Address > **No Fixed Address Indicator**	A flag to indicate whether or not the participant has no fixed address.	1..1	addr/**@nullFlavor**	If true, nullFlavor="NA". If false omit nullFlavor and fill in address.	
Address > **Australian or International Address**	Represents a choice to be made at run-time between an AUSTRALIAN ADDRESS and an INTERNATIONAL ADDRESS.	1..1	n/a		This logical NEHTA data component has no mapping to CDA. The cardinality of this component propagates to its children.
Address > Australian or International Address > **International Address**	The description of a non-Australian location where an entity is located or can be otherwise reached or found.	0..1	n/a		This logical NEHTA data component has no mapping to CDA. The cardinality of this component propagates to its children.
Address > Australian or International Address > International Address > **International Address Line**	A composite of address details comprising a low level geographical/physical description of a location that, used in conjunction with the other high level address components, i.e. international state/province, international postcode and country, forms a complete geographic/physical address	0..*	addr/**streetAddressLine**		
Address > Australian or International Address > International Address > **International State/Province**	The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country	0..1	addr/**state**		
Address > Australian or International Address > International Address > **International Postcode**	The alphanumeric descriptor for a postal delivery area (as defined by the postal service of a country other than Australia) aligned with locality, suburb or place for an address	0..1	addr/**postalCode**		
Address > Australian or International Address > International Address > **Country**	The country component of the address.	0..1	addr/**country**	Australia Bureau of Statistics, Standard Australian Classification of Countries (SACC) Cat. No. 1269 [ABS2008]	Use the name, not the numbered code.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Address > Australian or International Address > **Australian Address**	The description of an Australian location where an entity is located or can be otherwise reached or found.	0..1	n/a		This logical NEHTA data component has no mapping to CDA. The cardinality of this component propagates to its children.
Address > Australian or International Address > Australian Address > **Unstructured Australian Address Line**	A composite of one or more low level standard address components describing a geographical/physical location that, used in conjunction with the other high level address components, e.g. Australian suburb/town/locality name, Australian postcode and Australian State/Territory, forms a complete geographical/physical address.	0..*	addr/**streetAddressLine**		
Address > Australian or International Address > Australian Address > **Structured Australian Address Line**	The standard low level address components describing a geographical/physical location that, used in conjunction with the other high level address components, i.e. Australian suburb/ town/locality name, Australian postcode and Australian State/Territory, form a complete geographical/physical address.	0..1	n/a		This logical NEHTA data component has no mapping to CDA. The cardinality of this component propagates to its children.
Address > Australian or International Address > Australian Address > Structured Australian Address Line > **Australian Unit Type**	The specification of the type of a separately identifiable portion within a building/complex, marina etc. to clearly distinguish it from another.	0..1	addr/**unitType**	AS 5017 (2006) - Healthcare Client Identification: Australian Unit Type [SA2006a] AS 4846 (2006) - Healthcare Provider Identification: Australian Unit Type [SA2006b]	
Address > Australian or International Address > Australian Address > Structured Australian Address Line > **Australian Unit Number**	The specification of the number or identifier of a building/complex, marina etc. to clearly distinguish it from another.	0..1	addr/**unitID**		
Address > Australian or International Address > Australian Address > Structured Australian Address Line > **Australian Address Site Name**	The full name used to identify the physical building or property as part of its location.	0..1	addr/**additionalLocator**		
Address > Australian or International Address > Australian Address > Structured Australian Address Line > **Australian Level Type**	Descriptor used to classify the type of floor or level of a multistorey building/complex.	0..1	addr/**additionalLocator**	AS 5017 (2006) - Healthcare Client Identification: Australian Level Type [SA2006a] AS 4846 (2006) - Healthcare Provider Identification: Australian Level Type [SA2006b]	
Address > Australian or International Address > Australian Address > Structured Australian Address Line > **Australian Level Number**	Descriptor used to identify the floor or level of a multistorey building/complex.	0..1	addr/**additionalLocator**		
Address > Australian or International Address > Australian Address > Structured Australian Address Line > **Australian Street Number**	The numeric or alphanumeric reference number of a house or property that is unique within a street name.	0..1	addr/**houseNumber**		

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Address > Australian or International Address > Australian Address > Structured Australian Address Line > **Australian Lot Number**	The Australian Lot reference allocated to an address in the absence of street numbering.	0..1	addr/**additionalLocator**		
Address > Australian or International Address > Australian Address > Structured Australian Address Line > **Australian Street Name**	The name that identifies a public thoroughfare and differentiates it from others in the same suburb/town/locality.	0..1	addr/**streetName**		
Address > Australian or International Address > Australian Address > Structured Australian Address Line > **Australian Street Type**	A code that identifies the type of public thoroughfare.	0..1	addr/**streetNameType**	AS 5017 (2006) - Healthcare Client Identification: Australian Street Type Code [SA2006a] AS 4846 (2006) - Healthcare Provider Identification: Australian Street Type Code [SA2006b]	
Address > Australian or International Address > Australian Address > Structured Australian Address Line > **Australian Street Suffix**	Term used to qualify Australian Street Name used for directional references.	0..1	addr/**direction**	AS 5017 (2006) - Healthcare Client Identification: Australian Street Suffix [SA2006a] AS 4846 (2006) - Healthcare Provider Identification: Australian Street Suffix [SA2006b]	
Address > Australian or International Address > Australian Address > Structured Australian Address Line > **Australian Postal Delivery Type**	Identification for the channel of postal delivery.	0..1	addr/**deliveryAddressLine**	AS 5017 (2006) - Healthcare Client Identification: Australian Postal Delivery Type Code [SA2006a] AS 4846 (2006) - Healthcare Provider Identification: Australian Postal Delivery Type Code [SA2006b]	
Address > Australian or International Address > Australian Address > Structured Australian Address Line > **Australian Postal Delivery Number**	Identification number for the channel of postal delivery.	0..1	addr/**deliveryAddressLine**		
Address > Australian or International Address > Australian Address > **Australian Suburb/Town/Locality**	The full name of the general locality contained within the specific address.	0..1	addr/**city**	Values in this data element should comply with descriptions in the Australia Post Postcode File (see *www.auspost.com.au/postcodes*)	
Address > Australian or International Address > Australian Address > **Australian State/Territory**	The identifier of the Australian state or territory.	0..1	addr/**state**	AS 5017-2006 Australian State/Territory Identifier - Postal	
Address > Australian or International Address > Australian Address > **Australian Postcode**	The numeric descriptor for a postal delivery area (as defined by Australia Post), aligned with locality, suburb or place for the address.	0..1	addr/**postalCode**	Values in this data element should comply with descriptions in the Australia Post Postcode File (see *www.auspost.com.au/postcodes*)	
Address > Australian or International Address > Australian Address > **Australian Delivery Point Identifier**	A unique number assigned to a postal delivery point as recorded on the Australia Post Postal Address File.	0..1	addr/**additionalLocator**		
Address > **Address Purpose**	The purpose for which the address is being used by the entity.	1..1	addr/**@use**	AS 5017-2006: Health Care Client Identifier Address Purpose	Space separated list of codes.

