nehta

# Specialist Letter

## Structured Content Specification

Version 1.1 — 2 Dec 2011

Final

**National E-Health Transition Authority Ltd**

Level 25
56 Pitt Street
Sydney NSW 2000
Australia
www.nehta.gov.au

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# Document Information

## Document owner

| Document Owner |
| --- |
| The National Clinical Terminology and Information Service |

## Change history

| Version | Date | Comments |
| --- | --- | --- |
| 1.1 | 2 Dec 2011 | Initial draft. |

## Related documents

| Name | Version/Release Date |
| --- | --- |
| *NEHTA Acronyms, Abbreviations & Glossary of Terms* | Version 1.2, Issued 25 May 2005 |
| *Participation Data Specification* | Version 3.2, Issued 20 July 2011 |
| *Medication Instruction And Action Detailed Clinical Model Specification* | Version 2.1 |
| *Problem Diagnosis Detailed Clinical Model Specification* | Version 3.1 |
| *Procedure Detailed Clinical Model Specification* | Version 3.1 |
| *Miscellaneous Detailed Clinical Model Specification* | Version 1.2, Issued To Be Published |
| *Adverse Reaction Detailed Clinical Model Specification* | Version 3.1 |
| *Pathology Test Result Detailed Clinical Model Specification* | Version 2.1 |
| *Imaging Examination Result Detailed Clinical Model Specification* | Version 2.1 |

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- Standards Australia;
- Members of the Australian DataTypes Project;
- Australian Institute of Health & Welfare; and
- Ocean Informatics.

# Table of Contents

# 1 Introduction

This document is a Structured Content Specification (SCS, previously known as Structured Document Template) for a Specialist Letter. It specifies the information structure of NEHTA-compliant Specialist Letters in order to support the transfer of information about a specialist consultation initiated by a referral.

Appendix B: *Specification Guide for Use* provides definitional details on data type constraints applied to data elements defined in the SCS. It also provides important information on how to read and use the SCS best. Therefore, it is an essential compendium for better understanding of the SCS.

NEHTA values your questions and comments about this document. Please direct your questions or feedback to clinicalinformation@nehta.gov.au.

## 1.1 Document Purpose

This document describes the Structured Content Specification for a Specialist Letter from a clinical communication perspective.

The content within this document provides reviewers (software development teams, architects, designers, clinicians and informatics researchers) with the necessary information (or references to information held outside this document) to evaluate and assess the clinical suitability of NEHTA-endorsed specifications for the electronic transfer of Specialist Letter.

It is also a key input to the NEHTA Specialist Letter CDA Implementation Guide [NEHT2011be], which describes how to implement NEHTA-compliant Specialist Letters using the HL7 Clinical Document Architecture [HL7CDAR2].

## 1.2 Intended Audience

This document is aimed at software development teams, architects, designers, clinicians and informatics researchers who are responsible for the delivery of clinical applications, infrastructure components and messaging interfaces and also for those who wish to evaluate the clinical suitability of NEHTA-endorsed specifications.

## 1.3 Document Scope

This document specifies the essential clinical data groups and elements to be captured in a Specialist Letter exchange and the constraints that should be applied. Its scope is aligned to the document Concept of Operations: Relating to the introduction of a Personally Controlled Electronic Health Record System [DHA2011b].

This is not a guide to implementing any specific messaging standard.

## 1.4 Known Issues

This is a preliminary draft for trial implementation.

Known issues with this document are described in A: *Known Issues*.

# 2 Specialist Letter Structured Document

## 2.1 Purpose

The aim of a Specialist Letter is to provide response to the referring general practitioners about the specialist consultation.

## 2.2 Use

A Specialist Letter may also be used to update a health care provider's local record or to share information, at the discretion of the clinician and with the consent of the individual.

# 2.3 SPECIALIST LETTER

## Identification

| | |
|---|---|
| **Label** | SPECIALIST LETTER |
| **Metadata Type** | Structured Document |
| **Identifier** | SD-16615 |
| **OID** | 1.2.36.1.2001.1001.101.100.16615 |

## Definition

| | |
|---|---|
| **Definition** | Document containing information about a specialist consultation. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Data Hierarchy

| | | | | |
|---|---|---|---|---|
| | SPECIALIST LETTER | | | |
| CONTEXT | | | | |
| | | SUBJECT OF CARE | | 1..1 |
| | | DOCUMENT AUTHOR | | 1..1 |
| | | DateTime Authored | | 1..1 |
| | | DateTime Subject of Care Seen (DateTime Health Event Started) | | 1..1 |
| | | ~~DateTime Health Event Ended~~ | | ~~0..0~~ |
| | | ~~HEALTHCARE FACILITY~~ | | ~~0..0~~ |
| | | USUAL GP | | 0..1 |
| | | REFERRER | | 1..1 |
| | | DateTime Attested | | 1..1 |
| CONTENT | | | | |
| | | Response Details (RESPONSE DETAILS) | | 1..1 |
| | | | Diagnosis (PROBLEM/DIAGNOSIS) | 0..* |

| | | | | | |
|---|---|---|---|---|---|
| | | | | Diagnosis Name (Problem/Diagnosis Identification) | 1..1 |
| | | | | ~~Clinical Description~~ | ~~0..0~~ |
| | | | | ~~Severity~~ | ~~0..0~~ |
| | | | | ~~Date of Onset~~ | ~~0..0~~ |
| | | | | ~~Age at Onset~~ | ~~0..0~~ |
| | | | | ~~ANATOMICAL LOCATION~~ | ~~0..0~~ |
| | | | | ~~Occurrence Summary (PROBLEM/DIAGNOSIS OCCURRENCE SUMMARY)~~ | ~~0..0~~ |
| | | | | ~~RELATED ITEMS~~ | ~~0..0~~ |
| | | | | ~~Date of Resolution/Remission~~ | ~~0..0~~ |
| | | | | ~~Age at Resolution/Remission~~ | ~~0..0~~ |
| | | | | ~~Diagnostic Criteria~~ | ~~0..0~~ |
| | | | | ~~Clinical Stage/Grade~~ | ~~0..0~~ |
| | | | | ~~Comment (Problem/Diagnosis Comment)~~ | ~~0..0~~ |
| | | | | ~~Link to Supporting Clinical Evidence~~ | ~~0..0~~ |
| | | | | ~~Status~~ | ~~0..0~~ |
| | | | | ~~INFORMATION PROVIDER~~ | ~~0..0~~ |
| | | | | ~~SUBJECT~~ | ~~0..0~~ |
| | | | | ~~Problem/Diagnosis Identifier~~ | ~~0..0~~ |
| | | | | ~~LINK~~ | ~~0..0~~ |
| | | | | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ |
| | | | Procedure (PROCEDURE) | | 0..* |
| | | | | Procedure Name | 1..1 |
| | | | | ~~Description (Procedure Description)~~ | ~~0..0~~ |
| | | | | ~~Reason (Procedure Reason)~~ | ~~0..0~~ |

| | | | | | |
|---|---|---|---|---|---|
| | | | | ~~ANATOMICAL LOCATION~~ | ~~0..0~~ |
| | | | | ~~Procedure Detail~~ | ~~0..0~~ |
| | | | | ~~Duration (Procedure Duration)~~ | ~~0..0~~ |
| | | | | ~~Multimedia~~ | ~~0..0~~ |
| | | | | ~~Comment (Procedure Comment)~~ | ~~0..0~~ |
| | | | | ~~Start Date/Time (DateTime Started)~~ | ~~0..0~~ |
| | | | | ~~DEVICE~~ | ~~0..0~~ |
| | | | | ~~INFORMATION PROVIDER~~ | ~~0..0~~ |
| | | | | ~~SUBJECT~~ | ~~0..0~~ |
| | | | | ~~Procedure Identifier~~ | ~~0..0~~ |
| | | | | ~~LINK~~ | ~~0..0~~ |
| | | | | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ |
| | | | Other Diagnosis/Procedure Entry (CLINICAL SYNOPSIS) | | 0..* |
| | | | | ~~Clinical Synopsis Topic~~ | ~~0..0~~ |
| | | | | Other Diagnosis or Procedure Name (Clinical Synopsis Description) | 1..1 |
| | | | | ~~DateTime Recorded~~ | ~~0..0~~ |
| | | | | ~~INFORMATION PROVIDER~~ | ~~0..0~~ |
| | | | | ~~SUBJECT~~ | ~~0..0~~ |
| | | | | ~~Clinical Synopsis Identifier~~ | ~~0..0~~ |
| | | | | ~~LINK~~ | ~~0..0~~ |
| | | | | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ |
| | | | Response Narrative (CLINICAL SYNOPSIS) | | 1..1 |
| | | | | ~~Clinical Synopsis Topic~~ | ~~0..0~~ |
| | | | | Narrative (Clinical Synopsis Description) | 1..1 |

| | | | | | |
|---|---|---|---|---|---|
| | | | | ~~DateTime Recorded~~ | ~~0..0~~ |
| | | | | ~~INFORMATION PROVIDER~~ | ~~0..0~~ |
| | | | | ~~SUBJECT~~ | ~~0..0~~ |
| | | | | ~~Clinical Synopsis Identifier~~ | ~~0..0~~ |
| | | | | ~~LINK~~ | ~~0..0~~ |
| | | | | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ |
| | | Recommendations (RECOMMENDATIONS) | | | 1..1 |
| | | | Recommendation (RECOMMENDATION) | | 0..* |
| | | | | Addressee (RECOMMENDATION ADDRESSEE) | 1..1 |
| | | | | Time Frame (Recommendation Time Frame) | 1..1 |
| | | | | ~~INFORMATION PROVIDER~~ | ~~0..0~~ |
| | | | | ~~SUBJECT~~ | ~~0..0~~ |
| | | | | Recommendation Narrative | 1..1 |
| | | | | ~~DateTime Recommendation Expires~~ | ~~0..0~~ |
| | | | | ~~Recommendation Identifier~~ | ~~0..0~~ |
| | | | | ~~LINK~~ | ~~0..0~~ |
| | | | | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ |
| | | | Recommendations Exclusion (EXCLUSION STATEMENT) | | 0..1 |
| | | | | General Statement | 1..1 |
| | | | | ~~INFORMATION PROVIDER~~ | ~~0..0~~ |
| | | | | ~~SUBJECT~~ | ~~0..0~~ |
| | | | | ~~Exclusion Statement Identifier~~ | ~~0..0~~ |
| | | | | ~~LINK~~ | ~~0..0~~ |