Example 8.10. Address

```
<!-- These examples are provided for illustrative purposes only. They have had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<!— no fixed address -->
<addr nullFlavor="NA" />


<!—Australian home address (unstructured) -->
<addr use="H">
   <streetAddressLine>1 Clinician Street</streetAddressLine>
   <city>Nehtaville</city>
   <state>QLD</state>
   <postalCode>5555</postalCode>
   <additionalLocator>32568931</additionalLocator>
</addr>

<!—Australian business address (structured) -->
<addr use="WP">
   <houseNumber>1</houseNumber>
   <streetName>Clinician</streetName>
   <streetNameType>St</streetNameType>
   <city>Nehtaville</city>
   <state>QLD</state>
   <postalCode>5555</postalCode>
   <additionalLocator>32568931</additionalLocator>
</addr>

<!—international postal address -->
<addr use="PST">
   <streetAddressLine>51 Clinician Bay</streetAddressLine>
   <city>Healthville</city>
   <state>Manitoba</state>
   <postalCode>R3T 3C6</postalCode>
   <country>Canada</country>
</addr>
```

8.7 Electronic Communication Detail

CDA Mapping

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Data Elements					
Electronic Communication Detail	The electronic communication details of entities.	Cardinality comes from linking parent.	**telecom**		
Electronic Communication Detail > **Electronic Communication Medium**	A code representing a type of communication mechanism.	1..1	telecom/**@value**	AS 5017-2006: Health Care Client Electronic Communication Medium > HL7:URLScheme	Makes up part of the value attribute as 'tel:phone number', 'mailto:email address', http:URL', etc.
			telecom/**@use**	HL7 v3: TelecommunicationAddressUse > HL7:TelecommunicationAddressUse	Space separated list of codes. The section AS 5017-2006: Health Care Client Electronic Communication Usage Code explains how to map AS 5017-2006 to HL7 TelecommunicationAddressUse (HL7 TAU) code
Electronic Communication Detail > **Electronic Communication Usage Code**	The manner of use that is applied to an electronic communication medium.	0..1	telecom/**@use**	HL7 v3: TelecommunicationAddressUse > HL7:TelecommunicationAddressUse	Space separated list of codes. The section AS 5017-2006: Health Care Client Electronic Communication Usage Code explains how to map AS 5017-2006 to HL7 TelecommunicationAddressUse (HL7 TAU) code
Electronic Communication Detail > **Electronic Communication Address**	A unique combination of characters used as input to electronic telecommunication equipment for the purpose of contacting an entity.	1..1	telecom/**@value**		

Example 8.11. Electronic Communication Detail

```
<!-- These examples are provided for illustrative purposes only. They have had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<!—home telephone number -->
<telecom value="tel:0499999999" use="H" />


<!—pager -->
<telecom value="tel:0499999999" use="PG" />


<!—home email address -->
<telecom value="mailto:clinicial@clinician.com" use="H" />
```

8.8 Employment

CDA Mapping

Note

NS = 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.

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Data Elements					
Employment Detail	A person's occupation and employer.	Cardinality comes from linking parent.	n/a		This logical NEHTA data component has no mapping to CDA.
Employment Detail > **Employer Organisation**	The organisation that the individual is working for in respect to the role they are playing in the nominated participation.	0..*	**ext:asEmployment/ext:employerOrganization**		There is a known issue in NEHTA Participation Data Specification for this logical Data Component's cardinality. Furthermore the corresponding CDA elements ext:asEmployment and ext:employerOrganization doesn't allow the cardinality to be '0..*'/multiple. The cardinality SHALL be interpreted as '0..1' instead of '0..*'.
			ext:asEmployment/**@classCode="EMP"**		

[2] http://www.hl7.org/oid/index.cfm?ref=footer

NEHTA SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Employment Detail > Employer Organisation > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..*	ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Entity Identifier>**	The value of one Entity Identifier **SHALL** be an Australian HPI-O.	See common pattern: Entity Identifier.
Employment Detail > Employer Organisation > **Organisation**	Any organisation of interest to, or involved in, the business of healthcare service provision.	1..1	n/a		Not mapped directly, encompassed implicitly in assignedAuthor/ext:asEmployment/employerOrganization.
Employment Detail > Employer Organisation > Organisation > **Organisation Name**	The name by which an organisation is known or called.	1..1	ext:asEmployment/ext:employerOrganization/**asOrganizationPartOf/wholeOrganization/name**		
Employment Detail > Employer Organisation > Organisation > **Department/Unit**	The name by which a department or unit within a larger organisation is known or called.	0..1	ext:asEmployment/ext:employerOrganization/**name**		
Employment Detail > Employer Organisation > Organisation > **Organisation Name Usage**	The classification that enables differentiation between recorded names for an organisation or service location.	0..1	ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/name/**@use**	AS 4846-2006: Health Care Provider Organisation Name Usage	
Employment Detail > **Employment Type**	The basis on which the person is employed by the employer organisation.	0..1	ext:asEmployment/**ext:jobClassCode**	NS	
Employment Detail > **Occupation**	A descriptor of the class of job based on similarities in the tasks undertaken.	0..*	ext:asEmployment/**ext:jobCode**	1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, 2006 - METeOR 350899 [ABS2006]	The corresponding CDA element ext:jobCode doesn't allow the cardinality be '0..*'/multiple. The cardinality SHALL be interpreted as '0..1' instead of '0..*'.
Employment Detail > **Position In Organisation**	A descriptor of the job or the job role based on the management hierarchy of the organisation.	0..1	ext:asEmployment/**ext:code**	NS	

Example 8.12. Employment

```
<!-- This example is provided for illustrative purposes only. It has had no clinical validation.
While every effort has been taken to ensure that the examples are consistent with the message specification,
where there are conflicts with the written message specification or schema, the specification or schema shall be considered to take precedence -->

<!-- Employment Details -->
<ext:asEmployment classCode="EMP">
    <!-- Position In Organisation -->
    <ext:code>
        <originalText>Senior Medical Oncologist</originalText>
    </ext:code>
    <!-- Occupation -->
    <ext:jobCode code="253314" codeSystem="2.16.840.1.113883.13.62"
        codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, 2006"
        displayName="Medical Oncologist"/>
    <!-- Employment Type -->
    <ext:jobClassCode code="FT" codeSystem="2.16.840.1.113883.5.1059"
        codeSystemName="HL7:EmployeeJobClass" displayName="full-time"/>
    <!-- Employer Organisation -->
    <ext:employerOrganization>
        <!-- Department/Unit -->
        <name>GP Clinic</name>
        <asOrganizationPartOf>
            <wholeOrganization>
                <!-- Organisation Name -->
                <name use="ORGB">GP Clinics</name>
                <!-- Entity Identifier -->
                <ext:asEntityIdentifier classCode="IDENT">
                    <ext:id assigningAuthorityName="HPI-O"
                        root="1.2.36.1.2001.1003.0.8003621231167899"/>
                    <ext:assigningGeographicArea classCode="PLC">
                        <ext:name>National Identifier</ext:name>
                    </ext:assigningGeographicArea>
                </ext:asEntityIdentifier>
            </wholeOrganization>
        </asOrganizationPartOf>
    </ext:employerOrganization>
</ext:asEmployment>
```