| | | | | | |
|---|---|---|---|---|---|
| | | | | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ |
| | | Medications (MEDICATION ORDERS) | | | 1..1 |
| | | | EXCLUSION STATEMENT - MEDICATIONS | | 0..1 |
| | | | | Global Statement | 1..1 |
| | | | | ~~Not Currently Taking~~ | ~~0..0~~ |
| | | | | ~~Not Ever Taken~~ | ~~0..0~~ |
| | | | | ~~INFORMATION PROVIDER~~ | ~~0..0~~ |
| | | | | ~~SUBJECT~~ | ~~0..0~~ |
| | | | | ~~Exclusion Statement - Medications Identifier~~ | ~~0..0~~ |
| | | | | ~~LINK~~ | ~~0..0~~ |
| | | | | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ |
| | | | Medication (MEDICATION INSTRUCTION) | | 0..* |
| | | | | Medicine (Therapeutic Good Identification) | 1..1 |
| | | | | Directions | 0..1 |
| | | | | ~~Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)~~ | ~~0..0~~ |
| | | | | ~~Dose Description~~ | ~~0..0~~ |
| | | | | ~~Structured Dose (AMOUNT OF MEDICATION)~~ | ~~0..0~~ |
| | | | | ~~TIMING~~ | ~~0..0~~ |
| | | | | ~~Additional Instruction~~ | ~~0..0~~ |
| | | | | Clinical Indication | 0..1 |
| | | | | ~~Administration Details (MEDICATION ADMINISTRATION)~~ | ~~0..0~~ |
| | | | | Comment (Medication Instruction Comment) | 0..1 |
| | | | | ~~DISPENSING~~ | ~~0..0~~ |
| | | | | Change Type | 1..1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | Change or Recommendation? (Change Status) | | 1..1 |
| | | | | Change Description | | 0..1 |
| | | | | Change Reason (Change or Recommendation Reason) | | 0..1 |
| | | | | ~~Indication for Authorised Use~~ | | ~~0..0~~ |
| | | | | ~~Medication Instruction ID~~ | | ~~0..0~~ |
| | | | | ~~Concession Benefit~~ | | ~~0..0~~ |
| | | | | ~~INFORMATION PROVIDER~~ | | ~~0..0~~ |
| | | | | ~~SUBJECT~~ | | ~~0..0~~ |
| | | | | ~~Medication Instruction Narrative~~ | | ~~0..0~~ |
| | | | | ~~DateTime Medication Instruction Expires~~ | | ~~0..0~~ |
| | | | | ~~Medication Instruction Identifier~~ | | ~~0..0~~ |
| | | | | ~~LINK~~ | | ~~0..0~~ |
| | | | | ~~Detailed Clinical Model Identifier~~ | | ~~0..0~~ |
| | | Newly Identified Allergies and Adverse Reactions (ADVERSE REACTIONS) | | | | 0..1 |
| | | | ~~EXCLUSION STATEMENT - ADVERSE REACTIONS~~ | | | ~~0..0~~ |
| | | | ADVERSE REACTION | | | 1..* |
| | | | | Substance/Agent | | 1..1 |
| | | | | ~~Absolute Contraindication~~ | | ~~0..0~~ |
| | | | | ~~Comment (Adverse Reaction Comment)~~ | | ~~0..0~~ |
| | | | | REACTION EVENT | | 0..1 |
| | | | | | ~~Specific Substance/Agent~~ | ~~0..0~~ |
| | | | | | Manifestation | 1..* |
| | | | | | ~~Reaction Type~~ | ~~0..0~~ |
| | | | | | ~~Certainty (Adverse Reaction Certainty)~~ | ~~0..0~~ |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | ~~Reaction Description~~ | ~~0..0~~ |
| | | | | | ~~Onset of Reaction (Reaction Onset Date)~~ | ~~0..0~~ |
| | | | | | ~~Duration of Reaction~~ | ~~0..0~~ |
| | | | | | ~~Additional Reaction Detail (ANATOMICAL LOCATION)~~ | ~~0..0~~ |
| | | | | | ~~Exposure Description~~ | ~~0..0~~ |
| | | | | | ~~Earliest Exposure~~ | ~~0..0~~ |
| | | | | | ~~Duration of Exposure~~ | ~~0..0~~ |
| | | | | | ~~ADDITIONAL EXPOSURE DETAIL~~ | ~~0..0~~ |
| | | | | | ~~Clinical Management Description~~ | ~~0..0~~ |
| | | | | | ~~Multimedia~~ | ~~0..0~~ |
| | | | | | ~~Reporting Details~~ | ~~0..0~~ |
| | | | | | ~~Comment (Adverse Reaction Event Comment)~~ | ~~0..0~~ |
| | | | | ~~Reaction Reported~~ | | ~~0..0~~ |
| | | | | ~~Adverse Reaction Report~~ | | ~~0..0~~ |
| | | | | ~~Supporting Clinical Record Information~~ | | ~~0..0~~ |
| | | | | ~~INFORMATION PROVIDER~~ | | ~~0..0~~ |
| | | | | ~~SUBJECT~~ | | ~~0..0~~ |
| | | | | ~~Adverse Reaction Identifier~~ | | ~~0..0~~ |
| | | | | ~~LINK~~ | | ~~0..0~~ |
| | | | | ~~Detailed Clinical Model Identifier~~ | | ~~0..0~~ |
| | | DIAGNOSTIC INVESTIGATIONS | | | | 0..1 |
| | | | PATHOLOGY TEST RESULT | | | 0..* |
| | | | | Test Result Name (Pathology Test Result Name) | | 1..1 |
| | | | | Diagnostic Service | | 0..1 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | Test Specimen Detail (SPECIMEN) | | | | 1..* |
| | | | | | Specimen Tissue Type | | | 0..1 |
| | | | | | Collection Procedure | | | 0..1 |
| | | | | | Anatomical Site (ANATOMICAL LOCATION) | | | 0..* |
| | | | | | | SPECIFIC LOCATION | | 0..1 |
| | | | | | | | Name of Location (Anatomical Location Name) | 0..1 |
| | | | | | | | Side | 0..1 |
| | | | | | | | ~~Numerical Identifier~~ | ~~0..0~~ |
| | | | | | | | ~~Anatomical Plane~~ | ~~0..0~~ |
| | | | | | | ~~RELATIVE LOCATION~~ | | ~~0..0~~ |
| | | | | | | Description (Anatomical Location Description) | | 0..1 |
| | | | | | | ~~Visual Markings/Orientation~~ | | ~~0..0~~ |
| | | | | | | Image (Anatomical Location Image) | | 0..* |
| | | | | | Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) | | | 0..* |
| | | | | | | ~~Name (Physical Object Name)~~ | | ~~0..0~~ |
| | | | | | | Weight | | 0..1 |
| | | | | | | DIMENSIONS | | 0..1 |
| | | | | | | | ~~Diameter~~ | ~~0..0~~ |
| | | | | | | | ~~Circumference~~ | ~~0..0~~ |
| | | | | | | | ~~Length~~ | ~~0..0~~ |
| | | | | | | | ~~Breadth~~ | ~~0..0~~ |
| | | | | | | | ~~Depth~~ | ~~0..0~~ |
| | | | | | | | ~~Area~~ | ~~0..0~~ |
| | | | | | | | Volume | 0..1 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | Description (Object Description) | 0..1 |
| | | | | | | Image | 0..1 |
| | | | | | ~~NEEDLE BIOPSY CORE DETAILS~~ | | ~~0..0~~ |
| | | | | | COLLECTION AND HANDLING | | 0..1 |
| | | | | | | ~~Potential Risk / Biohazard~~ | ~~0..0~~ |
| | | | | | | Sampling Preconditions | 0..1 |
| | | | | | | ~~Number of Containers~~ | ~~0..0~~ |
| | | | | | | ~~Collection Procedure Details~~ | ~~0..0~~ |
| | | | | | | ~~Transport Medium~~ | ~~0..0~~ |
| | | | | | | ~~Testing Method~~ | ~~0..0~~ |
| | | | | | | ~~DEVICE~~ | ~~0..0~~ |
| | | | | | HANDLING AND PROCESSING | | 1..1 |
| | | | | | | Date and Time of Collection (Collection DateTime) | 1..1 |
| | | | | | | Collection Setting | 0..1 |
| | | | | | | Date and Time of Receipt (DateTime Received) | 0..1 |
| | | | | | | ~~Date and Time Processed (DateTime Processed)~~ | ~~0..0~~ |
| | | | | | ~~SPECIMEN QUALITY~~ | | ~~0..0~~ |
| | | | | | IDENTIFIERS | | 0..1 |
| | | | | | | Specimen Identifier | 0..1 |
| | | | | | | Parent Specimen Identifier | 0..1 |
| | | | | | | Container Identifier | 0..1 |
| | | | | | | ~~Specimen Collector Identifier~~ | ~~0..0~~ |
| | | | | | | ~~SPECIMEN COLLECTOR DETAILS~~ | ~~0..0~~ |
| | | | | Overall Pathology Test Status (Overall Pathology Test Result Status) | | | 1..1 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | Clinical Information Provided | | | | 0..1 |
| | | | | Result Group (PATHOLOGY TEST RESULT GROUP) | | | | 0..* |
| | | | | | Result Group Name (Pathology Test Result Group Name) | | | 1..1 |
| | | | | | Result (INDIVIDUAL PATHOLOGY TEST RESULT) | | | 1..* |
| | | | | | | Result Name (Individual Pathology Test Result Name) | | 1..1 |
| | | | | | | Result Value (Individual Pathology Test Result Value) | | 0..1 |
| | | | | | | Result Value Normal Status (Individual Pathology Test Result Value Normal Status) | | 0..1 |
| | | | | | | Result Value Reference Range Details (INDIVIDUAL PATHOLOGY TEST RESULT VALUE REFERENCE RANGE DETAILS) | | 0..* |
| | | | | | | | Result Value Reference Range Meaning (Individual Pathology Test Result Value Reference Range Meaning) | 1..1 |
| | | | | | | | Result Value Reference Range (Individual Pathology Test Result Value Reference Range) | 1..1 |
| | | | | | | Result Comment (Individual Pathology Test Result Comment) | | 0..* |
| | | | | | | Reference Range Guidance (Individual Pathology Test Result Reference Range Guidance) | | 0..1 |
| | | | | | | Result Status (Individual Pathology Test Result Status) | | 1..1 |
| | | | | | Result Group Specimen Detail (SPECIMEN) | | | 0..1 |
| | | | | | | Specimen Tissue Type | | 0..1 |
| | | | | | | Collection Procedure | | 0..1 |
| | | | | | | Anatomical Site (ANATOMICAL LOCATION) | | 0..* |
| | | | | | | | SPECIFIC LOCATION | 0..1 |
| | | | | | | | Name of Location (Anatomical Location Name) | 0..1 |
| | | | | | | | Side | 0..1 |
| | | | | | | | ~~Numerical Identifier~~ | ~~0..0~~ |
| | | | | | | | ~~Anatomical Plane~~ | ~~0..0~~ |
| | | | | | | ~~RELATIVE LOCATION~~ | | ~~0..0~~ |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Description (Anatomical Location Description) | | | 0..1 |
| | | | | | | ~~Visual Markings/Orientation~~ | | | ~~0..0~~ |
| | | | | | | Image (Anatomical Location Image) | | | 0..* |
| | | | | | Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) | | | | 0..* |
| | | | | | | ~~Name (Physical Object Name)~~ | | | ~~0..0~~ |
| | | | | | | Weight | | | 0..1 |
| | | | | | | DIMENSIONS | | | 0..1 |
| | | | | | | | ~~Diameter~~ | | ~~0..0~~ |
| | | | | | | | ~~Circumference~~ | | ~~0..0~~ |
| | | | | | | | ~~Length~~ | | ~~0..0~~ |
| | | | | | | | ~~Breadth~~ | | ~~0..0~~ |
| | | | | | | | ~~Depth~~ | | ~~0..0~~ |
| | | | | | | | ~~Area~~ | | ~~0..0~~ |
| | | | | | | | Volume | | 0..1 |
| | | | | | | Description (Object Description) | | | 0..1 |
| | | | | | | Image | | | 0..1 |
| | | | | | ~~NEEDLE BIOPSY CORE DETAILS~~ | | | | ~~0..0~~ |
| | | | | | COLLECTION AND HANDLING | | | | 0..1 |
| | | | | | | ~~Potential Risk / Biohazard~~ | | | ~~0..0~~ |
| | | | | | | Sampling Preconditions | | | 0..1 |
| | | | | | | ~~Number of Containers~~ | | | ~~0..0~~ |
| | | | | | | ~~Collection Procedure Details~~ | | | ~~0..0~~ |
| | | | | | | ~~Transport Medium~~ | | | ~~0..0~~ |
| | | | | | | ~~Testing Method~~ | | | ~~0..0~~ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | ~~DEVICE~~ | ~~0..0~~ |
| | | | | | | HANDLING AND PROCESSING | | 1..1 |
| | | | | | | | Date and Time of Collection (Collection DateTime) | 1..1 |
| | | | | | | | Collection Setting | 0..1 |
| | | | | | | | Date and Time of Receipt (DateTime Received) | 0..1 |
| | | | | | | | ~~Date and Time Processed (DateTime Processed)~~ | ~~0..0~~ |
| | | | | | | ~~SPECIMEN QUALITY~~ | | ~~0..0~~ |
| | | | | | | IDENTIFIERS | | 0..1 |
| | | | | | | | Specimen Identifier | 0..1 |
| | | | | | | | Parent Specimen Identifier | 0..1 |
| | | | | | | | Container Identifier | 0..1 |
| | | | | | | | ~~Specimen Collector Identifier~~ | ~~0..0~~ |
| | | | | | | | ~~SPECIMEN COLLECTOR DETAILS~~ | ~~0..0~~ |
| | | | | Pathological Diagnosis | | | | 0..* |
| | | | | Conclusion (Pathology Test Conclusion) | | | | 0..1 |
| | | | | Test Result Representation | | | | 0..1 |
| | | | | Test Comment | | | | 0..1 |
| | | | | ~~RECEIVING LABORATORY~~ | | | | ~~0..0~~ |
| | | | | TEST REQUEST DETAILS | | | | 0..* |
| | | | | | ~~Requester Order Identifier~~ | | | ~~0..0~~ |
| | | | | | Test Requested Name | | | 0..* |
| | | | | | ~~REQUESTER~~ | | | ~~0..0~~ |
| | | | | | ~~Receiver Order Identifier~~ | | | ~~0..0~~ |
| | | | | | Laboratory Test Result Identifier | | | 0..1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | ~~Test Procedure~~ | | ~~0..0~~ |
| | | | | ~~INFORMATION PROVIDER~~ | | ~~0..0~~ |
| | | | | ~~SUBJECT~~ | | ~~0..0~~ |
| | | | | Pathology Test Result DateTime | | 1..1 |
| | | | | ~~Pathology Test Result Duration~~ | | ~~0..0~~ |
| | | | | ~~Pathology Test Result Identifier~~ | | ~~0..0~~ |
| | | | | ~~LINK~~ | | ~~0..0~~ |
| | | | | ~~Detailed Clinical Model Identifier~~ | | ~~0..0~~ |
| | | | IMAGING EXAMINATION RESULT | | | 0..* |
| | | | | Examination Result Name (Imaging Examination Result Name) | | 1..1 |
| | | | | Modality (Imaging Modality) | | 0..1 |
| | | | | Anatomical Site (ANATOMICAL LOCATION) | | 0..* |
| | | | | | SPECIFIC LOCATION | 0..1 |
| | | | | | Name of Location (Anatomical Location Name) | 0..1 |
| | | | | | Side | 0..1 |
| | | | | | ~~Numerical Identifier~~ | ~~0..0~~ |
| | | | | | ~~Anatomical Plane~~ | ~~0..0~~ |
| | | | | | ~~RELATIVE LOCATION~~ | ~~0..0~~ |
| | | | | | Description (Anatomical Location Description) | 0..1 |
| | | | | | ~~Visual Markings/Orientation~~ | ~~0..0~~ |
| | | | | | Image (Anatomical Location Image) | 0..* |
| | | | | Imaging Examination Result Status | | 1..1 |
| | | | | Clinical Information Provided | | 0..1 |
| | | | | Findings | | 0..1 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | Result Group (IMAGING EXAMINATION RESULT GROUP) | | | 0..* |
| | | | | | Result Group Name (Imaging Examination Result Group Name) | | 1..1 |
| | | | | | Result (INDIVIDUAL IMAGING EXAMINATION RESULT) | | 1..* |
| | | | | | | Result Name (Individual Imaging Examination Result Name) | 1..1 |
| | | | | | | Result Value (Imaging Examination Result Value) | 0..1 |
| | | | | | | Result Value Normal Status (Imaging Examination Result Value Normal Status) | 0..1 |
| | | | | | | Result Value Reference Range Details (IMAGING EXAMINATION RESULT VALUE REFERENCE RANGE DETAILS) | 0..* |
| | | | | | | Result Value Reference Range Meaning (Imaging Examination Result Value Reference Range Meaning) | 1..1 |
| | | | | | | Result Value Reference Range (Imaging Examination Result Value Reference Range) | 1..1 |
| | | | | | | Result Comment | 0..* |
| | | | | | Result Group Anatomical Site (ANATOMICAL LOCATION) | | 0..1 |
| | | | | | | SPECIFIC LOCATION | 0..1 |
| | | | | | | Name of Location (Anatomical Location Name) | 0..1 |
| | | | | | | Side | 0..1 |
| | | | | | | ~~Numerical Identifier~~ | ~~0..0~~ |
| | | | | | | ~~Anatomical Plane~~ | ~~0..0~~ |
| | | | | | | ~~RELATIVE LOCATION~~ | ~~0..0~~ |
| | | | | | | Description (Anatomical Location Description) | 0..1 |
| | | | | | | ~~Visual Markings/Orientation~~ | ~~0..0~~ |
| | | | | | | Image (Anatomical Location Image) | 0..* |
| | | | | ~~Radiological Diagnosis~~ | | | ~~0..0~~ |
| | | | | ~~Conclusion (Imaging Examination Conclusion)~~ | | | ~~0..0~~ |
| | | | | Examination Result Representation | | | 0..1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | ~~Examination Comment~~ | | ~~0..0~~ |
| | | | | ~~RECEIVING IMAGING SERVICE~~ | | ~~0..0~~ |
| | | | | EXAMINATION REQUEST DETAILS | | 0..* |
| | | | | | ~~Requester Order Identifier~~ | ~~0..0~~ |
| | | | | | Examination Requested Name | 0..* |
| | | | | | ~~REQUESTER~~ | ~~0..0~~ |
| | | | | | ~~Receiver Order Identifier~~ | ~~0..0~~ |
| | | | | | DICOM Study Identifier | 0..1 |
| | | | | | Report Identifier | 0..1 |
| | | | | | IMAGE DETAILS | 0..* |
| | | | | | Image Identifier | 0..1 |
| | | | | | DICOM Series Identifier | 0..1 |
| | | | | | View (Image View Name) | 0..1 |
| | | | | | Position (Subject Position) | 0..1 |
| | | | | | Image DateTime | 0..1 |
| | | | | | Image | 0..1 |
| | | | | ~~Examination Procedure~~ | | ~~0..0~~ |
| | | | | ~~COMPARED IMAGE DETAILS~~ | | ~~0..0~~ |
| | | | | ~~INFORMATION PROVIDER~~ | | ~~0..0~~ |
| | | | | ~~SUBJECT~~ | | ~~0..0~~ |
| | | | | Imaging Examination Result DateTime | | 1..1 |
| | | | | ~~Imaging Examination Result Duration~~ | | ~~0..0~~ |
| | | | | ~~Imaging Examination Result Identifier~~ | | ~~0..0~~ |
| | | | | ~~LINK~~ | | ~~0..0~~ |

| | | | | | |
|---|---|---|---|---|---|
| | | | | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ |
| | | | ~~Diagnostic Investigation Synopsis (CLINICAL SYNOPSIS)~~ | | ~~0..0~~ |
| | | | Requested Service (REQUESTED SERVICE) | | 0..* |
| | | | | ~~Reason for Service~~ | ~~0..0~~ |
| | | | | Requested Service Description | 1..1 |
| | | | | ~~Intent of Request~~ | ~~0..0~~ |
| | | | | ~~Request Urgency~~ | ~~0..0~~ |
| | | | | DateTime Service Scheduled | 0..1 |
| | | | | Service Commencement Window | 0..1 |
| | | | | Service Booking Status | 1..1 |
| | | | | ~~Supplementary Information to Follow~~ | ~~0..0~~ |
| | | | | ~~Supplementary Information Expected~~ | ~~0..0~~ |
| | | | | Subject of Care Instruction Description | 0..1 |
| | | | | ~~DISTRIBUTION LIST~~ | ~~0..0~~ |
| | | | | ~~SERVICE REQUESTER~~ | ~~0..0~~ |
| | | | | SERVICE PROVIDER | 0..1 |
| | | | | ~~Request Validity Period~~ | ~~0..0~~ |
| | | | | ~~INFORMATION PROVIDER~~ | ~~0..0~~ |
| | | | | ~~SUBJECT~~ | ~~0..0~~ |
| | | | | Requested Service DateTime | 1..1 |
| | | | | ~~Requested Service Identifier~~ | ~~0..0~~ |
| | | | | ~~LINK~~ | ~~0..0~~ |
| | | | | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ |

# 2.4 SUBJECT OF CARE

## Identification

| | |
|---|---|
| **Label** | SUBJECT OF CARE |
| **Metadata Type** | Data Group |
| **Identifier** | DG-10296 |
| **OID** | 1.2.36.1.2001.1001.101.102.10296 |

## Definition

| | |
|---|---|
| **Definition** | Identification information about the patient that has been referred and is the subject of this specialist letter. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Patient |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v].<br><br>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B: *Specification Guide for Use*.<br><br>Additional obligation and occurrence constraints:<br><br>• Participation Period is **PROHIBITED**.<br><br>• LOCATION OF PARTICIPATION is **PROHIBITED**.<br><br>• Entity Identifier is **ESSENTIAL**.<br><br>• ADDRESS is **ESSENTIAL**.<br><br>• Relationship to Subject of Care is **PROHIBITED**.<br><br>• EMPLOYMENT DETAIL is **PROHIBITED**.<br><br>• DEMOGRAPHIC DATA is **ESSENTIAL**.<br><br>• Sex is **ESSENTIAL**.<br><br>• DATE OF BIRTH DETAIL is **ESSENTIAL**.<br><br>• Source of Death Notification is **PROHIBITED**.<br><br>• Mothers Original Family Name is **PROHIBITED**.<br><br>• Qualifications is **PROHIBITED**.<br><br>Other additional constraints: |

| | |
|---|---|
| | • Participation Type **SHALL** have an implementation-specific value equivalent to “Subject of Care”.<br>• Role **SHALL** have an implementation-specific value equivalent to “Patient”.<br>• The value of one Entity Identifier **SHALL** be an Australian IHI.<br>• PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON. |
| **Conditions of Use Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIALIST LETTER | 1..1 | |

# 2.5 DOCUMENT AUTHOR

## Identification

| | |
|---|---|
| **Label** | DOCUMENT AUTHOR |
| **Metadata Type** | Data Group |
| **Identifier** | DG-10296 |
| **OID** | 1.2.36.1.2001.1001.101.102.10296 |