8.9 PCEHR URN Scheme

The 'pcehr:URN' scheme is used to convey logical references to other CDA documents. A URN constructed by the pcehr: scheme has the following parts:

pcehr:[repository_id]/[document-id-root-as-OID](^[document-id-extension])

Note that the document-id-extension part is optional (and only supported if original document-id-root is an OID), if the original document didn't have an extension in its id. Both the repository id and the document id are required when retrieving the document from the PCEHR using the B2B interface.

As an example, the reference:

```
<linkHtml href="pcehr:1.2.36.1.2001.1007.10.8003640002000035/2.25.154933408817574926934338372917507695657^a12323">Document</linkHtml>
```

Creates a hyperlink that refers to the document with the following id element:

< id root="748f16d2-0f9a-4989-96b1-b1279140a429" extension="a12323"/ >

The document is found on the repository "1.2.36.1.2001.1007.10.8003640002000035".

The "2.25.154933408817574926934338372917507695657" is an OID formed using the UUID "748f16d2-0f9a-4989-96b1-b1279140a429" as defined in [ITU-X.667]

The full <linkHtml> format is as follows:

Example 8.13. PCEHR URN Scheme

```
<content>
    ...
    <linkHtml href="pcehr:1.2.36.1.2001.1007.10.8003640002000035/748f16d2-0f9a-4989-96b1-b1279140a429^a12323">Document</linkHtml>
    ...
 </content>
```

Notes:

- The pcehr: schema is not a URL – it does not refer directly to a document by its location. In order to retrieve the document, the contents must be parsed and used in a B2B getDocument call.
- The repository id is an opaque reference – the only use consumer applications can make of it is to pass it to the B2B interface when making a getDocument call.
- Documents are globally uniquely identified. Document ids **SHALL** never be changed and **SHALL NOT** be re-used.

- The reference to the CDA document **SHALL** be included in the CDA narrative in a <linkHTML> element.
- Systems should not assume that a particular document will always be associated with the same repository.
- Systems may store the PCEHR Prescription and Dispense View in order to retain clinical decision making evidence.
- Systems should not rely on the availability of links found in the PCEHR Prescription and Dispense View.
- System can rely on the fact that links provided in the PCEHR Prescription and Dispense View will never be re-used to point to other documents.

9 Australian CDA Extensions

As part of the CDA, standard extensions are allowed as follows:

> Locally-defined markup may be used when local semantics have no corresponding representation in the CDA specification. CDA seeks to standardize the highest level of shared meaning while providing a clean and standard mechanism for tagging meaning that is not shared. In order to support local extensibility requirements, it is permitted to include additional XML elements and attributes that are not included in the CDA schema. These extensions should not change the meaning of any of the standard data items, and receivers must be able to safely ignore these elements. Document recipients must be able to faithfully render the CDA document while ignoring extensions.
>
> Extensions may be included in the instance in a namespace other than the HL7v3 namespace, but must not be included within an element of type ED (e.g., <text> within <procedure>) since the contents of an ED datatype within the conformant document may be in a different namespace. Since all conformant content (outside of elements of type ED) is in the HL7 namespace, the sender can put any extension content into a foreign namespace (any namespace other than the HL7 namespace). Receiving systems must not report an error if such extensions are present. "HL7 Clinical Document Architecture, Release 2" [HL7CDAR2]

As such the following extensions have been defined where Australian concepts were not represented in CDA.

This section is provided for clarity only. Please see the relevant mappings section where these extensions have been used for actual mapping details.

9.1 ClinicalDocument.completionCode

Figure 9.1, “CDA R-MIM Representation” shows a subset of the CDA R-MIM containing those classes with the relevant Australian CDA extension represented.

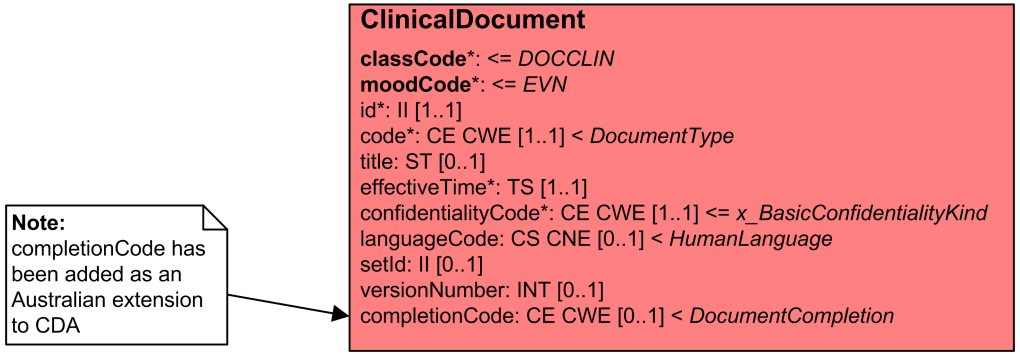

Figure 9.1. CDA R-MIM Representation

9.2 EntityIdentifier

Figure 9.2, “CDA R-MIM Representation” shows a subset of the CDA R-MIM containing those classes with the relevant Australian CDA extension represented.