## Definition

| | |
|---|---|
| **Definition** | The healthcare provider who is the source of this specialist letter. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Specialist<br>Consultant |
| **Notes** | The specialist who is responsible for the content of the letter, even if someone else did physically author or compose the letter in the specialist name. |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v].<br><br>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B: *Specification Guide for Use*.<br><br>Additional obligation and occurrence constraints:<br><br>• LOCATION OF PARTICIPATION is **PROHIBITED**.<br>• Entity Identifier is **ESSENTIAL**.<br>• ADDRESS is **ESSENTIAL**.<br>• ELECTRONIC COMMUNICATION DETAIL is **ESSENTIAL**.<br>• Relationship to Subject of Care is **PROHIBITED**.<br>• EMPLOYMENT DETAIL is **ESSENTIAL**.<br>• EMPLOYER ORGANISATION is **ESSENTIAL**.<br>• EMPLOYER ORGANISATION.Entity Identifier is **ESSENTIAL**.<br>• Occupation is **ESSENTIAL**.<br>• DEMOGRAPHIC DATA is **PROHIBITED**.<br>• ENTITLEMENT is **PROHIBITED**.<br>• Qualifications is **PROHIBITED**. |

| | |
|---|---|
| | Other additional constraints:<br>• Participation Type **SHALL** have an implementation-specific value equivalent to “Document Author”.<br>• Role **SHOULD** have a value chosen from 1220.0 – ANZSCO – Australia and New Zealand Standard Classification of Occupations, First Edition, 2006 – METeOR 350899. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used.<br>• The value of one Entity Identifier **SHALL** be an Australian HPI-I.<br>• The value of one EMPLOYER ORGANISATION.Entity Identifier **SHALL** be an Australian HPI-O.<br>• AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.<br>• PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON. |
| **Conditions of Use Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIALIST LETTER | 1..1 | |

# 2.6 DateTime Authored

## Identification

| | |
|---|---|
| **Label** | DateTime Authored |
| **Metadata Type** | Data Element |
| **Identifier** | DE-20405 |
| **OID** | 1.2.36.1.2001.1001.101.103.20405 |

## Definition

| | |
|---|---|
| **Definition** | The date or date and time that authoring of the Specialist Letter by the authoring healthcare provider is started or done. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | DateTime Specialist Letter Created<br>DateTime Created<br>DateTime Issued. |
| **Data Type** | DateTime |

## Usage

| | |
|---|---|
| **Examples** | 1. 31/03/2004.<br>2. 03/2004.<br>3. 2004.<br>4. 31/03/2004 13:10. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | SPECIALIST LETTER | 1..1 | |

# 2.7 DateTime Health Event Started

## Identification

| | |
|---|---|
| **Label** | DateTime Subject of Care Seen |
| **Metadata Type** | Data Element |
| **Identifier** | DE-15507 |
| **OID** | 1.2.36.1.2001.1001.101.103.15507 |

## Definition

| | |
|---|---|
| **Definition** | The date and time when the specialist consultation took place. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Calculations on this date will be required, i.e. validity duration of the referral commences from this date. |
| **Data Type** | DateTime |

## Usage

| | |
|---|---|
| **Conditions of Use** | Exact dates **SHALL** be used. |
| **Conditions of Use Source** | NEHTA |
| **Misuse** | Entering approximate date (time) is **PROHIBITED**. |
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIALIST LETTER | 1..1 | |

# 2.8 USUAL GP

## Identification

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

## Definition

| | |
|---|---|
| **Definition** | A healthcare provider (person or organisation) nominated by the subject of care as being primarily responsible for their ongoing healthcare. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Scope** | In general, this is a healthcare provider as nominated by the subject of care at the time as being their main primary healthcare provider or the primary healthcare provider with whom communications should be conducted for the purposes of the heatlhcare event in question. As such, it is not necessarily their "usual GP"; indeed, it may not be a GP at all. However, the *current* scope is limited to the primary healthcare provider that's deemed to be the subject of care's usual GP. |
| **Scope Source** | NEHTA |
| **Notes** | If the 'Usual GP' component is populated, the usual GP is one of the recipients of the specialist letter. |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v].<br><br>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B: *Specification Guide for Use*.<br><br>Additional obligation and occurrence constraints:<br><br>• Participation Period is **PROHIBITED**.<br><br>• LOCATION OF PARTICIPATION is **PROHIBITED**.<br><br>• ADDRESS is **ESSENTIAL**.<br><br>• Entity Identifier is **ESSENTIAL**.<br><br>• ELECTRONIC COMMUNICATION DETAIL is **ESSENTIAL**.<br><br>• Relationship to Subject of Care is **PROHIBITED**.<br><br>• DEMOGRAPHIC DATA is **PROHIBITED**. |

| | |
|---|---|
| | • ENTITLEMENT is **PROHIBITED**.<br>• Qualifications is **PROHIBITED**.<br>Other additional constraints when the Usual GP is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON):<br>• EMPLOYMENT DETAIL is **ESSENTIAL**.<br>• EMPLOYER ORGANISATION is **ESSENTIAL**.<br>• EMPLOYER ORGANISATION.Entity Identifier is **ESSENTIAL**.<br>• Participation Type **SHALL** have an implementation-specific value equivalent to “Usual GP”.<br>• Role **SHOULD** have a value chosen from 1220.0 – ANZSCO – Australia and New Zealand Standard Classification of Occupations, First Edition, 2006 – METeOR 350899. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used.<br>• The value of one Entity Identifier **SHALL** be an Australian HPI-I.<br>• The value of one EMPLOYER ORGANISATION.Entity Identifier **SHALL** be an Australian HPI-O.<br>• AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.<br>• PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.<br>Other additional constraints when the Usual GP is an Organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an ORGANISATION):<br>• Participation Type **SHALL** have an implementation-specific value equivalent to “Usual GP”.<br>• Role **SHALL** have a value representing the type of Facility e.g. Clinic.<br>• The value of one Entity Identifier **SHALL** be an Australian HPI-O.<br>• AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.<br>• PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as an ORGANISATION. |
| **Conditions of Use Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIALIST LETTER | 0..1 | |

# 2.9 REFERRER

## Identification

| | |
|---|---|
| **Label** | REFERRER |
| **Metadata Type** | Data Group |
| **Identifier** | DG-10296 |
| **OID** | 1.2.36.1.2001.1001.101.102.10296 |

## Definition

| | |
|---|---|
| **Definition** | The healthcare provider from whom the subject of care was referred to this specialist. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | The referrer is the main recipient of the specialist letter. |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v].<br><br>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B: *Specification Guide for Use*.<br><br>Additional obligation and occurrence constraints:<br><br>• LOCATION OF PARTICIPATION is **PROHIBITED**.<br><br>• Entity Identifier is **ESSENTIAL**.<br><br>• ADDRESS is **ESSENTIAL**.<br><br>• ELECTRONIC COMMUNICATION DETAIL is **ESSENTIAL**.<br><br>• Relationship to Subject of Care is **PROHIBITED**.<br><br>• EMPLOYMENT DETAIL is **ESSENTIAL**.<br><br>• EMPLOYER ORGANISATION is **ESSENTIAL**.<br><br>• EMPLOYER ORGANISATION.Entity Identifier is **ESSENTIAL**.<br><br>• DEMOGRAPHIC DATA is **PROHIBITED**.<br><br>• ENTITLEMENT is **PROHIBITED**.<br><br>• Qualifications is **PROHIBITED**.<br><br>Other additional constraints: |

| | |
|---|---|
| | • Participation Type **SHALL** have an implementation-specific value equivalent to “Referrer”.<br>• Role **SHOULD** have a value chosen from 1220.0 – ANZSCO – Australia and New Zealand Standard Classification of Occupations, First Edition, 2006 – METeOR 350899. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used.<br>• The value of one Entity Identifier **SHALL** be an Australian HPI-I.<br>• The value of one EMPLOYER ORGANISATION.Entity Identifier **SHALL** be an Australian HPI-O.<br>• AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.<br>• PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON. |
| **Conditions of Use Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIALIST LETTER | 1..1 | |

# 2.10 DateTime Attested

## Identification

| | |
|---|---|
| **Label** | DateTime Attested |
| **Metadata Type** | Data Element |
| **Identifier** | DE-20106 |
| **OID** | 1.2.36.1.2001.1001.101.103.20106 |

## Definition

| | |
|---|---|
| **Definition** | The date (and time if known) that the document author or document authoriser/approver confirms (usually by signature) that a document is complete and genuine. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Date Sent<br>DateTime Document Sent<br>DateTime Document Transmitted |
| **Context** | For use in a healthcare setting.<br><br>The date and time value when the document author determines the document is complete and can be sent by the authoring provider to the document recipients.<br><br>In an electronic environment, the date and time when the document is last saved by the document authoring application. |
| **Context Source** | NEHTA |
| **Data Type** | DateTime |

## Usage

| | |
|---|---|
| **Conditions of Use** | Where possible, exact dates should be used. Incomplete dates should generally only be used for retrospective data collection. |
| **Conditions of Use Source** | NEHTA |
| **Examples** | |
| **Misuse** | Entering approximate dates when an exact date is available. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIALIST LETTER | 1..1 | |

# 2.11 RESPONSE DETAILS

## Identification

| | |
|---|---|
| **Label** | Response Details |
| **Metadata Type** | Section |
| **Identifier** | S-16611 |
| **OID** | 1.2.36.1.2001.1001.101.101.16611 |

## Definition

| | |
|---|---|
| **Definition** | A section that captures the main clinical outcome (diagnoses, procedures and narrative synopsis statement) about the response from the specialist following the referral. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

## Usage

| | |
|---|---|
| **Conditions of Use** | Additional obligation and occurrence constraints:<br>• Each instance of this section **SHALL** have at least one instance of 'Daignosis (PROBLEM/DIAGNOSIS)' OR 'Procedure(PROCEDURE)' OR 'Other Diagnosis/Procedure Entry (CLINICAL SYNOPSIS)'.<br>• Each instance of this section **SHALL** have one instance of 'Response Narrative (CLINICAL SYNOPSIS)'. |
| **Conditions of Use Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIALIST LETTER | 1..1 | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Diagnosis (PROBLEM/DIAGNOSIS) | 0..* | |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Procedure (PROCEDURE) | 0..* | |
|  | Other Diagnosis/Procedure Entry (CLINICAL SYNOPSIS) | 0..* | |
|  | Response Narrative (CLINICAL SYNOPSIS) | 1..1 | |

# 2.12 RECOMMENDATIONS

## Identification

| | |
|---|---|
| **Label** | Recommendations |
| **Metadata Type** | Section |
| **Identifier** | S-16606 |
| **OID** | 1.2.36.1.2001.1001.101.101.16606 |

## Definition

| | |
|---|---|
| **Definition** | A section that captures the recommendations by the referee/specialist to a recipient healthcare provider regarding the continuity of care and the ongoing management of the subject of care. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

## Usage

| | |
|---|---|
| **Conditions of Use** | Additional obligation and occurrence constraints:<br>• Each instance of this section either **SHALL** have exactly one instance of 'Recommendations Exclusion (EXCLUSION STATEMENT)' OR **SHALL** have one or more instances of 'RECOMMENDATION' but **SHALL NOT** have both. |
| **Conditions of Use Source** | NEHTA |
| **Misuse** | This section excludes recommendations specifically related to medications. 'Medications' section must be used for this purpose. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIALIST LETTER | 1..1 | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Recommendation (RECOMMENDATION) | 0..* | |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Recommendations Exclusion (EXCLUSION STATEMENT) | 0..1 | |

# 2.13 MEDICATION ORDERS

## Identification

| | |
|---|---|
| **Label** | Medications |
| **Metadata Type** | Section |
| **Identifier** | S-16146 |
| **OID** | 1.2.36.1.2001.1001.101.101.16146 |

## Definition

| | |
|---|---|
| **Definition** | A section that captures medication changes made and change recommendations regarding which medicines the subject of care should continue/commence/cease/alter relevant to and as a consequence of their interaction with the specialist. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Scope** | This is not meant to be a comprehensive medicine list but includes medicines that the specialist decides to make comment about to inform the referring/usual GP. |
| **Scope Source** | NEHTA |

## Usage

| | |
|---|---|
| **Conditions of Use** | Additional obligation and occurrence constraints:<br>• Each instance of this section either **SHALL** have exactly one instance of 'EXCLUSION STATEMENT - MEDICATIONS' OR **SHALL** have one or more instances of 'Medication (MEDICATION INSTRUCTION)' but **SHALL NOT** have both. |
| **Conditions of Use Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIALIST LETTER | 1..1 | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | EXCLUSION STATEMENT - MEDICATIONS | 0..1 | |
|  | Medication (MEDICATION INSTRUCTION) | 0..* | |

# 2.14 ADVERSE REACTIONS

## Identification

| | |
|---|---|
| **Label** | Newly Identified Allergies and Adverse Reactions |
| **Metadata Type** | Section |
| **Identifier** | S-20113 |
| **OID** | 1.2.36.1.2001.1001.101.101.20113 |

## Definition

| | |
|---|---|
| **Definition** | Information about adverse reactions and/or propensity to adverse reaction of the subject of care (including allergies and intolerances), and any relevant reaction details. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Scope** | Includes adverse reactions of which the author became aware during the health event. |
| **Scope Source** | NEHTA |

## Usage

| | |
|---|---|
| **Conditions of Use** | Adverse reactions identified in the event **SHALL** be included.<br><br>Adverse reactions NOT identified in the event **SHOULD NOT** be included. |
| **Conditions of Use Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIALIST LETTER | 0..1 | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~EXCLUSION STATEMENT - ADVERSE REACTIONS~~ | ~~0..0~~ | - |
|  | ADVERSE REACTION | 1..* | |

# 2.15 DIAGNOSTIC INVESTIGATIONS

## Identification

| | |
|---|---|
| **Label** | DIAGNOSTIC INVESTIGATIONS |
| **Metadata Type** | Section |
| **Identifier** | S-20117 |
| **OID** | 1.2.36.1.2001.1001.101.101.20117 |

## Definition

| | |
|---|---|
| **Definition** | Describes the diagnostic tests or procedures performed on or requested for the subject of care during the healthcare event, that are considered to be relevant to the subject of care's ongoing care. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Pathology/Diagnostic Imaging Results<br>Investigations Performed |

## Usage

| | |
|---|---|
| **Conditions of Use** | Additional obligation and occurrence constraints:<br>• Each instance of this section **SHALL** have at least one instance of 'PATHOLOGY TEST RESULT' OR 'IMAGING EXAMINATION RESULT'. |
| **Conditions of Use Source** | NEHTA |
| **Misuse** | Used to include results of all diagnostic tests performed on the subject of care during a healthcare event/visit. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIALIST LETTER | 0..1 | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | PATHOLOGY TEST RESULT | 0..* | |
|  | IMAGING EXAMINATION RESULT | 0..* | |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~Diagnostic Investigation Synopsis (CLINICAL SYNOPSIS)~~ | ~~0..0~~ | - |
|  | Requested Service (REQUESTED SERVICE) | 0..* | |

# 3 Problem/Diagnosis Data Group

## 3.1 Purpose

To record details about a problem or diagnosis by a clinician.

## 3.2 Use

Use to record detailed information about problems or diagnoses recognised by a clinician. There are many uses including: recording a Diagnosis during an Encounter; populating a Problem List or a Summary Statement, such as a Discharge Summary.

Use to record all problems or diagnoses, including those with context-specific qualifiers such as past/present, primary/secondary, active/inactive etc. These qualifiers can be documented separately and included in the ‘Status’ data group, because their use varies in different settings.

## 3.3 Misuse

Not to be used to record 'Differential Diagnoses' - use the *Differential Diagnosis* DCM.

Not to be used to record 'Reason for Encounter' - use the *Reason for Encounter* DCM.

Not to be used to record 'Presenting Complaint' - which is information captured early in the encounter, usually prior to full assessment and will be represented using a separate DCM.

Not to be used to record procedures - use the *Procedure* DCM.

Not to be used to record symptoms or signs - these should be recorded as part of a patient story or history. A problem such as 'Chest pain' may masquerade as a symptom, however in this context we are recording it as a problem the person has.

# 3.4 PROBLEM/DIAGNOSIS

## Identification

| | |
|---|---|
| **Label** | Diagnosis |
| **Metadata Type** | Data Group |
| **Identifier** | DG-15530 |
| **OID** | 1.2.36.1.2001.1001.101.102.15530 |

## Definition

| | |
|---|---|
| **Definition** | Information about the subject of care problem or diagnosis as established by the specialist. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is a reuse of the PROBLEM/DIAGNOSIS data group, which is described in Problem Diagnosis Detailed Clinical Model Specification [NEHT2011az]. |
| **Conditions of Use Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Response Details (RESPONSE DETAILS) | 0..* | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Diagnosis Name (Problem/Diagnosis Identification) | 1..1 | |
| | ~~Clinical Description~~ | ~~0..0~~ | - |
| | ~~Severity~~ | ~~0..0~~ | - |
| | ~~Date of Onset~~ | ~~0..0~~ | - |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~Age at Onset~~ | ~~0..0~~ | - |
|  | ~~ANATOMICAL LOCATION~~ | ~~0..0~~ | - |
|  | ~~Occurrence Summary (PROBLEM/DIAGNOSIS OCCURRENCE SUMMARY)~~ | ~~0..0~~ | - |
|  | ~~RELATED ITEMS~~ | ~~0..0~~ | - |
|  | ~~Date of Resolution/Remission~~ | ~~0..0~~ | - |
|  | ~~Age at Resolution/Remission~~ | ~~0..0~~ | - |
|  | ~~Diagnostic Criteria~~ | ~~0..0~~ | - |
|  | ~~Clinical Stage/Grade~~ | ~~0..0~~ | - |
|  | ~~Comment (Problem/Diagnosis Comment)~~ | ~~0..0~~ | - |
|  | ~~Link to Supporting Clinical Evidence~~ | ~~0..0~~ | - |
|  | ~~Status~~ | ~~0..0~~ | - |
|  | ~~INFORMATION PROVIDER~~ | ~~0..0~~ | - |
|  | ~~SUBJECT~~ | ~~0..0~~ | - |
|  | ~~Problem/Diagnosis Identifier~~ | ~~0..0~~ | - |
|  | ~~LINK~~ | ~~0..0~~ | - |
|  | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ | - |

# 3.5 Problem/Diagnosis Identification

## Identification

| | |
|---|---|
| **Label** | Diagnosis Name |
| **Metadata Type** | Data Element |
| **Identifier** | DE-15514 |
| **OID** | 1.2.36.1.2001.1001.101.103.15514 |

## Definition

| | |
|---|---|
| **Definition** | Identification of the problem or diagnosis. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | This item denotes the name of the condition used by the healthcare provider, after assessment, to describe the health problem or diagnosis experienced by the subject of care. |
| **Data Type** | CodeableText |
| **Value Domain** | Problem/Diagnosis Reference Set |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Diagnosis (PROBLEM/DIAGNOSIS) | 1..1 | |

# 3.6 Problem/Diagnosis Reference Set

## Identification

| | |
|---|---|
| **Label** | Problem/Diagnosis Reference Set |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16617 |
| **OID** | 1.2.36.1.2001.1001.101.104.16617 |
| **External Identifier** | SNOMED CT-AU Concept Id: 32570581000036105 |

## Definition

| | |
|---|---|
| **Definition** | The Problem/Diagnosis reference set provides terminology to support the recording of a patient problem or diagnosis for medical records within Australia. |
| **Definition Source** | NEHTA |

## Value Domain

| | |
|---|---|
| **Source** | SNOMED CT-AU |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Diagnosis Name (Problem/Diagnosis Identification) | 1..1 | |

# 4 Procedure (Action) Data Group

## 4.1 Purpose

To record information about the activities required to carry out a procedure, including the planning, scheduling, performance, suspension, cancellation, documentation and completion.

## 4.2 Use

Use to record information about the activities required to carry out a procedure, including the planning, scheduling, performance, suspension, cancellation, documentation and completion. This is done by the recording of data against specific activities in the care pathway, which covers the entirety of steps required to effect this action, including booking, performing, etc.

The scope of this DCM encompasses activities for a broad range of clinical procedures performed for therapeutic, evaluative, investigative, screening or diagnostic purposes. Examples range from the relatively simple activities, such as insertion of an intravenous cannula, through to complex surgical operations.

Additional structured and detailed information about the procedure can be captured using purpose-specific data groups inserted into the 'Procedure detail' slot, where required.

Start date/time is included in the Protocol. If this is recorded against the Scheduled care pathway step, it captures the scheduled start time; if recorded against the Procedure performed step, then it captures the actual start time of the procedure.

End date/time has not been specifically modelled in this DCM as this is the date/time that is recorded (per the reference model) as each action or care pathway step is completed.

Within the context of an Operation Report, this DCM will be used to record only what was done during the procedure. Separate DCMs will be used to record the other required components of the Operation Report, including the taking of tissue specimen samples, use of imaging guidance, operation findings, post-operative instructions and plans for followup.

Within the context of a Problem list or summary, this DCM may be used to represent procedures that have been performed. The Problem Diagnosis DCM will be used to represent the patient's problems and diagnoses.

In practice, many procedures (for example, in ambulatory care) will occur once and not be ordered in advance. The pathway step, ‘Procedure completed’ (or ‘Failed attempt’, or ‘Procedure aborted’) will be recorded and the details added. In some cases a recurring procedure will be ordered, and in this situation data against the ‘Procedure undertaken’ step will be recorded on each occasion, leaving the instruction in the active state. When the last occurrence is recorded the ‘Procedure completed’ action is recorded showing that this order is now in the completed state.

In other situations, such as secondary care, there may be a formal order for a procedure using corresponding DCMs. This Procedure DCM can then be used to record the workflow of when and how the order has been carried out.

Recording information using this Procedure DCM indicates that some sort of activity has actually occurred; this will usually be the procedure itself but may be a failed attempt or another activity such as postponing the procedure. If there is a formal order for the procedure, the state of this order is represented by the Pathway step against which the data is recorded. For example, using this DCM the progressing state of a Gastroscopy order may be recorded through separate entries in the EHR progress notes at each 'Pathway' step:

- record the scheduled Start date/time for the gastroscopy (Procedure scheduled);
- record the gastroscopy was attempted but failed (Failed attempt); and
- record that the gastroscopy procedure has been completed, including information about the procedure details (Procedure completed).

# 4.3 Misuse

Not to be used to record details about related DCMs such as use of imaging guidance during the procedure or collection of tissue samples for analysis - use specific DCMs for this purpose.

Not to be used to record a whole operation or procedure report.

Not to be used to record an observation such as a pathology test result or an imaging test.

# 4.4 PROCEDURE

## Identification

| | |
|---|---|
| **Label** | Procedure |
| **Metadata Type** | Data Group |
| **Identifier** | DG-15514 |
| **OID** | 1.2.36.1.2001.1001.101.102.15514 |

## Definition

| | |
|---|---|
| **Definition** | A clinical activity carried out for therapeutic, evaluative, investigative, screening or diagnostic purposes. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Clinical Intervention |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is a reuse of the Procedure data group, which is described in Procedure Detailed Clinical Model Specification [NEHT2011ba]. |
| **Conditions of Use Source** | NEHTA |
| **Misuse** | This data group **SHALL** not to be used to record relevant pathology (incl. laboratory) tests and radiology examinations. The diagnostic investigations section must be used for this purpose. |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Response Details (RESPONSE DETAILS) | 0..* | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Procedure Name | 1..1 | |
|  | ~~Description (Procedure Description)~~ | ~~0..0~~ | - |
|  | ~~Reason (Procedure Reason)~~ | ~~0..0~~ | - |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~ANATOMICAL LOCATION~~ | ~~0..0~~ | - |
|  | ~~Procedure Detail~~ | ~~0..0~~ | - |
|  | ~~Duration (Procedure Duration)~~ | ~~0..0~~ | - |
|  | ~~Multimedia~~ | ~~0..0~~ | - |
|  | ~~Comment (Procedure Comment)~~ | ~~0..0~~ | - |
|  | ~~Start Date/Time (DateTime Started)~~ | ~~0..0~~ | - |
|  | ~~DEVICE~~ | ~~0..0~~ | - |
|  | ~~INFORMATION PROVIDER~~ | ~~0..0~~ | - |
|  | ~~SUBJECT~~ | ~~0..0~~ | - |
|  | ~~Procedure Identifier~~ | ~~0..0~~ | - |
|  | ~~LINK~~ | ~~0..0~~ | - |
|  | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ | - |

# 4.5 Procedure Name

## Identification

| | |
|---|---|
| **Label** | Procedure Name |
| **Metadata Type** | Data Element |
| **Identifier** | DE-15579 |
| **OID** | 1.2.36.1.2001.1001.101.103.15579 |

## Definition

| | |
|---|---|
| **Definition** | The name of the procedure (to be) performed. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodeableText |
| **Value Domain** | Procedure Foundation Reference Set |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Procedure (PROCEDURE) | 1..1 | |

# 4.6 Procedure Foundation Reference Set

## Identification

| | |
|---|---|
| **Label** | Procedure Foundation Reference Set |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16580 |
| **OID** | 1.2.36.1.2001.1001.101.104.16580 |
| **External Identifier** | SNOMED CT-AU Concept Id: 32570141000036105 |

## Definition

| | |
|---|---|
| **Definition** | The Procedure foundation reference set provides the broadest possible terminology to support the recording of clinical interventions in Australian eHealth implementations. |
| **Definition Source** | NEHTA |

## Value Domain

| | |
|---|---|
| **Source** | SNOMED CT-AU |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Procedure Name | 1..1 | |

# 5 Clinical Synopsis Data Group

## 5.1 Purpose

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

## 5.2 Use

Used by the healthcare provider to describe additional information such as interpretation and the subject of care's understanding of the health care event that are not captured by other structured or unstructured information components pertinent to that health care event.

## 5.3 Misuse

Used in place of other individual data items.

# 5.4 CLINICAL SYNOPSIS

## Identification

| | |
|---|---|
| **Label** | Other Diagnosis/Procedure Entry |
| **Metadata Type** | Data Group |
| **Identifier** | DG-15513 |
| **OID** | 1.2.36.1.2001.1001.101.102.15513 |

## Definition

| | |
|---|---|
| **Definition** | Information about a subject of care problem or diagnosis established by the specialist; or procedure performed on the subject of care by the specialist. The information not available/captured as structured data. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is a reuse of the CLINICAL SYNOPSIS data group, which is described in Miscellaneous Detailed Clinical Model Specification [NEHT2011aq]. |
| **Conditions of Use Source** | NEHTA |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Response Details (RESPONSE DETAILS) | 0..* | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~Clinical Synopsis Topic~~ | ~~0..0~~ | - |
|  | Other Diagnosis or Procedure Name (Clinical Synopsis Description) | 1..1 | |
|  | ~~DateTime Recorded~~ | ~~0..0~~ | - |
|  | ~~INFORMATION PROVIDER~~ | ~~0..0~~ | - |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~SUBJECT~~ | ~~0..0~~ | - |
|  | ~~Clinical Synopsis Identifier~~ | ~~0..0~~ | - |
|  | ~~LINK~~ | ~~0..0~~ | - |
|  | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ | - |

# 5.5 Clinical Synopsis Description

## Identification

| | |
|---|---|
| **Label** | Other Diagnosis or Procedure Name |
| **Metadata Type** | Data Element |
| **Identifier** | DE-15582 |
| **OID** | 1.2.36.1.2001.1001.101.103.15582 |

## Definition

| | |
|---|---|
| **Definition** | The clinical synopsis/summary of the specialist letter, written in free text. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Clinical Summary Description |
| **Notes** | The description may include a summary of the issues/problems, management strategies, outcomes/progress and possible prognosis. |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | 1. Admitted for elective bronchoscopy for assessment of left lingular and bibasal pneumonia. No focal endobronchial pathology identified. No evidence of malignancy and no pathogens isolated on bronchial brushings and washings.<br>2. 3/52 ago involved in a rear end motor vehicle accident, mid-velocity impact-complaining of neck pain, dizziness, nausea and difficulties concentrating. Disturbed sleep. No spinal cord signs. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Other Diagnosis/Procedure Entry (CLINICAL SYNOPSIS) | 1..1 | |

# 6 Clinical Synopsis Data Group

## 6.1 Purpose

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

## 6.2 Use

Used by the healthcare provider to describe additional information such as interpretation and the subject of care's understanding of the health care event that are not captured by other structured or unstructured information components pertinent to that health care event.

## 6.3 Misuse

Used in place of other individual data items.

# 6.4 CLINICAL SYNOPSIS

## Identification

| | |
|---|---|
| **Label** | Response Narrative |
| **Metadata Type** | Data Group |
| **Identifier** | DG-15513 |
| **OID** | 1.2.36.1.2001.1001.101.102.15513 |

## Definition

| | |
|---|---|
| **Definition** | Information about a diagnosis and/or procedure as established/performed during or relevant to the specialist consultation not available as structured data. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is a reuse of the CLINICAL SYNOPSIS data group, which is described in Miscellaneous Detailed Clinical Model Specification [NEHT2011aq]. |
| **Conditions of Use Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Response Details (RESPONSE DETAILS) | 1..1 | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~Clinical Synopsis Topic~~ | ~~0..0~~ | - |
|  | Narrative (Clinical Synopsis Description) | 1..1 | |
|  | ~~DateTime Recorded~~ | ~~0..0~~ | - |
|  | ~~INFORMATION PROVIDER~~ | ~~0..0~~ | - |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~SUBJECT~~ | ~~0..0~~ | - |
|  | ~~Clinical Synopsis Identifier~~ | ~~0..0~~ | - |
|  | ~~LINK~~ | ~~0..0~~ | - |
|  | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ | - |

# 6.5 Clinical Synopsis Description

## Identification

| | |
|---|---|
| **Label** | Narrative |
| **Metadata Type** | Data Element |
| **Identifier** | DE-15582 |
| **OID** | 1.2.36.1.2001.1001.101.103.15582 |

## Definition

| | |
|---|---|
| **Definition** | The clinical narrative capturing the clinical story / summary of the specialist letter. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Clinical Summary Description |
| **Notes** | The description may include a summary of the issues/problems, management strategies, outcomes/progress and possible prognosis. |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | I was delighted to see Mrs. Smith, looking well today following her recent normal gastroscopy and colonoscopy. I reassured her accordingly and discharged her back to your care. I have not arranged to see her again, but will happily do so if required. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Response Narrative (CLINICAL SYNOPSIS) | 1..1 | |

# 7 Recommendations (Instruction) Data Group

## 7.1 Purpose

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

## 7.2 Use

Often used in a letter from a specialist to the referring health care provider.

# 7.3 RECOMMENDATION

## Identification

| | |
|---|---|
| **Label** | Recommendation |
| **Metadata Type** | Data Group |
| **Identifier** | DG-20116 |
| **OID** | 1.2.36.1.2001.1001.101.102.20116 |

## Definition

| | |
|---|---|
| **Definition** | Recommendation by a clinician to a recipient health care provider regarding the management of the subject of care. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Recommendations (RECOMMENDATIONS) | 0..* | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Addressee (RECOMMENDATION ADDRESSEE) | 1..1 | |
|  | Time Frame (Recommendation Time Frame) | 1..1 | |
|  | ~~INFORMATION PROVIDER~~ | ~~0..0~~ | - |
|  | ~~SUBJECT~~ | ~~0..0~~ | - |
|  | Recommendation Narrative | 1..1 | |
|  | ~~DateTime Recommendation Expires~~ | ~~0..0~~ | - |
|  | ~~Recommendation Identifier~~ | ~~0..0~~ | - |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~LINK~~ | ~~0..0~~ | - |
|  | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ | - |

# 7.4 RECOMMENDATION ADDRESSEE

## Identification

| | |
|---|---|
| **Label** | Addressee |
| **Metadata Type** | Data Group |
| **Identifier** | DG-10296 |
| **OID** | 1.2.36.1.2001.1001.101.102.10296 |

## Definition

| | |
|---|---|
| **Definition** | The individual or organisation who the recommendation is aimed at and/or who should follow up on the action. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | This is a person and the types of sources include:<br>• the clinician,<br>• a healthcare provider; and<br>• a Community Nursing. |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v].<br><br>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in *Appendix B*.<br>• Participation Period is **PROHIBITED**.<br>• LOCATION OF PARTICIPATION is **PROHIBITED**.<br>• Entity Identifier is **ESSENTIAL**.<br>• Relationship to Subject of Care is **PROHIBITED**.<br>• DEMOGRAPHIC DATA is **PROHIBITED**.<br>• ENTITLEMENT is **PROHIBITED**.<br>• Qualifications is **PROHIBITED**.<br><br>Other additional constraints when the Recommendation Addressee is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON):<br>• Participation Type **SHALL** have an implementation-specific value equivalent to “Recommendation Addressee”. |

| | |
|---|---|
| | • Role **SHOULD** have a value chosen from 1220.0 – ANZSCO – Australia and New Zealand Standard Classification of Occupations, First Edition, 2006 – METeOR 350899. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used.<br>• The value of one Entity Identifier **SHALL** be an Australian HPI-I.<br>• The value of one ORGANISATION.Entity Identifier **SHALL** be an Australian HPI-O.<br>• AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.<br>• PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.<br>Other additional constraints when the Recommendation Addressee is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as a ORGANISATION):<br>• Participation Type **SHALL** have an implementation-specific value equivalent to “Recommendation Addressee”.<br>• Role **SHOULD** have a value chosen from 1220.0 – ANZSCO – Australia and New Zealand Standard Classification of Occupations, First Edition, 2006 – METeOR 350899. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used.<br>• The value of one Entity Identifier **SHALL** be an Australian HPI-O.<br>• AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.<br>• PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a ORGANISATION. |
| **Conditions of Use Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Recommendation (RECOMMENDATION) | 1..1 | |

# 7.5 Recommendation Time Frame

## Identification

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

## Definition

| | |
|---|---|
| **Definition** | The time or time period for which the recommendation applies. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | DateTime<br>Duration |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Recommendation (RECOMMENDATION) | 1..1 | |

# 7.6 Recommendation Narrative

## Identification

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

## Definition

| | |
|---|---|
| **Definition** | A textual narrative describing what the Recommendation instruction is about. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Conditions of Use** | Details of the recommendation given by the referee. Typically this include a recommendation regarding when the subject of care should see the specialist again/discharge from the specialist's care, changes initiation of treatment or recommended investigations. |
| **Conditions of Use Source** | NEHTA |
| **Examples** | 1. Monitor diabetic status, renal function and digoxin levels.<br>2. Review cardiac status. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Recommendation (RECOMMENDATION) | 1..1 | |

# 8 Exclusion Statement Data Group

## 8.1 Purpose

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

## 8.2 Use

Use to record the positive exclusion or absence of clinical findings or evaluations within the health record. This detailed clinical model (DCM) avoids the need to use terminology to express negation about any item within the health record. Specialisations of this DCM will capture specific and more detailed information about common exclusions, such as problems or diagnoses. This DCM has been deliberately kept simple and open in order to capture simple statements about anything that may be usefully recorded as absent or excluded within the health record.