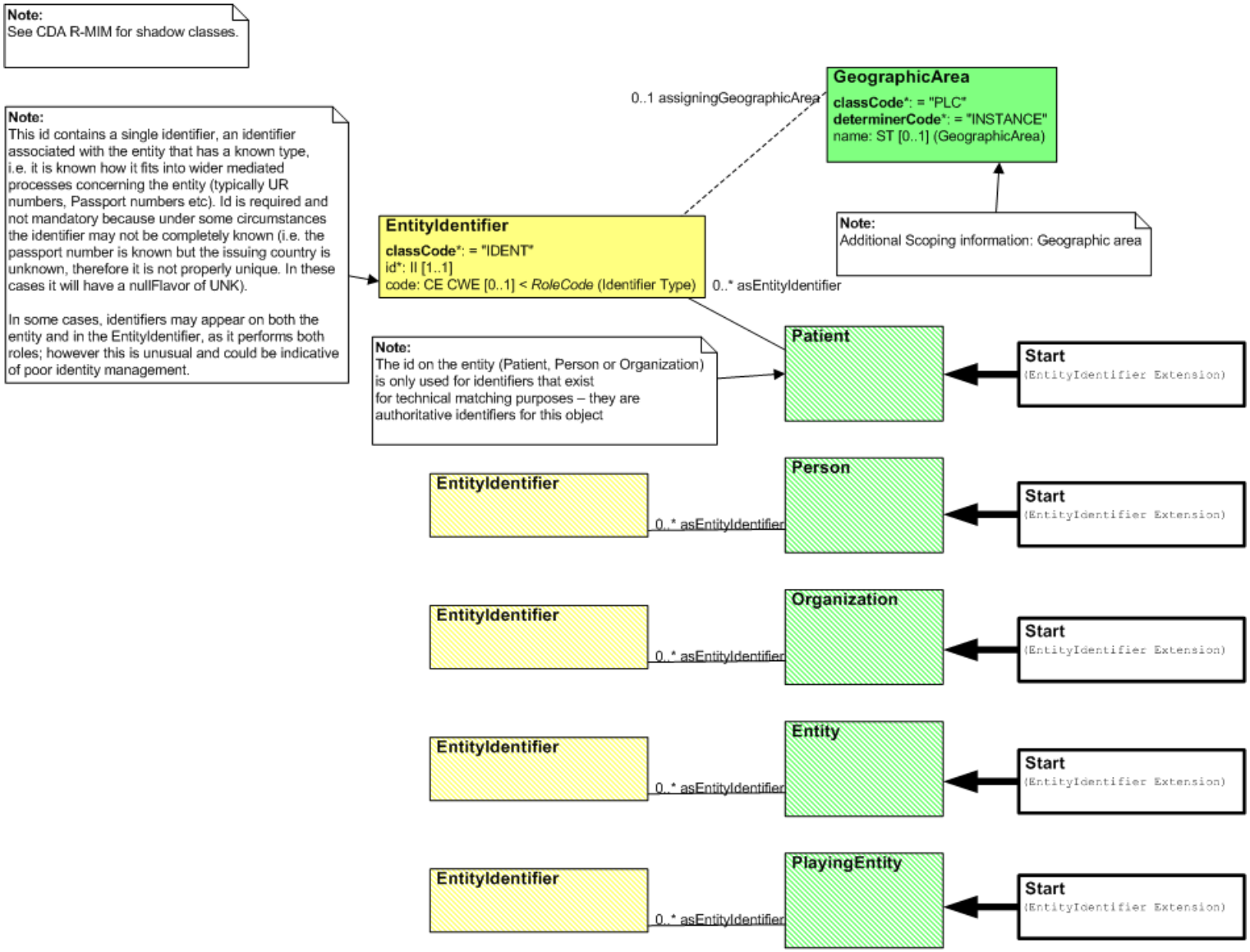

Figure 9.2. CDA R-MIM Representation

9.3 Entitlement

Figure 9.3, “CDA R-MIM Representation” shows a subset of the CDA R-MIM containing those classes with the relevant Australian CDA extension represented.

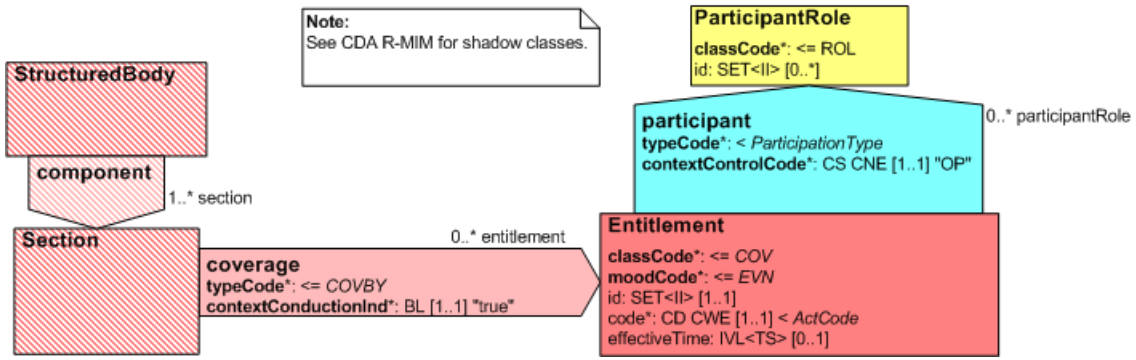

Figure 9.3. CDA R-MIM Representation

9.4 Multiple Birth

Figure 9.4, “CDA R-MIM Representation” shows a subset of the CDA R-MIM containing those classes with the relevant Australian CDA extension represented.

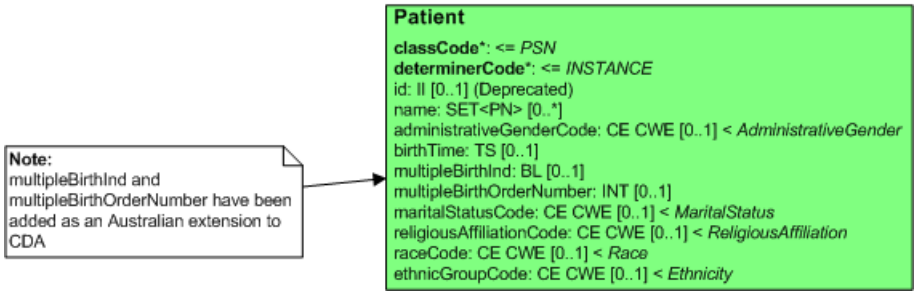

Figure 9.4. CDA R-MIM Representation

9.5 Administrative Gender Code

Figure 9.5, “CDA R-MIM Representation” shows a subset of the CDA R-MIM containing those classes with the relevant Australian CDA extension represented.

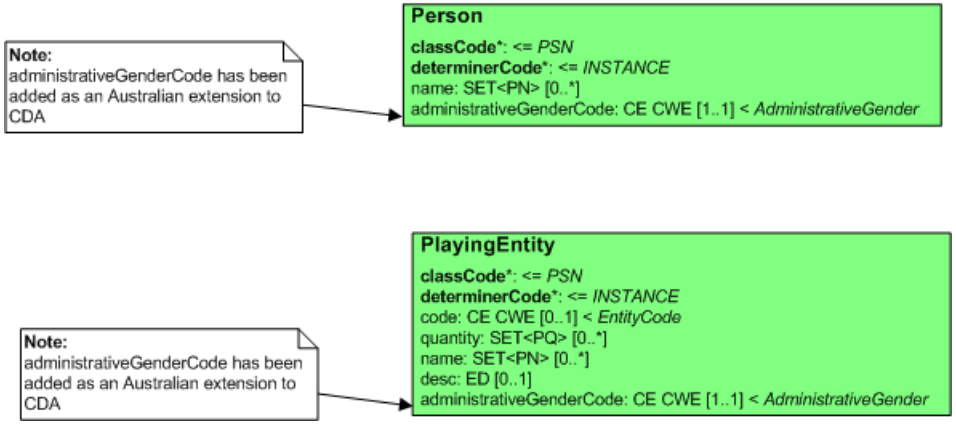

Figure 9.5. CDA R-MIM Representation

9.6 Birth Time

Figure 9.6, “CDA R-MIM Representation” shows a subset of the CDA R-MIM containing those classes with the relevant Australian CDA extension represented.

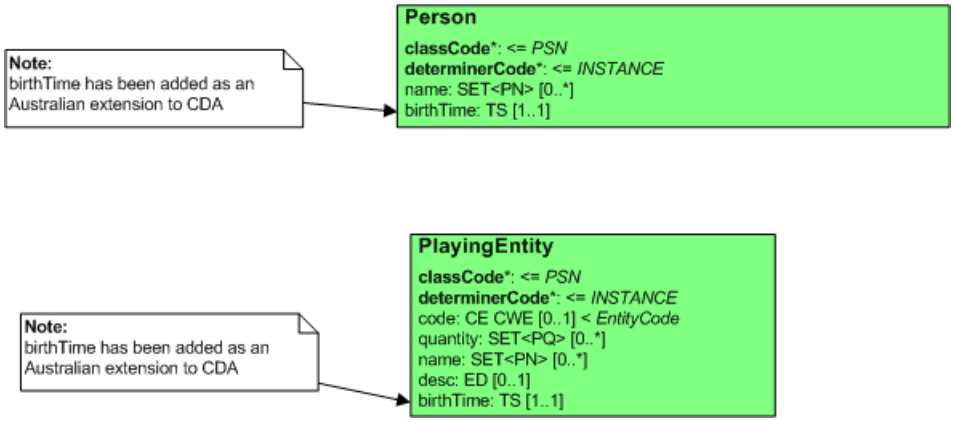

Figure 9.6. CDA R-MIM Representation

9.7 Deceased Time

Figure 9.7, “CDA R-MIM Representation” shows a subset of the CDA R-MIM containing those classes with the relevant Australian CDA extension represented.

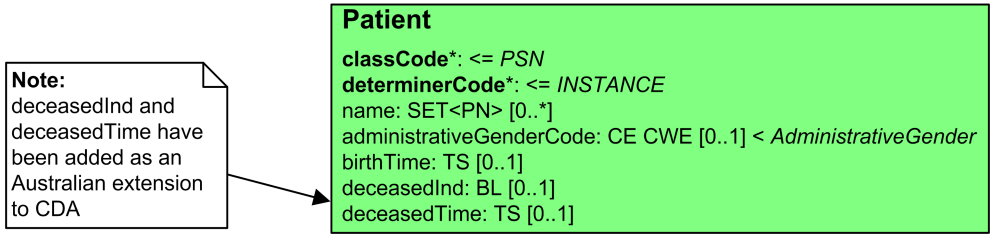

Figure 9.7. CDA R-MIM Representation

9.8 Employment

Figure 9.8, “CDA R-MIM Representation” shows a subset of the CDA R-MIM containing those classes with the relevant Australian CDA extension represented.

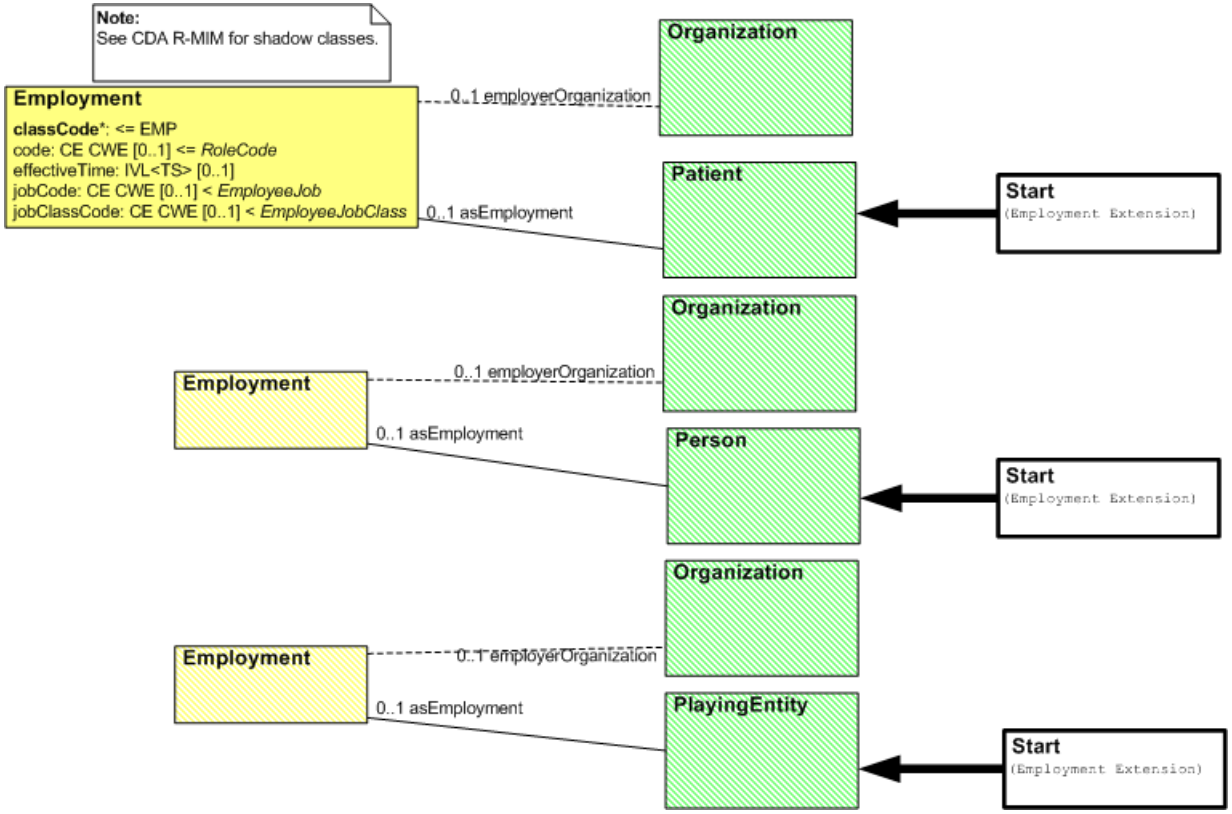

Figure 9.8. CDA R-MIM Representation

9.9 Qualifications

Figure 9.9, “CDA R-MIM Representation” shows a subset of the CDA R-MIM containing those classes with the relevant Australian CDA extension represented.