## 8.3 Misuse

Do not use to record the exclusion or absence of adverse reactions, problems, diagnoses or interventions - use specific specialisations of this DCM.

# 8.4 EXCLUSION STATEMENT

## Identification

| | |
|---|---|
| **Label** | Recommendations Exclusion |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16134 |
| **OID** | 1.2.36.1.2001.1001.101.102.16134 |

## Definition

| | |
|---|---|
| **Definition** | An explicit statement that no recommendation was made. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Recommendations (RECOMMENDATIONS) | 0..1 | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | General Statement | 1..1 | |
|  | ~~INFORMATION PROVIDER~~ | ~~0..0~~ | - |
|  | ~~SUBJECT~~ | ~~0..0~~ | - |
|  | ~~Exclusion Statement Identifier~~ | ~~0..0~~ | - |
|  | ~~LINK~~ | ~~0..0~~ | - |
|  | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ | - |

# 8.5 General Statement

## Identification

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

## Definition

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

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Recommendations Exclusion (EXCLUSION STATEMENT) | 1..1 | |

# 9 Exclusion Statement - Medications Data Group

## 9.1 Purpose

To positively record the absence or exclusion of any medication use within the health record.

## 9.2 Use

Use to record the positive exclusion or absence of medication use within the health record. This data group avoids the need to use terminology to express negation about any item within the health record. This data group is only to be used to record 'point in time' or event-based information. It is not to be used for a persistent storage of information as the patient should always be questioned about current or past medication use prior to initiation of any treatment or management plan.

# 9.3 EXCLUSION STATEMENT - MEDICATIONS

## Identification

| | |
|---|---|
| **Label** | EXCLUSION STATEMENT - MEDICATIONS |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16136 |
| **OID** | 1.2.36.1.2001.1001.101.102.16136 |

## Definition

| | |
|---|---|
| **Definition** | Statement positively asserting that the patient has not been prescribed or is not taking any medication. |
| **Definition Source** | openEHR Foundation |
| **Scope** | To positively record the absence or exclusion of any medication use within the health record. |
| **Scope Source** | openEHR Foundation |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is a reuse of the EXCLUSION STATEMENT - MEDICATIONS data group, which is described in Medication Instruction And Action Detailed Clinical Specification [NEHT2011ay]. |
| **Conditions of Use Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Medications (MEDICATION ORDERS) | 0..1 | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Global Statement | 1..1 | |
|  | ~~Not Currently Taking~~ | ~~0..0~~ | - |
|  | ~~Not Ever Taken~~ | ~~0..0~~ | - |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~INFORMATION PROVIDER~~ | ~~0..0~~ | - |
|  | ~~SUBJECT~~ | ~~0..0~~ | - |
|  | ~~Exclusion Statement - Medications Identifier~~ | ~~0..0~~ | - |
|  | ~~LINK~~ | ~~0..0~~ | - |
|  | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ | - |

# 9.4 Global Statement

## Identification

| | |
|---|---|
| **Label** | Global Statement |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16302 |
| **OID** | 1.2.36.1.2001.1001.101.103.16302 |

## Definition

| | |
|---|---|
| **Definition** | The statement about the absence or exclusion of certain medication. |
| **Definition Source** | openEHR Foundation |
| **Synonymous Names** | |
| **Context** | Use to capture any information that is needed to be explicitly recorded as being absent or excluded within the record. |
| **Context Source** | openEHR Foundation |
| **Data Type** | CodedText |
| **Value Domain** | Global Statement Values |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | EXCLUSION STATEMENT - MEDICATIONS | 1..1 | |

# 9.5 Global Statement Values

## Identification

| | |
|---|---|
| **Label** | Global Statement Values |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16299 |
| **OID** | 1.2.36.1.2001.1001.101.104.16299 |

## Definition

| | |
|---|---|
| **Definition** | The set of values for the statement about the absence or exclusion. |
| **Definition Source** | openEHR Foundation |

## Value Domain

| | | |
|---|---|---|
| **Source** | NEHTA | |
| **Permissible Values** | *Not asked* | No information about taking any medication is available because the patient was not asked or not able to be asked |
| | *None known* | No information about taking any medication is known |
| | *None supplied* | No information about taking any medication is supplied |
| | Please see Appendix A, *Known Issues* | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Global Statement | 1..1 | |

# 10 Medication Instruction Data Group

## 10.1 Purpose

Recording intent to use or to continue to use a medicine, vaccine or other therapeutic good including instructions on use, dispensing and administration, where necessary.

## 10.2 Use

For recording instructions to dispense, administer or use a medicine, vaccine or other therapeutic good. This medication instruction can be used in many circumstances including: a record in a progress note; an item in a medication list, prescription or drug chart (to be dispensed and/or administered); or in a summary document such as discharge summary or a referral for care. The instruction may be complex and involve more than one activity, such as in the case of a reducing dose of Predisolone, or multiple medications as components of the same order. This would include a written order by a physician, dentist, nurse practitioner, or other designated health professional for a medication to be dispensed and administered to a patient.

This instruction will generally apply to things that can be prescribed or are available 'over the counter'.

Use for orders for vaccinations or other therapeutic goods. These may be presented differently in different applications but require the same structure.

Use for the consistent representation of an item in a medication list comprising the medicines that a clinicians collectively expect the individual to be taking.

The information recorded may separate dose, route and timing to achieve a computable and sharable specification but also allows for narrative instructions for orders like 'Frusemide 40mg two tablets in the morning and one at lunch' to ensure compatibility with existing systems. To achieve a structure statement for such compound orders, two items are required: 'Frusemide 40mg two tablets in the morning' and 'Frusemide 40mg one tablet at lunch'. The instruction will usually include information about the timing and dose (which may be structured) and in some settings will include the route of administration. The amount of the medicines will usually be given in terms of a number and a dose unit but may be a textural statement to ensure compatibility with existing systems and also coverage of all scenarios.

Use to represent a prescription item for a medicine, vaccine or other therapeutic good within a document such as an electronic prescription or a medication chart.

The content is potentially complex. Where the content is re-usable in other contexts, especially the paired Medication Action DCM (for recording dispensing, administration etc) the content has been specified in re-useable data groups. For example: Amount and Amount range data groups contain the detail about Medication dose; Timing data group contains detail about structured dose timing; Medication administration data group contains structure around administration for both the order and the action; and Chemical description data group described the specific ingredients within a medicine. All of these data groups together are required to make up the total maximal dataset for a re-useable medication instruction.

## 10.3 Misuse

Not to be used to record administration, use or dispensing. (For those use Medication Action DCM)

Not to be used to record ordering of blood products, implants or major devices such as pacemakers and defibrillators, etc.

# 10.4 MEDICATION INSTRUCTION

## Identification

| | |
|---|---|
| **Label** | Medication |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16211 |
| **OID** | 1.2.36.1.2001.1001.101.102.16211 |

## Definition

| | |
|---|---|
| **Definition** | Information pertaining to one or more therapeutic goods that is represented to achieve, or is likely to achieve, its principal intended action by pharmacological, chemical, immunological or metabolic means in or on the body of a human. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Drug<br>Medicine<br>Potion<br>Therapeutic |
| **Scope** | For use in the healthcare setting. Captures detailed information on the medication being used by or prescribed for the subject of care for their personal healthcare. This only includes legal substances.<br><br>Such information covers not only aspects of the medication itself, but information relating to the ordering, dispensing, administration and review of medications. The specifications herein are presented grouped according to these process states.<br><br>Recording legal substances such as over-the-counter medications, complementary and alternative medications, and prescribed medications. |
| **Scope Source** | NEHTA |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is a reuse of the MEDICATIONS data group, which is described in Medication Instruction And Action Detailed Clinical Specification [NEHT2011ay]. |
| **Conditions of Use Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Medications (MEDICATION ORDERS) | 0..* | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Medicine (Therapeutic Good Identification) | 1..1 | |
|  | Directions | 0..1 | |
|  | ~~Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)~~ | ~~0..0~~ | - |
|  | ~~Dose Description~~ | ~~0..0~~ | - |
|  | ~~Structured Dose (AMOUNT OF MEDICATION)~~ | ~~0..0~~ | - |
|  | ~~TIMING~~ | ~~0..0~~ | - |
|  | ~~Additional Instruction~~ | ~~0..0~~ | - |
|  | Clinical Indication | 0..1 | |
|  | ~~Administration Details (MEDICATION ADMINISTRATION)~~ | ~~0..0~~ | - |
|  | Comment (Medication Instruction Comment) | 0..1 | |
|  | ~~DISPENSING~~ | ~~0..0~~ | - |
|  | Change Type | 1..1 | |
|  | Change or Recommendation? (Change Status) | 1..1 | |
|  | Change Description | 0..1 | |
|  | Change Reason (Change or Recommendation Reason) | 0..1 | |
|  | ~~Indication for Authorised Use~~ | ~~0..0~~ | - |
|  | ~~Medication Instruction ID~~ | ~~0..0~~ | - |
|  | ~~Concession Benefit~~ | ~~0..0~~ | - |
|  | ~~INFORMATION PROVIDER~~ | ~~0..0~~ | - |
|  | ~~SUBJECT~~ | ~~0..0~~ | - |
|  | ~~Medication Instruction Narrative~~ | ~~0..0~~ | - |
|  | ~~DateTime Medication Instruction Expires~~ | ~~0..0~~ | - |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~Medication Instruction Identifier~~ | ~~0..0~~ | - |
|  | ~~LINK~~ | ~~0..0~~ | - |
|  | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ | - |

# 10.5 Therapeutic Good Identification

## Identification

| | |
|---|---|
| **Label** | Medicine |
| **Metadata Type** | Data Element |
| **Identifier** | DE-10194 |
| **OID** | 1.2.36.1.2001.1001.101.103.10194 |

## Definition

| | |
|---|---|
| **Definition** | The medicine, vaccine or other therapeutic good being ordered, administered to or used by the subject of care. |
| **Definition Source** | Therapeutic Goods Administration |
| **Synonymous Names** | Item Name |
| **Context** | This includes medications and medical devices. It includes drugs, appliances, dressings and reagents. |
| **Context Source** | NEHTA |
| **Notes** | Identifies a therapeutic good, which is broadly defined as a good which is represented in any way to be, or is likely to be taken to be, for therapeutic use (unless specifically excluded or included under Section 7 of the Therapeutic Goods Act 1989).<br><br>Therapeutic use means use in or in connection with:<br><br>• preventing, diagnosing, curing or alleviating a disease, ailment, defect or injury;<br><br>• influencing, inhibiting or modifying a physiological process;<br><br>• testing the susceptibility of persons to a disease or ailment;<br><br>• influencing, controlling or preventing conception;<br><br>• testing for pregnancy; or<br><br>• replacement or modification of parts of the anatomy.<br><br>From [TGA1989a].<br><br>The formal definition of a therapeutic good (from the Therapeutic Goods Act 1989) can be found at: [TGA1989a]. |
| **Data Type** | CodeableText |
| **Value Domain** | Medicines Terminology |

## Usage

| | |
|---|---|
| **Conditions of Use** | Where the therapeutic good can be identified by an AMT (Australian Medicines Terminology) concept, this **SHALL** be the AMT ConceptID and Preferred Term. For details see Medicines Terminology. |

| | |
|---|---|
| | For items without an AMT code (including some extemporaneous preparations), a text description is suitable. For a medication this **SHALL** include the name of the medication (brand name or generic name equivalent), strength and dose form, where appropriate. |
| **Conditions of Use Source** | NEHTA |
| **Examples** | Some examples of AMT ConceptID and their AMT Preferred Term are:<br>1. 293049011000036110, paracetamol 500 mg + codeine phosphate 30 mg tablet<br>2. 327004011000036118, paracetamol 500 mg + codeine phosphate 30 mg tablet, 20<br>3. 234184011000036115, Panadeine Forte tablet: uncoated, 20 tablets<br>4. 192727011000036112, Panadeine Forte (paracetamol 500 mg + codeine phosphate 30 mg) tablet: uncoated, 1 tablet<br>5. 278453011000036118, Panadeine Forte tablet: uncoated, 20 tablets, blister pack<br>6. 315236011000036113, bandage compression 10 cm x 3.5 m bandage: high stretch, 1 bandage<br>7. 186324011000036116, Eloflex (2480) (bandage compression 10 cm x 3.5 m) bandage: high stretch, 1 bandage<br>8. 73875011000036101, Je-Vax (Japanese encephalitis virus inactivated vaccine) injection: powder for, vial |
| **Misuse** | Detailing the formula of a compounded (extemporaneous) medication. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Medication (MEDICATION INSTRUCTION) | 1..1 | |

# 10.6 Medicines Terminology

## Identification

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

## Definition

| | |
|---|---|
| **Definition** | A set of values used to refer to medicines and other therapeutic goods. |
| **Definition Source** | NEHTA |
| **Notes** | An explanation of AMT concepts can be found in Australian Medicines Terminology Editorial Rules [NEHT2009r].<br><br>Prescribing and dispensing use different sets of values. |

## Value Domain

| | |
|---|---|
| **Source** | Australian Medicines Terminology |
| **Permissible Values** | The permissible values are the members of the following 7 AMT reference sets:<br>• \|929360061000036106 *Medicinal product reference set*\|<br>• \|929360081000036101 *Medicinal product pack reference set*\|<br>• \|929360071000036103 *Medicinal product unit of use reference set*\|<br>• \|929360021000036102 *Trade product reference set*\|<br>• \|929360041000036105 *Trade product pack reference set*\|<br>• \|929360031000036100 *Trade product unit of use reference set*\|<br>• \|929360051000036108 *Containered trade product pack reference set*\|<br><br>Different reference sets are allowed in the differing contexts of prescribing and administering and are listed below.<br><br>Prescribing:<br>• \|929360081000036101 *Medicinal product pack reference set*\|<br>• \|929360071000036103 *Medicinal product unit of use reference set*\|<br>• \|929360041000036105 *Trade product pack reference set*\|<br>• \|929360031000036100 *Trade product unit of use reference set*\|<br>• \|929360051000036108 *Containered trade product pack reference set*\| |

Administering:

- |929360031000036100 *Trade product unit of use reference set*|

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Medicine (Therapeutic Good Identification) | 1..1 | |

# 10.7 Directions

## Identification

| | |
|---|---|
| **Label** | Directions |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16429 |
| **OID** | 1.2.36.1.2001.1001.101.103.16429 |

## Definition

| | |
|---|---|
| **Definition** | A complete narrative description of how much, when and how to use the medicine, vaccine or other therapeutic good. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Medication (MEDICATION INSTRUCTION) | 0..1 | |

# 10.8 Clinical Indication

## Identification

| | |
|---|---|
| **Label** | Clinical Indication |
| **Metadata Type** | Data Element |
| **Identifier** | DE-10141 |
| **OID** | 1.2.36.1.2001.1001.101.103.10141 |

## Definition

| | |
|---|---|
| **Definition** | A reason for ordering the medicine, vaccine or other therapeutic good. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Reason for prescribing |
| **Notes** | The clinical justification (e.g. specific therapeutic effect intended) for this subject of care's use of the therapeutic good. |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Conditions of Use** | For inpatient discharge summaries, this should always be recorded. |
| **Conditions of Use Source** | NEHTA |
| **Examples** | 1. Long-term maintenance treatment of bronchospasm and dyspnoea. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Medication (MEDICATION INSTRUCTION) | 0..1 | |

# 10.9 Medication Instruction Comment

## Identification

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

## Definition

| | |
|---|---|
| **Definition** | Any additional information that may be needed to ensure the continuity of supply, rationale for current dose and timing, or safe and appropriate use. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | 1. Patient requires an administration aid.<br>2. Portable Pulse Oximeter measurement to be taken by clipping the sensor onto the tip of a finger.<br>3. Consulted prescriber concerning dose. |
| **Misuse** | Use for information that could be recorded as structured data. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Medication (MEDICATION INSTRUCTION) | 0..1 | |