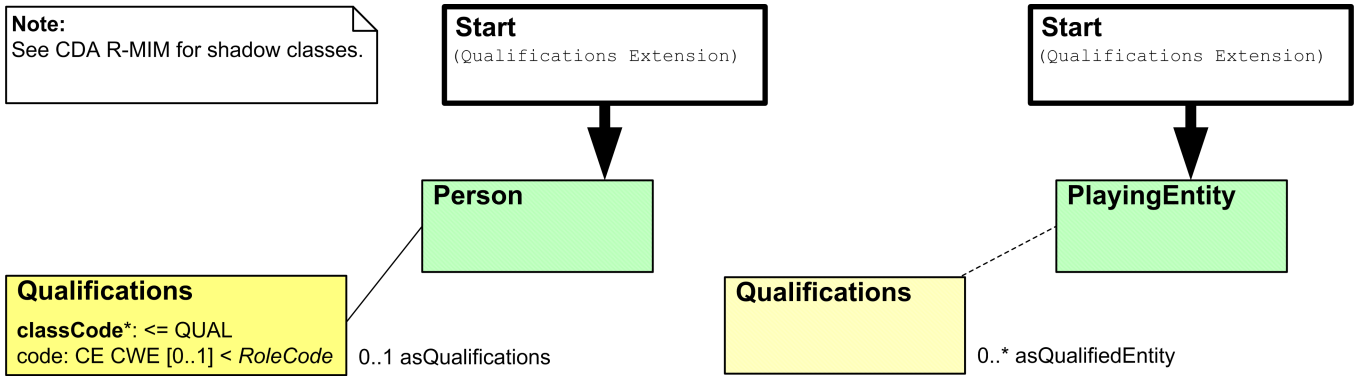

Figure 9.9. CDA R-MIM Representation

9.10 BrandSubstituteAllowed

Figure 9.10, “CDA R-MIM Representation”

Note:
See CDA R-MIM for shadow classes.

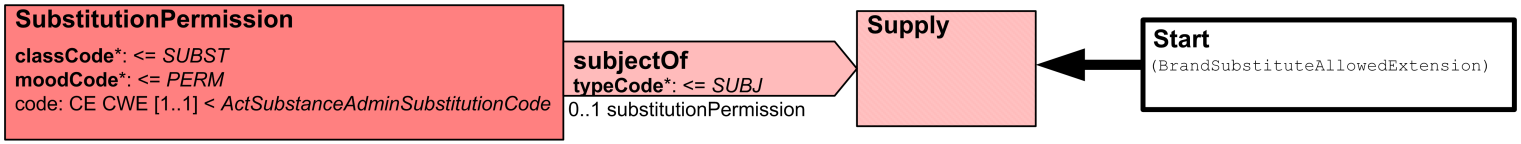

Figure 9.10. CDA R-MIM Representation

10 Vocabularies/Code Sets

When referencing the following vocabulary tables, if one column in the code set table is bolded, use the code in that column, otherwise use the values in all columns.

Example 10.1. All values

```
<code
   code="103.16044.4.1.1"
   codeSystem="1.2.36.1.2001.1001"
   codeSystemName="&NCTIS_CODE_SYSTEM_NAME;"
   displayName="Additional Comments" />
```

Example 10.2. One value

```
<name use="L">
   {name}
</name>
```

10.1 HL7 v3: TelecommunicationAddressUse

Code	Value
H	Home
HP	Primary Home
HV	Vacation Home
WP	Workplace
AS	Answering Service
EC	Emergency Contact
MC	Mobile Contact
PG	Pager

10.2 AS 5017-2006 Health Care Client Identifier Sex

displayName	code	codeSystemName	codeSystem
Male	M	AS 5017-2006 Health Care Client Identifier Sex	2.16.840.1.113883.13.68
Female	F	AS 5017-2006 Health Care Client Identifier Sex	2.16.840.1.113883.13.68
Intersex or Indeterminate	I	AS 5017-2006 Health Care Client Identifier Sex	2.16.840.1.113883.13.68
Not Stated/Inadequately Described	N	AS 5017-2006 Health Care Client Identifier Sex	2.16.840.1.113883.13.68

10.3 AS 5017-2006: Health Care Client Name Usage

Code Set AS 5017-2006 mapped to HL7 Name Use Code

Note

CDA Release 2 uses HL7 Data Types Release 1. For some of the AS 5017-2006 values there are no satisfactory equivalents in the HL7 Name Use R1 code set. In these cases (marked R2) an HL7 Name Use R2 code has been used.

Note

In cases (marked EXT) where there are no suitable HL7 codes, extension codes have been created.

AS 5017-2006 Code	AS 5017-2006 Alternative Code	AS 5017-2006 Descriptor	HL7 Name Use Code	HL7 Name Use Name	HL7 Name Use Definition
1	L	Registered Name (Legal Name)	**L**	(R1) Legal	(R1) Known as/conventional/the one you use
2	R	Reporting Name	**C**	(R1) License	(R1) As recorded on a license, record, certificate, etc. (only if different from legal name)
3	N	Newborn Name	**NB**	(EXT)	(EXT)
4	B	Professional or Business Name	**A**	(R1) Artist/Stage	(R1) Includes writer's pseudonym, stage name, etc
5	M	Maiden Name (Name at birth)	**M**	(R2) Maiden Name	A name used prior to marriage.
8	O	Other Name (Alias)	**P**	(R1) Pseudonym	(R1) A self-asserted name that the person is using or has used

10.4 AS 4846-2006: Health Care Provider Organisation Name Usage

Code Set AS 5017-2006 Organisation Name Usage mapped to HL7 Name Use Code

Note

There are no suitable HL7 codes so extension codes have been created.

AS 4846-2006 Code	AS 4846-2006 Alternative Code	AS 4846-2006 Descriptor	HL7 Name Use Code	HL7 Name Use Name	HL7 Name Use Definition
1	U	Organizational unit/section/division name	**ORGU**	(EXT)	(EXT)
2	S	Service location name	**ORGS**	(EXT)	(EXT)
3	B	Business name	**ORGB**	(EXT)	(EXT)
4	L	Locally used name	**ORGL**	(EXT)	(EXT)
5	A	Abbreviated name	**ORGA**	(EXT)	(EXT)
6	E	Enterprise name	**ORGE**	(EXT)	(EXT)
8	X	Other	**ORGX**	(EXT)	(EXT)
9	Y	Unknown	**ORGY**	(EXT)	(EXT)

10.5 AS 5017-2006: Health Care Client Source of Death Notification

displayName	code	codeSystemName	codeSystem
Official death certificate or death register	D	AS 5017-2006 Health Care Client Source of Death Notification	2.16.840.1.113883.13.64
Health Care Provider	H	AS 5017-2006 Health Care Client Source of Death Notification	2.16.840.1.113883.13.64
Relative	R	AS 5017-2006 Health Care Client Source of Death Notification	2.16.840.1.113883.13.64
Other	O	AS 5017-2006 Health Care Client Source of Death Notification	2.16.840.1.113883.13.64
Unknown	U	AS 5017-2006 Health Care Client Source of Death Notification	2.16.840.1.113883.13.64