# 10.10 Change Type

## Identification

| | |
|---|---|
| **Label** | Change Type |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16593 |
| **OID** | 1.2.36.1.2001.1001.101.103.16593 |

## Definition

| | |
|---|---|
| **Definition** | The way in which this instruction differs from the previous instruction. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodedText |
| **Value Domain** | Change Type Values |

## Usage

| | |
|---|---|
| **Examples** | 1. New prescription<br>2. Change of previous<br>3. Cancellation |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Medication (MEDICATION INSTRUCTION) | 1..1 | |

# 10.11 Change Type Values

## Identification

| | |
|---|---|
| **Label** | Change Type Values |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16592 |
| **OID** | 1.2.36.1.2001.1001.101.104.16592 |

## Definition

| | |
|---|---|
| **Definition** | The set of values for the *Change Type*. |
| **Definition Source** | NEHTA |

## Value Domain

| | | |
|---|---|---|
| **Source** | NEHTA | |
| **Permissible Values** | Unchanged | There is no change to the instruction |
| | Changed | There is a change to the instruction |
| | Ceased | The instruction has been ended |
| | Prescribed | A new prescription has been issued |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Change Type | 1..1 | |

# 10.12 Change Status

## Identification

| | |
|---|---|
| **Label** | Change or Recommendation? |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16595 |
| **OID** | 1.2.36.1.2001.1001.101.103.16595 |

## Definition

| | |
|---|---|
| **Definition** | Identifies whether the change has already been made or is a recommendation which has not been made. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodedText |
| **Value Domain** | Change Status Values |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Medication (MEDICATION INSTRUCTION) | 1..1 | |

# 10.13 Change Status Values

## Identification

| | |
|---|---|
| **Label** | Change Status Values |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16626 |
| **OID** | 1.2.36.1.2001.1001.101.104.16626 |

## Definition

| | |
|---|---|
| **Definition** | The set of values for the *Change Status*. |
| **Definition Source** | NEHTA |

## Value Domain

| | | |
|---|---|---|
| **Source** | NEHTA | |
| **Permissible Values** | Change recommended | The change has not been made, but it is recommended to be made |
| | Change made | The change has been made |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Change or Recommendation? (Change Status) | 1..1 | |

# 10.14 Change Description

## Identification

| | |
|---|---|
| **Label** | Change Description |
| **Metadata Type** | Data Element |
| **Identifier** | DE-10176 |
| **OID** | 1.2.36.1.2001.1001.101.103.10176 |

## Definition

| | |
|---|---|
| **Definition** | Description of the change in the subject of care's medication item information. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | 1. Correction of prescription error.<br>2. Cessation of medication.<br>3. Change of dose.<br>4. Addition of drug.<br>5. Substitution of drug. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Medication (MEDICATION INSTRUCTION) | 0..1 | |

# 10.15 Change or Recommendation Reason

## Identification

| | |
|---|---|
| **Label** | Change Reason |
| **Metadata Type** | Data Element |
| **Identifier** | DE-10177 |
| **OID** | 1.2.36.1.2001.1001.101.103.10177 |

## Definition

| | |
|---|---|
| **Definition** | The justification for the stated change in medication. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Reason for Alteration<br>Reason for Modification |
| **Notes** | Should be completed if a change has been made. |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | 1. Optimise drug therapy.<br>2. Intolerable side effect of dizziness. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Medication (MEDICATION INSTRUCTION) | 0..1 | |

# 11 Adverse Reaction Data Group

## 11.1 Purpose

To record health information that will inform a clinical assessment of the propensity of an individual for a future reaction to a substance, class of substance or agent.

To record information about exposure events to a substance, building up a persisting and evolving summary over time.

To record information about any adverse reaction, including:

- immune mediated reactions Types I-IV (including allergic reactions and hypersensitivities), and
- non-immune mediated reactions (including pseudoallergic reactions, side effects, intolerances, drug toxicities (e.g. Gentamycin), drug-drug interactions, food-drug interactions, drug-disease interactions and idiosyncratic reactions).

## 11.2 Use

Use to record all information about adverse reactions (including allergic reactions) that are required to support direct clinical care of an individual, safe exchange of information about adverse reactions and to enable computerised knowledge-based activities such as clinical decision support and alerts.

Use to provide a single place within the health record to record a range of clinical statements about adverse reactions, including:

- record cumulative information about each exposure to a known substance, class of substance or agent; and
- record a clinician's opinion that administration of, or exposure to, a substance or agent is absolutely contraindicated.

Use to record the information about an adverse reaction that might be exchanged with other systems, including as part of an adverse reaction report sent to statutory authorities. It is likely that a formal Adverse Reaction report will require additional information that will be captured in the health record using other data groups, for example medication and problem/diagnosis etc.

This data group has been designed to allow recording of information about a more generic substance, class of substance or agent, and then allow more specific details to be recorded including identification of the specific substance on a per exposure basis, including links to other parts of the health record where further details may be located. Note: it is possible on second or subsequent exposures to a previously identified substance for a reaction not to occur and this data group allows for these events to be closely linked in a way that will assist in determining if the adverse reaction has been incorrectly identified.

In addition, it is anticipated that in some very specific clinical situations, such as immunologist assessment or for use in clinical trials, more information about the adverse reaction may be required. Additional details can be added as cluster data groups using the ‘Further Exposure Details’ and ‘Further Reaction Details’ slots. Similarly, additional details that are required only for reporting can be added using the ‘Reporting Details’ slot.

The act of recording an adverse reaction in the health record implies there is a potential hazard for the individual if they are exposed to the same substance/agent in the future - a relative contraindication. If a clinician considers that it is not safe for the individual to be deliberately re-exposed to the substance/agent again, for example, following a manifestation of anaphylaxis, the 'Absolute contraindication'

data flag should be recorded as ‘True’. Note: Conversely, a statement about ‘Severity’ of propensity (with possible values such as Mild, Moderate and Severe) has deliberately not been modelled explicitly. Predicting or estimating the grade of possible severity of a future reaction is not safe to record and persist in data, except where it is absolutely clear that the risk of deliberate re-exposure is unacceptable and highly likely to cause significant harm, such as a previous manifestation of anaphylaxis, and in this case the ‘Absolute contraindication’ data flag should be used.

Valuable first-level information that could be presented to the clinician when they need to assess propensity for future reactions are:

- statements about previous clinical manifestations following exposure,
- source of the information/reporter, and
- a flag for absolute contra-indication.

Second-level information can be drawn from each exposure event and links to additional detailed information such as history, examination and diagnoses stored elsewhere in the record, if it is available.

# 11.3 Misuse

1. Not to be used for recording the absence (or negative presence) of a reaction to 'any substances' or to identified substances – use the EVALUATION.exclusion family of data groups to express a positive statement of exclusion.
2. Not to be used for recording that no information was able to be obtained about the Adverse Reaction status of a patient. Use the EVALUATION.absent_information family of data group to record a positive statement of absent information about Adverse Reactions was able to be obtained, for example, if a non-cooperative patient refuses to answer questions.
3. Not to be used to record adverse events, including failures of clinical process, interventions or products. For example: abnormal use or mistakes/errors made in administration of an agent or substance; mislabelling; harm or injury caused by an intervention or procedure; overdose, etc.
4. Not to be used for recording alerts.

# 11.4 ADVERSE REACTION

## Identification

| | |
|---|---|
| **Label** | ADVERSE REACTION |
| **Metadata Type** | Data Group |
| **Identifier** | DG-15517 |
| **OID** | 1.2.36.1.2001.1001.101.102.15517 |

## Definition

| | |
|---|---|
| **Definition** | A harmful or undesirable effect associated with exposure to any substance or agent, including food, plants, animals, venom from animal stings or a medication at therapeutic or sub-therapeutic doses. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is a reuse of the ADVERSE REACTION data group, which is described in Adverse Reaction Detailed Clinical Model Specification [NEHT2011bb]. |
| **Conditions of Use Source** | NEHTA |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Newly Identified Allergies and Adverse Reactions (ADVERSE REACTIONS) | 1..* | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Substance/Agent | 1..1 | |
| | ~~Absolute Contraindication~~ | ~~0..0~~ | - |
| | ~~Comment (Adverse Reaction Comment)~~ | ~~0..0~~ | - |
| | REACTION EVENT | 0..1 | |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~Reaction Reported~~ | ~~0..0~~ | - |
|  | ~~Adverse Reaction Report~~ | ~~0..0~~ | - |
|  | ~~Supporting Clinical Record Information~~ | ~~0..0~~ | - |
|  | ~~INFORMATION PROVIDER~~ | ~~0..0~~ | - |
|  | ~~SUBJECT~~ | ~~0..0~~ | - |
|  | ~~Adverse Reaction Identifier~~ | ~~0..0~~ | - |
|  | ~~LINK~~ | ~~0..0~~ | - |
|  | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ | - |

# 11.5 Substance/Agent

## Identification

| | |
|---|---|
| **Label** | Substance/Agent |
| **Metadata Type** | Data Element |
| **Identifier** | DE-15521 |
| **OID** | 1.2.36.1.2001.1001.101.103.15521 |

## Definition

| | |
|---|---|
| **Definition** | Identification of a substance, agent, or a class of substance, that is considered to be responsible for the adverse reaction. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Agent<br>Substance |
| **Notes** | An agent can be a substance such as food, drug or an environmental allergen. |
| **Data Type** | CodeableText |
| **Value Domain** | Substance/Agent Values |

## Usage

| | |
|---|---|
| **Examples** | 1. Animal protein<br>2. Latex<br>3. Peanut<br>4. Penicillin<br>5. Bee venom |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ADVERSE REACTION | 1..1 | |

# 11.6 Substance/Agent Values

## Identification

| | |
|---|---|
| **Label** | Substance/Agent Values |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-15521 |
| **OID** | 1.2.36.1.2001.1001.101.104.15521 |

## Definition

| | |
|---|---|
| **Definition** | The set of values for the agent/substance causing the adverse reaction experienced by the patient. |
| **Definition Source** | NEHTA |

## Value Domain

| | |
|---|---|
| **Source** | NEHTA |
| **Permissible Values** | The permissible values are the members of the following 8 reference sets.<br>From SNOMED CT-AU:<br>• \|32570211000036100 *Substance foundation reference set*\|<br>From AMT:<br>• \|929360061000036106 *Medicinal product reference set*\|<br>• \|929360081000036101 *Medicinal product pack reference set*\|<br>• \|929360071000036103 *Medicinal product unit of use reference set*\|<br>• \|929360021000036102 *Trade product reference set*\|<br>• \|929360041000036105 *Trade product pack reference set*\|<br>• \|929360031000036100 *Trade product unit of use reference set*\|<br>• \|929360051000036108 *Containered trade product pack reference set*\| |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Substance/Agent | 1..1 | |

# 11.7 REACTION EVENT

## Identification

| | |
|---|---|
| **Label** | REACTION EVENT |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16474 |
| **OID** | 1.2.36.1.2001.1001.101.102.16474 |

## Definition

| | |
|---|---|
| **Definition** | Details about each adverse reaction event. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | ADVERSE REACTION | 0..1 | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | ~~Specific Substance/Agent~~ | ~~0..0~~ | - |
| | Manifestation | 1..* | |
| | ~~Reaction Type~~ | ~~0..0~~ | - |
| | ~~Certainty (Adverse Reaction Certainty)~~ | ~~0..0~~ | - |
| | ~~Reaction Description~~ | ~~0..0~~ | - |
| | ~~Onset of Reaction (Reaction Onset Date)~~ | ~~0..0~~ | - |
| | ~~Duration of Reaction~~ | ~~0..0~~ | - |
| | ~~Additional Reaction Detail (ANATOMICAL LOCATION)~~ | ~~0..0~~ | - |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~Exposure Description~~ | ~~0..0~~ | - |
|  | ~~Earliest Exposure~~ | ~~0..0~~ | - |
|  | ~~Duration of Exposure~~ | ~~0..0~~ | - |
|  | ~~ADDITIONAL EXPOSURE DETAIL~~ | ~~0..0~~ | - |
|  | ~~Clinical Management Description~~ | ~~0..0~~ | - |
|  | ~~Multimedia~~ | ~~0..0~~ | - |
|  | ~~Reporting Details~~ | ~~0..0~~ | - |
|  | ~~Comment (Adverse Reaction Event Comment)~~ | ~~0..0~~ | - |

# 11.8 Manifestation

## Identification

| | |
|---|---|
| **Label** | Manifestation |
| **Metadata Type** | Data Element |
| **Identifier** | DE-15564 |
| **OID** | 1.2.36.1.2001.1001.101.103.15564 |

## Definition

| | |
|---|---|
| **Definition** | Clinical manifestation of the adverse reaction expressed as a single word, phrase or brief description. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Reaction |
| **Notes** | The signs, symptoms, severity and/or certainty of the adverse reaction are relevant as it contributes towards the decision as to the immediacy and extent of treatment to be provided, as determined by a healthcare provider.<br><br>Given that an adverse reaction has occurred, it is important to determine the manifestations of that reaction. |
| **Data Type** | CodeableText |
| **Value Domain** | Clinical Manifestation Values |

## Usage

| | |
|---|---|
| **Examples** | 1. Itchy eyes.<br>2. Dysphagia.<br>3. Tinnitus.<br>4. Nausea.<br>5. Rash. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | REACTION EVENT | 1..* | |

# 11.9 Clinical Manifestation Values

## Identification

| | |
|---|---|
| **Label** | Clinical Manifestation Values |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-15564 |
| **OID** | 1.2.36.1.2001.1001.101.104.15564 |
| **External Identifier** | SNOMED CT-AU Concept ID: 32570071000036102 |

## Definition

| | |
|---|---|
| **Definition** | The Clinical Manifestation values reference set provides the broadest possible terminology to support the recording of Clinical manifestation of the adverse reaction in Australian eHealth implementations. |
| **Definition Source** | NEHTA |

## Value Domain

| | | |
|---|---|---|
| **Source** | SNOMED CT-AU | |
| **Permissible Values** | *Not Defined* | Mapped to Clinical finding foundation reference set (SNOMED CT-AU Concept ID: 32570071000036102). |
| | Please see Appendix A, *Known Issues* | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Manifestation | 1..1 | |

# 12 Pathology Test Result Data Group

## 12.1 Purpose

To record the findings and interpretation of pathology tests performed on tissues and body fluids. This is typically done in a laboratory but may be done in other environments such as at the point of care.

## 12.2 Use

Use to record any pathology test result, including the result of a test on a specimen taken as part of a composite procedure or operation.

Multi-analyte panels can be represented using templates or specialised DCMs.

More complex tests such as histopathology or microbiology should be represented using specialised DCMs where additional report content is required.

Will normally be reported back to the requesting clinician as one component within the context of an overall COMPOSITION-based report.

## 12.3 Misuse

Not to be used for reporting on non-pathology test results e.g. diagnostic imaging, ECG or respiratory function tests.

Not to be used to represent an entire cumulative report. This Pathology test result DCM represents only one of the result sets that is usually viewed as a vertical in a cumulative test report. A cumulative report is a view that is constructed from the results represented by multiple DCMs.

This DCM is suitable for representation of general pathology test results, but not intended to cover full synoptic reports. For these, additional specialising DCMs are required to represent the data.