10.6 AS 5017-2006: Health Care Client Identifier Address Purpose

AS 5017-2006 mapped to HL7 Address Use Code

AS 5017-2006 Code	AS 5017-2006 Alternative Code	AS 5017-2006 Descriptor	HL7 Address Use Code	HL7 Address Use Name	HL7 Address Use Definition
1	B	Business	**WP**	Work Place	An office address. First choice for business related contacts during business hours.
2	M	Mailing or Postal	**PST**	Postal Address	Used to send mail.
3	T	Temporary Accommodation (individual provider only)	**TMP**	Temporary Address	A temporary address, may be good for visit or mailing.
4	R	Residential (permanent) (individual provider only)	**H**	Home Address	A communication address at a home.
9	U	Not Stated/Unknown/Inadequately Described	**In this case simply omit the Address Use Code**		

10.7 AS 5017-2006: Health Care Client Identifier Geographic Area

displayName	code	codeSystemName	codeSystem
Local Client (Unit Record) Identifier	L	AS 5017-2006 Health Care Client Identifier Geographic Area	2.16.840.1.113883.13.63
Area/Region/District Identifier	A	AS 5017-2006 Health Care Client Identifier Geographic Area	2.16.840.1.113883.13.63
State or Territory Identifier	S	AS 5017-2006 Health Care Client Identifier Geographic Area	2.16.840.1.113883.13.63
National Identifier	N	AS 5017-2006 Health Care Client Identifier Geographic Area	2.16.840.1.113883.13.63

10.8 AS 5017-2006: Health Care Client Electronic Communication Medium

AS 5017-2006 Code	AS 5017-2006 Descriptor	AS 5017-2006 Alternative Code	HL7 URLScheme Code	HL7 URLScheme Name	HL7 URLScheme Definition
1	Telephone (excluding mobile telephone)	T	**tel**	Telephone	A voice telephone number.
2	Mobile (cellular) telephone NOTE: Mobile will also need a Telecommunication-Address Use code of MC (Mobile Contact) (see HL7 v3: TelecommunicationAddressUse)	M	**tel**	Telephone	A voice telephone number.
3	Facsimile machine	F	**fax**	Fax	A telephone number served by a fax device.
4	Pager NOTE: Pager will also need a TelecommunicationAddress Use code of PG (Pager) (see HL7 v3: TelecommunicationAddressUse)	P	**tel**	Telephone	A voice telephone number
5	Email	E	**mailto**	Mailto	Electronic mail address.

AS 5017-2006 Code	AS 5017-2006 Descriptor	AS 5017-2006 Alternative Code	HL7 URLScheme Code	HL7 URLScheme Name	HL7 URLScheme Definition
6	URL	U	Use the most appropriate code from the list below:		
			file	File	Host-specific local file names [RCF 1738]. Note that the file scheme works only for local files. There is little use for exchanging local file names between systems, since the receiving system likely will not be able to access the file.
			ftp	FTP	The File Transfer Protocol (FTP).
			http	HTTP	Hypertext Transfer Protocol.
			mllp	MLLP	The traditional HL7 Minimal Lower Layer Protocol. The URL has the form of a common IP URL e.g., mllp://<host>:<port>/ with <host> being the IP address or DNS hostname and <port> being a port number on which the MLLP protocol is served.
			modem	Modem	A telephone number served by a modem device.
			nfs	NFS	Network File System protocol. Some sites use NFS servers to share data files.
			telnet	Telnet	Reference to interactive sessions. Some sites, (e.g., laboratories) have TTY based remote query sessions that can be accessed through telnet.

10.9 AS 5017-2006: Health Care Client Electronic Communication Usage Code

AS 5017-2006 mapped to HL7 TelecommunicationAddressUse (HL7 TAU) Code

Code	Descriptor	Alternative Code	HL7 TAU Code	HL7 TAU Name	HL7 TAU Description
1	Business	B	**WP**	Work place	An office address. First choice for business related contacts during business hours.
2	Personal	P	**H**	Home address	A communication address at a home, attempted contacts for business purposes might intrude privacy and chances are one will contact family or other household members instead of the person one wishes to call. Typically used with urgent cases, or if no other contacts are available.
3	Both business and personal use	A	**WP H**	Both Work place and Home address	

10.10 AS 5017-2006 Australian State/Territory Identifier - Postal

Code	Descriptor
NSW	New South Wales
VIC	Victoria
QLD	Queensland
SA	South Australia
WA	Western Australia
TAS	Tasmania
NT	Northern Territory
ACT	Australian Capital Territory
U	Unknown

10.11 AS 5017-2006 Health Care Client Identifier Date Accuracy Indicator

The data elements that use this value set consist of a combination of three codes, each of which denotes the accuracy of one date component:

A – The referred date component is ‘accurately known’.

E – The referred date component is an ‘estimate’.

U – The referred date component is ‘unknown’.

The data elements that use this value set contain positional fields (DMY).

Field 1 (D) – refers to the accuracy of the ‘day component’.

Field 2 (M) – refers to the accuracy of the ‘month component’.

Field 3 (Y) – refers to the accuracy of the ‘year component’.

Note

The order of the date components in the HL7 date and time datatypes (YYYYMMDD) is the reverse of that specified above.

The possible combinations are as follows:

code	descriptor
AAA	Accurate date
AAE	Accurate day and month, estimated year
AEA	Accurate day, estimated month, accurate year
AAU	Accurate day and month, unknown year
AUA	Accurate day, unknown month, accurate year
AEE	Accurate day, estimated month and year
AUU	Accurate day, unknown month and year
AEU	Accurate day, estimated month, unknown year

code	descriptor
AUE	Accurate day, unknown month
EEE	Estimated date
EEA	Estimated day and month, accurate year
EAE	Estimated day, accurate month
EEU	Estimated day and month, unknown year
EUE	Estimated day, unknown month, estimated year
EAA	Estimated day, accurate month and year
EUU	Estimated day, unknown month and year
EAU	Estimated day, accurate month, unknown year
EUA	Estimated day, unknown month, accurate year
UUU	Unknown date
UUA	Unknown day and month, accurate year
UAU	Unknown day, accurate month, unknown year
UUE	Unknown day and month, estimated year
UEU	Unknown day, estimated month, unknown year
UAA	Unknown day, accurate month and year
UEE	Unknown day, estimated month and year
UAE	Unknown day, accurate month, estimated year
UEA	Unknown day, estimated month, accurate year