# 12.4 PATHOLOGY TEST RESULT

## Identification

| | |
|---|---|
| **Label** | PATHOLOGY TEST RESULT |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16144 |
| **OID** | 1.2.36.1.2001.1001.101.102.16144 |

## Definition

| | |
|---|---|
| **Definition** | The result of a laboratory test which may be used to record a single valued test but will often be specialised or templated to represent multiple value or 'panel' tests. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Lab test<br>Pathology<br>Biochemistry<br>Haematology<br>Microbiology<br>Immunology |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is a reuse of the PATHOLOGY TEST RESULT data group, which is described in Pathology Test Result Detailed Clinical Model Specification [NEHT2011bc]. |
| **Conditions of Use Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | DIAGNOSTIC INVESTIGATIONS | 0..* | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Test Result Name (Pathology Test Result Name) | 1..1 | |
|  | Diagnostic Service | 0..1 | |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Test Specimen Detail (SPECIMEN) | 1..* | |
|  | Overall Pathology Test Status (Overall Pathology Test Result Status) | 1..1 | |
|  | Clinical Information Provided | 0..1 | |
|  | Result Group (PATHOLOGY TEST RESULT GROUP) | 0..* | |
|  | Pathological Diagnosis | 0..* | |
|  | Conclusion (Pathology Test Conclusion) | 0..1 | |
|  | Test Result Representation | 0..1 | |
|  | Test Comment | 0..1 | |
|  | ~~RECEIVING LABORATORY~~ | ~~0..0~~ | - |
|  | TEST REQUEST DETAILS | 0..* | |
|  | ~~Test Procedure~~ | ~~0..0~~ | - |
|  | ~~INFORMATION PROVIDER~~ | ~~0..0~~ | - |
|  | ~~SUBJECT~~ | ~~0..0~~ | - |
|  | Pathology Test Result DateTime | 1..1 | |
|  | ~~Pathology Test Result Duration~~ | ~~0..0~~ | - |
|  | ~~Pathology Test Result Identifier~~ | ~~0..0~~ | - |
|  | ~~LINK~~ | ~~0..0~~ | - |
|  | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ | - |

# 12.5 Pathology Test Result Name

## Identification

| | |
|---|---|
| **Label** | Test Result Name |
| **Metadata Type** | Data Element |
| **Identifier** | DE-11017 |
| **OID** | 1.2.36.1.2001.1001.101.103.11017 |

## Definition

| | |
|---|---|
| **Definition** | Identification of the pathology test performed, sometimes including specimen type. |
| **Definition Source** | NEHTA |
| **Notes** | The test name can refer to a single test (e.g. HbA1c) or to a test group such as electrolytes, FBC or coagulation tests. |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | PATHOLOGY TEST RESULT | 1..1 | |

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

# 12.6 Diagnostic Service

## Identification

| | |
|---|---|
| **Label** | Diagnostic Service |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16149 |
| **OID** | 1.2.36.1.2001.1001.101.103.16149 |

## Definition

| | |
|---|---|
| **Definition** | The diagnostic service that performs the examination. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodeableText |
| **Value Domain** | Diagnostic Service Values |

## Usage

| | |
|---|---|
| **Examples** | 1. Microbiology.<br>2. Haematology. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | PATHOLOGY TEST RESULT | 0..1 | |

# 12.7 Diagnostic Service Values

## Identification

| | |
|---|---|
| **Label** | Diagnostic Service Values |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16148 |
| **OID** | 1.2.36.1.2001.1001.101.104.16148 |
| **External Identifier** | HL7 table 0074 - Diagnostic service section ID |

## Definition

| | |
|---|---|
| **Definition** | The set of values for the type of high-level diagnostic service, e.g. biochemistry, haematology. |
| **Definition Source** | NEHTA |

## Value Domain

| | |
|---|---|
| **Source** | HL7 |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Diagnostic Service | 1..1 | |

# 12.8 SPECIMEN

## Identification

| | |
|---|---|
| **Label** | Test Specimen Detail |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16156 |
| **OID** | 1.2.36.1.2001.1001.101.102.16156 |

## Definition

| | |
|---|---|
| **Definition** | Details about specimens to which this test result refers. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Do not include specimens described in PATHOLOGY TEST RESULT GROUP. |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | PATHOLOGY TEST RESULT | 1..* | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Specimen Tissue Type | 0..1 | |
| | Collection Procedure | 0..1 | |
| | Anatomical Site (ANATOMICAL LOCATION) | 0..* | |
| | Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) | 0..* | |
| | ~~NEEDLE BIOPSY CORE DETAILS~~ | ~~0..0~~ | - |
| | COLLECTION AND HANDLING | 0..1 | |
| | HANDLING AND PROCESSING | 1..1 | |
| | ~~SPECIMEN QUALITY~~ | ~~0..0~~ | - |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IDENTIFIERS | 0..1 | |

# 12.9 Specimen Tissue Type

## Identification

| | |
|---|---|
| **Label** | Specimen Tissue Type |
| **Metadata Type** | Data Element |
| **Identifier** | DE-11008 |
| **OID** | 1.2.36.1.2001.1001.101.103.11008 |

## Definition

| | |
|---|---|
| **Definition** | The type of specimen to be collected. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | The categorisation of the sample taken from an individual and submitted for pathology investigation. |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is the actual specimen being submitted to the laboratory for analysis. |
| **Conditions of Use Source** | NEHTA |
| **Examples** | 1. Venous blood.<br>2. Prostate tissue, left base.<br>3. Urine.<br>4. Sputum.<br>5. Scraping.<br>6. Catheter tip.<br>7. Single core (yellow-tan) liver tissue. |

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

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Test Specimen Detail (SPECIMEN) | 0..1 | |

# 12.10 Collection Procedure

## Identification

| | |
|---|---|
| **Label** | Collection Procedure |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16111 |
| **OID** | 1.2.36.1.2001.1001.101.103.16111 |

## Definition

| | |
|---|---|
| **Definition** | The method of collection to be used. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[3] with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | 1. Venepuncture<br><br>2. Biopsy<br><br>3. Resection |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Test Specimen Detail (SPECIMEN) | 0..1 | |

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

# 12.11 ANATOMICAL LOCATION

## Identification

| | |
|---|---|
| **Label** | Anatomical Site |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16150 |
| **OID** | 1.2.36.1.2001.1001.101.102.16150 |

## Definition

| | |
|---|---|
| **Definition** | The anatomical site from where the specimen was taken. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Test Specimen Detail (SPECIMEN) | 0..* | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | SPECIFIC LOCATION | 0..1 | |
| | ~~RELATIVE LOCATION~~ | ~~0..0~~ | - |
| | Description (Anatomical Location Description) | 0..1 | |
| | ~~Visual Markings/Orientation~~ | ~~0..0~~ | - |
| | Image (Anatomical Location Image) | 0..* | |

# 12.12 SPECIFIC LOCATION

## Identification

| | |
|---|---|
| **Label** | SPECIFIC LOCATION |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16151 |
| **OID** | 1.2.36.1.2001.1001.101.102.16151 |

## Definition

| | |
|---|---|
| **Definition** | Specific and identified anatomical location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Anatomical Site (ANATOMICAL LOCATION) | 0..1 | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Name of Location (Anatomical Location Name) | 0..1 | |
|  | Side | 0..1 | |
|  | ~~Numerical Identifier~~ | ~~0..0~~ | - |
|  | ~~Anatomical Plane~~ | ~~0..0~~ | - |

# 12.13 Anatomical Location Name

## Identification

| | |
|---|---|
| **Label** | Name of Location |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16153 |
| **OID** | 1.2.36.1.2001.1001.101.103.16153 |

## Definition

| | |
|---|---|
| **Definition** | The name of an anatomical location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodeableText |
| **Value Domain** | Body Structure Foundation Reference Set |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIFIC LOCATION | 0..1 | |

# 12.14 Body Structure Foundation Reference Set

## Identification

| | |
|---|---|
| **Label** | Body Structure Foundation Reference Set |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16152 |
| **OID** | 1.2.36.1.2001.1001.101.104.16152 |
| **External Identifier** | SNOMED CT-AU Concept Id: 32570061000036105 |

## Definition

| | |
|---|---|
| **Definition** | The set of values for named anatomical locations. |
| **Definition Source** | NEHTA |

## Value Domain

| | |
|---|---|
| **Source** | SNOMED CT-AU |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Name of Location (Anatomical Location Name) | 1..1 | |

# 12.15 Side

## Identification

| | |
|---|---|
| **Label** | Side |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16336 |
| **OID** | 1.2.36.1.2001.1001.101.103.16336 |

## Definition

| | |
|---|---|
| **Definition** | The laterality of an anatomical location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Laterality |
| **Data Type** | CodedText |
| **Value Domain** | Laterality Reference Set |

## Usage

| | |
|---|---|
| **Examples** | 1. Right.<br>2. Left.<br>3. Bilalteral. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIFIC LOCATION | 0..1 | |

# 12.16 Laterality Reference Set

## Identification

| | |
|---|---|
| **Label** | Laterality Reference Set |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16312 |
| **OID** | 1.2.36.1.2001.1001.101.104.16312 |
| **External Identifier** | SNOMED CT-AU Concept Id: 32570611000036103 |

## Definition

| | |
|---|---|
| **Definition** | The set of values for identifying laterality of an anatomical location. |
| **Definition Source** | NEHTA |

## Value Domain

| | |
|---|---|
| **Source** | SNOMED CT-AU |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Side | 1..1 | |

# 12.17 Anatomical Location Description

## Identification

| | |
|---|---|
| **Label** | Description |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16319 |
| **OID** | 1.2.36.1.2001.1001.101.103.16319 |

## Definition

| | |
|---|---|
| **Definition** | Description of anatomical location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Anatomical Site (ANATOMICAL LOCATION) | 0..1 | |

# 12.18 Anatomical Location Image

## Identification

| | |
|---|---|
| **Label** | Image |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16199 |
| **OID** | 1.2.36.1.2001.1001.101.103.16199 |

## Definition

| | |
|---|---|
| **Definition** | Image or images used to identify a location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Context** | This element is intended to be an image, e.g. photo of the anatomical site such as a wound on the leg. |
| **Context Source** | NEHTA |
| **Data Type** | EncapsulatedData |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Anatomical Site (ANATOMICAL LOCATION) | 0..* | |

# 12.19 PHYSICAL PROPERTIES OF AN OBJECT

## Identification

| | |
|---|---|
| **Label** | Physical Details |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16166 |
| **OID** | 1.2.36.1.2001.1001.101.102.16166 |

## Definition

| | |
|---|---|
| **Definition** | Record of physical details such as weight and dimensions, of a body part, device, device, lesion or specimen. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Test Specimen Detail (SPECIMEN) | 0..* | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | ~~Name (Physical Object Name)~~ | ~~0..0~~ | - |
| | Weight | 0..1 | |
| | DIMENSIONS | 0..1 | |
| | Description (Object Description) | 0..1 | |
| | Image | 0..1 | |

# 12.20 Weight

## Identification

| | |
|---|---|
| **Label** | Weight |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16327 |
| **OID** | 1.2.36.1.2001.1001.101.103.16327 |

## Definition

| | |
|---|---|
| **Definition** | Weight of the object. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Quantity |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) | 0..1 | |

# 12.21 DIMENSIONS

## Identification

| | |
|---|---|
| **Label** | DIMENSIONS |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16328 |
| **OID** | 1.2.36.1.2001.1001.101.102.16328 |

## Definition

| | |
|---|---|
| **Definition** | The dimensions of the object. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) | 0..1 | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | ~~Diameter~~ | ~~0..0~~ | - |
| | ~~Circumference~~ | ~~0..0~~ | - |
| | ~~Length~~ | ~~0..0~~ | - |
| | ~~Breadth~~ | ~~0..0~~ | - |
| | ~~Depth~~ | ~~0..0~~ | - |
| | ~~Area~~ | ~~0..0~~ | - |
| | Volume | 0..1 | |

# 12.22 Volume

## Identification

| | |
|---|---|
| **Label** | Volume |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16335 |
| **OID** | 1.2.36.1.2001.1001.101.103.16335 |

## Definition

| | |
|---|---|
| **Definition** | Volume of the object. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Quantity |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | DIMENSIONS | 0..1 | |

# 12.23 Object Description

## Identification

| | |
|---|---|
| **Label** | Description |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16621 |
| **OID** | 1.2.36.1.2001.1001.101.103.16621 |

## Definition

| | |
|---|---|
| **Definition** | A general description of the specimen preparation. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) | 0..1 | |

# 12.24 Image

## Identification

| | |
|---|---|
| **Label** | Image |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16199 |
| **OID** | 1.2.36.1.2001.1001.101.103.16199 |

## Definition

| | |
|---|---|
| **Definition** | A picture of the specimen. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | EncapsulatedData |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) | 0..1 | |

# 12.25 COLLECTION AND HANDLING

## Identification

| | |
|---|---|
| **Label** | COLLECTION AND HANDLING |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16167 |
| **OID** | 1.2.36.1.2001.1001.101.102.16167 |

## Definition

| | |
|---|---|
| **Definition** | Collection and handling requirements. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Test Specimen Detail (SPECIMEN) | 0..1 | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~Potential Risk / Biohazard~~ | ~~0..0~~ | - |
|  | Sampling Preconditions | 0..1 | |
|  | ~~Number of Containers~~ | ~~0..0~~ | - |
|  | ~~Collection Procedure Details~~ | ~~0..0~~ | - |
|  | ~~Transport Medium~~ | ~~0..0~~ | - |
|  | ~~Testing Method~~ | ~~0..0~~ | - |
|  | ~~DEVICE~~ | ~~0..0~~ | - |

# 12.26 Sampling Preconditions

## Identification

| | |
|---|---|
| **Label** | Sampling Preconditions |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16171 |
| **OID** | 1.2.36.1.2001.1001.101.103.16171 |

## Definition

| | |
|---|---|
| **Definition** | Any conditions to be met before the sample should be taken. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Can also be used to document any known deviations from collection or handling instructions, e.g. patient was not fasted.<br><br>Examples include fasting, 'full bladder', 'sterile field' or any special instructions on the handling or immediate processing of the sample e.g. centrifuge on receipt. |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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*[4] with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | COLLECTION AND HANDLING | 0..1 | |

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

# 12.27 HANDLING AND PROCESSING

## Identification

| | |
|---|---|
| **Label** | HANDLING AND PROCESSING |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16528 |
| **OID** | 1.2.36.1.2001.1001.101.102.16528 |

## Definition

| | |
|---|---|
| **Definition** | Workflow of specimen processing/handling. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Test Specimen Detail (SPECIMEN) | 1..1 | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Date and Time of Collection (Collection DateTime) | 1..1 | |
|  | Collection Setting | 0..1 | |
|  | Date and Time of Receipt (DateTime Received) | 0..1 | |
|  | ~~Date and Time Processed (DateTime Processed)~~ | ~~0..0~~ | - |

# 12.28 Collection DateTime

## Identification

| | |
|---|---|
| **Label** | Date and Time of Collection |
| **Metadata Type** | Data Element |
| **Identifier** | DE-11013 |
| **OID** | 1.2.36.1.2001.1001.101.103.11013 |

## Definition

| | |
|---|---|
| **Definition** | The date and time that collection has been ordered to take place or has taken place. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Collected Date/Time |
| **Notes** | This provides a point in time reference for linking of result data to request data, and a point in time reference within a health record that the clinician may refer to. |
| **Data Type** | DateTime |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | HANDLING AND PROCESSING | 1..1 | |

# 12.29 Collection Setting

## Identification

| | |
|---|---|
| **Label** | Collection Setting |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16529 |
| **OID** | 1.2.36.1.2001.1001.101.103.16529 |

## Definition

| | |
|---|---|
| **Definition** | Identification of the setting at which the specimen was collected from a subject of care. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | The specimen is often collected by a healthcare provider, but may be collected directly by the patient or carer at home. This specifies the specimen collection location within the healthcare environment. It enables the laboratory to ask questions about the collection of the specimen, if required. The specimen collection setting may provide additional information relevant to the analysis of the result data. |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | HANDLING AND PROCESSING | 0..1 | |

# 12.30 DateTime Received

## Identification

| | |
|---|---|
| **Label** | Date and Time of Receipt |
| **Metadata Type** | Data Element |
| **Identifier** | DE-11014 |
| **OID** | 1.2.36.1.2001.1001.101.103.11014 |

## Definition

| | |
|---|---|
| **Definition** | The date and time that the sample was received at the laboratory. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Received Date/Time |
| **Notes** | This provides a point in time reference for linking of result data to request data, and a point in time reference within a health record that the clinician may refer to. |
| **Data Type** | DateTime |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | HANDLING AND PROCESSING | 0..1 | |

# 12.31 IDENTIFIERS

## Identification

| | |
|---|---|
| **Label** | IDENTIFIERS |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16186 |
| **OID** | 1.2.36.1.2001.1001.101.102.16186 |

## Definition

| | |
|---|---|
| **Definition** | Sample identifications. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Test Specimen Detail (SPECIMEN) | 0..1 | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Specimen Identifier | 0..1 | |
|  | Parent Specimen Identifier | 0..1 | |
|  | Container Identifier | 0..1 | |
|  | ~~Specimen Collector Identifier~~ | ~~0..0~~ | - |
|  | ~~SPECIMEN COLLECTOR DETAILS~~ | ~~0..0~~ | - |

# 12.32 Specimen Identifier

## Identification

| | |
|---|---|
| **Label** | Specimen Identifier |
| **Metadata Type** | Data Element |
| **Identifier** | DE-11012 |
| **OID** | 1.2.36.1.2001.1001.101.103.11012 |

## Definition

| | |
|---|---|
| **Definition** | Unique identifier of the specimen, normally assigned by the laboratory. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | The assignment of an identification code to a specimen allows the tracking of the specimen through receipt, processing, analysis, reporting and storage within the laboratory.<br><br>This identifier may be placed on several vials of the same specimen type collected at the same time as in the case of blood vials. |
| **Data Type** | UniqueIdentifier |

## Usage

| | |
|---|---|
| **Conditions of Use** | It is desirable that each specimen has an identifier. |
| **Conditions of Use Source** | NEHTA |
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IDENTIFIERS | 0..1 | |

# 12.33 Parent Specimen Identifier

## Identification

| | |
|---|---|
| **Label** | Parent Specimen Identifier |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16187 |
| **OID** | 1.2.36.1.2001.1001.101.103.16187 |

## Definition

| | |
|---|---|
| **Definition** | Unique identifier of the parent specimen, where the specimen is split into sub-samples. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | UniqueIdentifier |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IDENTIFIERS | 0..1 | |

# 12.34 Container Identifier

## Identification

| | |
|---|---|
| **Label** | Container Identifier |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16188 |
| **OID** | 1.2.36.1.2001.1001.101.103.16188 |