10.12 NCTIS: Admin Codes - Sections/Entries

displayName	code	codeSystemName	codeSystem
Additional Comments	103.16044	NCTIS Data Components	1.2.36.1.2001.1001.101
Administrative Observations	102.16080	NCTIS Data Components	1.2.36.1.2001.1001.101
Age	103.20109	NCTIS Data Components	1.2.36.1.2001.1001.101
Age Accuracy Indicator	103.16279	NCTIS Data Components	1.2.36.1.2001.1001.101
Birth Plurality	103.16249	NCTIS Data Components	1.2.36.1.2001.1001.101
Brand Substitution Occurred	103.16064	NCTIS Data Components	1.2.36.1.2001.1001.101
Date of Birth Accuracy Indicator	102.16234	NCTIS Data Components	1.2.36.1.2001.1001.101
Date of Birth is Calculated From Age	103.16233	NCTIS Data Components	1.2.36.1.2001.1001.101
Formula	103.16272	NCTIS Data Components	1.2.36.1.2001.1001.101
Therapeutic Good Strength (Dispense Item)	103.16769.171.1.1	NCTIS Data Components	1.2.36.1.2001.1001.101
Therapeutic Good Strength (Prescription Item)	103.16769.170.1.1	NCTIS Data Components	1.2.36.1.2001.1001.101
Unique Pharmacy Prescription Number	103.16786	NCTIS Data Components	1.2.36.1.2001.1001.101
Qualifications	103.16268	NCTIS Data Components	1.2.36.1.2001.1001.101
Reason for Therapeutic Good	103.10141	NCTIS Data Components	1.2.36.1.2001.1001.101

10.13 NCTIS: Admin Codes - Document Status

displayName	code	codeSystemName	codeSystem
Interim	I	NCTIS Document Status Values	1.2.36.1.2001.1001.101.104.20104
Final	F	NCTIS Document Status Values	1.2.36.1.2001.1001.101.104.20104
Withdrawn	W	NCTIS Document Status Values	1.2.36.1.2001.1001.101.104.20104

10.14 NCTIS: Admin Codes - Global Statement Values

displayName	code	codeSystemName	codeSystem
None known	01	NCTIS Global Statement Values	1.2.36.1.2001.1001.101.104.16299
Not asked	02	NCTIS Global Statement Values	1.2.36.1.2001.1001.101.104.16299
None supplied	03	NCTIS Global Statement Values	1.2.36.1.2001.1001.101.104.16299

10.15 NCTIS: Admin Codes - Entitlement Type

displayName	code	codeSystemName	codeSystem
Medicare Benefits	1	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Pensioner Concession	2	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Commonwealth Seniors Health Concession	3	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Health Care Concession	4	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Repatriation Health Gold Benefits	5	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Repatriation Health White Benefits	6	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Repatriation Health Orange Benefits	7	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Safety Net Concession	8	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Safety Net Entitlement	9	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Medicare Prescriber Number	10	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Medicare Pharmacy Approval Number	11	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047

10.16 NCTIS: CDA Template OIDS

Document Type	TemplateId
PCEHR Prescription Record	1.2.36.1.2001.1001.100.1002.170
PCEHR Dispense Record	1.2.36.1.2001.1001.100.1002.171

10.17 HL7 v3 CDA: Act.moodCode

Code	Value	Definition
EVN	Event	The entry defines an actual occurrence of an event.
INT	Intent	The entry is intended or planned.
APT	Appointment	The entry is planned for a specific time and place.
ARQ	Appointment Request	The entry is a request for the booking of an appointment.
PRMS	Promise	A commitment to perform the stated entry.
PRP	Proposal	A proposal that the stated entry be performed.
RQO	Request	A request or order to perform the stated entry.
DEF	Definition	The entry defines a service (master).

10.18 HL7 v3 CDA: RelatedDocument.typeCode

Code	Value	Definition
RPLC	Replace	The current document is a replacement of the ParentDocument.
XFRM	Transform	The current document is a transformation of the ParentDocument.

10.19 METeOR 291036: Indigenous Status

displayName	code	codeSystemName	codeSystem
Aboriginal but not Torres Strait Islander origin	1	METeOR Indigenous Status	2.16.840.1.113883.3.879.291036
Torres Strait Islander but not Aboriginal origin	2	METeOR Indigenous Status	2.16.840.1.113883.3.879.291036
Both Aboriginal and Torres Strait Islander origin	3	METeOR Indigenous Status	2.16.840.1.113883.3.879.291036
Neither Aboriginal nor Torres Strait Islander origin	4	METeOR Indigenous Status	2.16.840.1.113883.3.879.291036
Not stated/inadequately described	9	METeOR Indigenous Status	2.16.840.1.113883.3.879.291036

10.20 NCTIS: Admin Codes - Result Status

displayName	code	codeSystemName	codeSystem
Registered [No result yet available.]	1	NCTIS Result Status Values	1.2.36.1.2001.1001.101.104.16501
Interim [This is an initial or interim result: data may be missing or verification not been performed.]	2	NCTIS Result Status Values	1.2.36.1.2001.1001.101.104.16501
Final [The result is complete and verified by the responsible practitioner.]	3	NCTIS Result Status Values	1.2.36.1.2001.1001.101.104.16501
Amended [The result has been modified subsequent to being Final, and is complete and verified by the practitioner.]	4	NCTIS Result Status Values	1.2.36.1.2001.1001.101.104.16501
Cancelled / Aborted [The result is not available because the examination was not started or completed.]	5	NCTIS Result Status Values	1.2.36.1.2001.1001.101.104.16501

10.21 OIDs

codeSystem (OID)	codeSystemName
2.16.840.1.113883.13.62	1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, 2006
2.16.840.1.113883.13.65	AIHW Mode of Separation
2.16.840.1.113883.6.96	SNOMED CT
2.16.840.1.113883.6.96	Australian Medicines Terminology (AMT)
2.16.840.1.113883.6.1	LOINC
1.2.36.1.2001.1005.17	Australian Vaccine Code
1.2.36.1.2001.1007	PCEHR Identifiers

Appendix A. CDA Narratives

CDA requires that each Section in its Body include a narrative block, containing a clinically complete version of the section's encoded content using custom hypertext markup defined by HL7. The narrative is the human-readable and attestable part of a CDA document, and must stand alone as an accurate representation of the content of the document without any need to consult entries in the body.

There is no canonical markup for specific CDA components, but some conformance points apply:

- The narrative block **SHALL** be encapsulated within text component of the CDA Section.
- The narrative contents **SHALL** conform to the requirements specified in the CDA Rendering Specification.
    - In accordance with the requirement to completely represent Section contents, values of codedText or codedableText data elements defined in the SCS **SHALL** include an originalText or a displayName component (or both). Where available, the originalText **SHOULD** be found in the narrative, otherwise the displayName **SHOULD** be found in the narrative.
- It **SHALL** completely and accurately represent the clinical information encoded in the Section. Content **SHALL NOT** be omitted from the narrative.
- It **SHALL** conform to the content requirements of the CDA specification [HL7CDAR2] and/or XML Schema.

Clinical judgement is required to determine the appropriate presentation for narrative. NEHTA may release additional guidance in this regard. The examples provided in sections of this document, and the separate full example, offer some guidance for narrative block markup. They may be easily adapted as boilerplate markup.

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