## Definition

| | |
|---|---|
| **Definition** | Unique identifier given to the container in which the specimen is transported or processed. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | UniqueIdentifier |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IDENTIFIERS | 0..1 | |

# 12.35 Overall Pathology Test Result Status

## Identification

| | |
|---|---|
| **Label** | Overall Pathology Test Status |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16155 |
| **OID** | 1.2.36.1.2001.1001.101.103.16155 |

## Definition

| | |
|---|---|
| **Definition** | The status of the pathology test result as a whole. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodedText |
| **Value Domain** | Pathology Test Result Status Values |

## Usage

| | |
|---|---|
| **Examples** | 1. Interim<br>2. Final |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | PATHOLOGY TEST RESULT | 1..1 | |

# 12.36 Pathology Test Result Status Values

## Identification

| | |
|---|---|
| **Label** | Pathology Test Result Status Values |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16488 |
| **OID** | 1.2.36.1.2001.1001.101.104.16488 |

## Definition

| | |
|---|---|
| **Definition** | The set of values for the pathology test result status. |
| **Definition Source** | NEHTA |

## Value Domain

| | | |
|---|---|---|
| **Source** | NEHTA (outsourced from HL7 table 0085 - Observation result status codes interpretation, HL7 table 0123 - Result status and other sources). | |
| **Permissible Values** | Registered | No result yet available. |
| | Interim | This is an initial or interim result: data may be missing or verification not been performed. |
| | Final | The result is complete and verified by the responsible pathologist. |
| | Amended | The result has been modified subsequent to being Final, and is complete and verified by the responsible pathologist. |
| | Cancelled/Aborted | The result is unavailable because the test was not started or not completed. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Overall Pathology Test Status (Overall Pathology Test Result Status) | 1..1 | |

# 12.37 Clinical Information Provided

## Identification

| | |
|---|---|
| **Label** | Clinical Information Provided |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16397 |
| **OID** | 1.2.36.1.2001.1001.101.103.16397 |

## Definition

| | |
|---|---|
| **Definition** | Description of clinical information available at the time of interpretation of results, or a link to the original clinical information provided in the test request. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | PATHOLOGY TEST RESULT | 0..1 | |

# 12.38 PATHOLOGY TEST RESULT GROUP

## Identification

| | |
|---|---|
| **Label** | Result Group |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16469 |
| **OID** | 1.2.36.1.2001.1001.101.102.16469 |

## Definition

| | |
|---|---|
| **Definition** | A group of results. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Results may be grouped by specimen, or by some other name or code to describe what binds all the results together. |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | PATHOLOGY TEST RESULT | 0..* | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result Group Name (Pathology Test Result Group Name) | 1..1 | |
| | Result (INDIVIDUAL PATHOLOGY TEST RESULT) | 1..* | |
| | Result Group Specimen Detail (SPECIMEN) | 0..1 | |

# 12.39 Pathology Test Result Group Name

## Identification

| | |
|---|---|
| **Label** | Result Group Name |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16428 |
| **OID** | 1.2.36.1.2001.1001.101.103.16428 |

## Definition

| | |
|---|---|
| **Definition** | The name of a group of pathology test results. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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*[5] with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result Group (PATHOLOGY TEST RESULT GROUP) | 1..1 | |

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

# 12.40 INDIVIDUAL PATHOLOGY TEST RESULT

## Identification

| | |
|---|---|
| **Label** | Result |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16489 |
| **OID** | 1.2.36.1.2001.1001.101.102.16489 |

## Definition

| | |
|---|---|
| **Definition** | Specific detailed result, including both the value of the result item, and additional information that may be useful for clinical interpretation. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Results include whatever specific data items pathology labs report as part of the clinical service; it is not confined to measurements. The result is identified by *Individual Pathology Test Result Name.* |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result Group (PATHOLOGY TEST RESULT GROUP) | 1..* | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result Name (Individual Pathology Test Result Name) | 1..1 | |
| | Result Value (Individual Pathology Test Result Value) | 0..1 | |
| | Result Value Normal Status (Individual Pathology Test Result Value Normal Status) | 0..1 | |
| | Result Value Reference Range Details (INDIVIDUAL PATHOLOGY TEST RESULT VALUE REFERENCE RANGE DETAILS) | 0..* | |
| | Result Comment (Individual Pathology Test Result Comment) | 0..* | |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Reference Range Guidance (Individual Pathology Test Result Reference Range Guidance) | 0..1 | |
|  | Result Status (Individual Pathology Test Result Status) | 1..1 | |

# 12.41 Individual Pathology Test Result Name

## Identification

| | |
|---|---|
| **Label** | Result Name |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16571 |
| **OID** | 1.2.36.1.2001.1001.101.103.16571 |

## Definition

| | |
|---|---|
| **Definition** | The name of an individual pathology test result. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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*[6] with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | 1. Serum glucose level.<br><br>2. Haemoglobin concentration.<br><br>3. Hepatitis B surface antibody titre.<br><br>4. Prothrombin Time. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result (INDIVIDUAL PATHOLOGY TEST RESULT) | 1..1 | |

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

# 12.42 Individual Pathology Test Result Value

## Identification

| | |
|---|---|
| **Label** | Result Value |
| **Metadata Type** | Data Element |
| **Identifier** | DE-11023 |
| **OID** | 1.2.36.1.2001.1001.101.103.11023 |

## Definition

| | |
|---|---|
| **Definition** | Actual value of the result. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Most result values will be numerical measurements, but others may be coded concepts and free text. |
| **Data Type** | CodeableText<br>QuantityRange<br>Quantity |
| **Value Domain** | Result Value Values |

## Usage

| | |
|---|---|
| **Examples** | 1. 140.<br>2. ++.<br>3. Neg. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result (INDIVIDUAL PATHOLOGY TEST RESULT) | 0..1 | |

# 12.43 Result Value Values

## Identification

| | |
|---|---|
| **Label** | Result Value Values |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-11023 |
| **OID** | 1.2.36.1.2001.1001.101.104.11023 |

## Definition

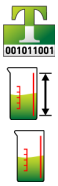
| | |
|---|---|
| **Definition** | The set of values for the measured level/magnitude of the test result component. |
| **Definition Source** | NEHTA |

## Value Domain

| | |
|---|---|
| **Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result Value (Individual Pathology Test Result Value) | 1..1 | |

# 12.44 Individual Pathology Test Result Value Normal Status

## Identification

| | |
|---|---|
| **Label** | Result Value Normal Status |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16572 |
| **OID** | 1.2.36.1.2001.1001.101.103.16572 |

## Definition

| | |
|---|---|
| **Definition** | An interpretation of an observation to indicate whether the result is considered normal or abnormal. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Often included by lab, even if the normal range itself is not included. |
| **Data Type** | CodeableText |
| **Value Domain** | Individual Pathology Test Result Value Normal Status Values |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result (INDIVIDUAL PATHOLOGY TEST RESULT) | 0..1 | |

# 12.45 Individual Pathology Test Result Value Normal Status Values

## Identification

| | |
|---|---|
| **Label** | Result Value Normal Status Values |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16572 |
| **OID** | 1.2.36.1.2001.1001.101.104.16572 |

## Definition

| | |
|---|---|
| **Definition** | The set of values to indicate whether an observation result is considered normal or abnormal. |
| **Definition Source** | NEHTA |

## Value Domain

| | |
|---|---|
| **Source** | HL7 V3: ObservationInterpretationNormality code set |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result Value Normal Status (Individual Pathology Test Result Value Normal Status) | 1..1 | |

# 12.46 INDIVIDUAL PATHOLOGY TEST RESULT VALUE REFERENCE RANGE DETAILS

## Identification

| | |
|---|---|
| **Label** | Result Value Reference Range Details |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16325 |
| **OID** | 1.2.36.1.2001.1001.101.102.16325 |

## Definition

| | |
|---|---|
| **Definition** | Tagged reference ranges for this value in its particular measurement context. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Defines a range to be associated with any Quantity datum.<br><br>Each such range is particular to the patient and context, e.g. sex, age, and any other factor which affects ranges. |

## Usage

| | |
|---|---|
| **Conditions of Use** | May be used to represent normal, therapeutic, dangerous, critical etc ranges. |
| **Conditions of Use Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result (INDIVIDUAL PATHOLOGY TEST RESULT) | 0..* | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result Value Reference Range Meaning (Individual Pathology Test Result Value Reference Range Meaning) | 1..1 | |
| | Result Value Reference Range (Individual Pathology Test Result Value Reference Range) | 1..1 | |

# 12.47 Individual Pathology Test Result Value Reference Range Meaning

## Identification

| | |
|---|---|
| **Label** | Result Value Reference Range Meaning |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16574 |
| **OID** | 1.2.36.1.2001.1001.101.103.16574 |

## Definition

| | |
|---|---|
| **Definition** | Term whose value indicates the meaning of this range. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Default value is "normal". |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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*[7] with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | 1. "Normal".<br><br>2. "Critical".<br><br>3. "Therapeutic". |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result Value Reference Range Details (INDIVIDUAL PATHOLOGY TEST RESULT VALUE REFERENCE RANGE DETAILS) | 1..1 | |

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

# 12.48 Individual Pathology Test Result Value Reference Range

## Identification

| | |
|---|---|
| **Label** | Result Value Reference Range |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16566 |
| **OID** | 1.2.36.1.2001.1001.101.103.16566 |

## Definition

| | |
|---|---|
| **Definition** | The data range for the associated meaning. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | QuantityRange |

## Usage

| | |
|---|---|
| **Examples** | 1. 60-400 U/L (male)<br>2. 40-150 U/L (female) |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result Value Reference Range Details (INDIVIDUAL PATHOLOGY TEST RESULT VALUE REFERENCE RANGE DETAILS) | 1..1 | |

# 12.49 Individual Pathology Test Result Comment

## Identification

| | |
|---|---|
| **Label** | Result Comment |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16466 |
| **OID** | 1.2.36.1.2001.1001.101.103.16466 |

## Definition

| | |
|---|---|
| **Definition** | Comments that may include statements about significant, unexpected or unreliable values, or information about the source of the value where this may be relevant to the interpretation of the result. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result (INDIVIDUAL PATHOLOGY TEST RESULT) | 0..* | |

# 12.50 Individual Pathology Test Result Reference Range Guidance

## Identification

| | |
|---|---|
| **Label** | Reference Range Guidance |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16467 |
| **OID** | 1.2.36.1.2001.1001.101.103.16467 |

## Definition

| | |
|---|---|
| **Definition** | Additional advice on the applicability of the reference range. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result (INDIVIDUAL PATHOLOGY TEST RESULT) | 0..1 | |

# 12.51 Individual Pathology Test Result Status

## Identification

| | |
|---|---|
| **Label** | Result Status |
| **Metadata Type** | Data Element |
| **Identifier** | DE-11029 |
| **OID** | 1.2.36.1.2001.1001.101.103.11029 |

## Definition

| | |
|---|---|
| **Definition** | The status of the result value. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Allows a report with more than one result to be issued and for each result to have a different status associated with it.<br><br>The status of a result is included within the report to inform the requester or receiver whether it is final or there is more to expect, or if amendments have been made. This indicates whether the results are able to be acted upon by the clinician. |
| **Data Type** | CodedText |
| **Value Domain** | Pathology Test Result Status Values |

## Usage

| | |
|---|---|
| **Examples** | 1. Corrected/Amended<br>2. Final<br>3. Interim<br>4. Preliminary<br>5. Supplementary |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result (INDIVIDUAL PATHOLOGY TEST RESULT) | 1..1 | |

# 12.52 SPECIMEN

## Identification

| | |
|---|---|
| **Label** | Result Group Specimen Detail |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16156 |
| **OID** | 1.2.36.1.2001.1001.101.102.16156 |

## Definition

| | |
|---|---|
| **Definition** | Details about the individual specimen to which these ‘Result group’ test results refer, where testing of multiple specimens is required. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result Group (PATHOLOGY TEST RESULT GROUP) | 0..1 | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Specimen Tissue Type | 0..1 | |
| | Collection Procedure | 0..1 | |
| | Anatomical Site (ANATOMICAL LOCATION) | 0..* | |
| | Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) | 0..* | |
| | ~~NEEDLE BIOPSY CORE DETAILS~~ | ~~0..0~~ | - |
| | COLLECTION AND HANDLING | 0..1 | |
| | HANDLING AND PROCESSING | 1..1 | |
| | ~~SPECIMEN QUALITY~~ | ~~0..0~~ | - |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IDENTIFIERS | 0..1 | |

# 12.53 Specimen Tissue Type

## Identification

| | |
|---|---|
| **Label** | Specimen Tissue Type |
| **Metadata Type** | Data Element |
| **Identifier** | DE-11008 |
| **OID** | 1.2.36.1.2001.1001.101.103.11008 |

## Definition

| | |
|---|---|
| **Definition** | The type of specimen to be collected. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | The categorisation of the sample taken from an individual and submitted for pathology investigation. |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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*[8] with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is the actual specimen being submitted to the laboratory for analysis. |
| **Conditions of Use Source** | NEHTA |
| **Examples** | 1. Venous blood.<br><br>2. Prostate tissue, left base.<br><br>3. Urine.<br><br>4. Sputum.<br><br>5. Scraping.<br><br>6. Catheter tip.<br><br>7. Single core (yellow-tan) liver tissue. |

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

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result Group Specimen Detail (SPECIMEN) | 0..1 | |

# 12.54 Collection Procedure

## Identification

| | |
|---|---|
| **Label** | Collection Procedure |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16111 |
| **OID** | 1.2.36.1.2001.1001.101.103.16111 |

## Definition

| | |
|---|---|
| **Definition** | The method of collection to be used. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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*[9] with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | 1. Venepuncture<br><br>2. Biopsy<br><br>3. Resection |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result Group Specimen Detail (SPECIMEN) | 0..1 | |

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

# 12.55 ANATOMICAL LOCATION

## Identification

| | |
|---|---|
| **Label** | Anatomical Site |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16150 |
| **OID** | 1.2.36.1.2001.1001.101.102.16150 |

## Definition

| | |
|---|---|
| **Definition** | The anatomical site from where the specimen was taken. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result Group Specimen Detail (SPECIMEN) | 0..* | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | SPECIFIC LOCATION | 0..1 | |
| | ~~RELATIVE LOCATION~~ | ~~0..0~~ | - |
| | Description (Anatomical Location Description) | 0..1 | |
| | ~~Visual Markings/Orientation~~ | ~~0..0~~ | - |
| | Image (Anatomical Location Image) | 0..* | |

# 12.56 SPECIFIC LOCATION

## Identification

| | |
|---|---|
| **Label** | SPECIFIC LOCATION |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16151 |
| **OID** | 1.2.36.1.2001.1001.101.102.16151 |

## Definition

| | |
|---|---|
| **Definition** | Specific and identified anatomical location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Anatomical Site (ANATOMICAL LOCATION) | 0..1 | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Name of Location (Anatomical Location Name) | 0..1 | |
| | Side | 0..1 | |
| | ~~Numerical Identifier~~ | ~~0..0~~ | - |
| | ~~Anatomical Plane~~ | ~~0..0~~ | - |

# 12.57 Anatomical Location Name

## Identification

| | |
|---|---|
| **Label** | Name of Location |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16153 |
| **OID** | 1.2.36.1.2001.1001.101.103.16153 |

## Definition

| | |
|---|---|
| **Definition** | The name of an anatomical location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodeableText |
| **Value Domain** | Body Structure Foundation Reference Set |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIFIC LOCATION | 0..1 | |

# 12.58 Body Structure Foundation Reference Set

## Identification

| | |
|---|---|
| **Label** | Body Structure Foundation Reference Set |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16152 |
| **OID** | 1.2.36.1.2001.1001.101.104.16152 |
| **External Identifier** | SNOMED CT-AU Concept Id: 32570061000036105 |

## Definition

| | |
|---|---|
| **Definition** | The set of values for named anatomical locations. |
| **Definition Source** | NEHTA |

## Value Domain

| | |
|---|---|
| **Source** | SNOMED CT-AU |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Name of Location (Anatomical Location Name) | 1..1 | |

# 12.59 Side

## Identification

| | |
|---|---|
| **Label** | Side |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16336 |
| **OID** | 1.2.36.1.2001.1001.101.103.16336 |

## Definition

| | |
|---|---|
| **Definition** | The laterality of an anatomical location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Laterality |
| **Data Type** | CodedText |
| **Value Domain** | Laterality Reference Set |

## Usage

| | |
|---|---|
| **Examples** | 1. Right.<br>2. Left.<br>3. Bilalteral. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIFIC LOCATION | 0..1 | |

# 12.60 Laterality Reference Set

## Identification

| | |
|---|---|
| **Label** | Laterality Reference Set |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16312 |
| **OID** | 1.2.36.1.2001.1001.101.104.16312 |
| **External Identifier** | SNOMED CT-AU Concept Id: 32570611000036103 |

## Definition

| | |
|---|---|
| **Definition** | The set of values for identifying laterality of an anatomical location. |
| **Definition Source** | NEHTA |

## Value Domain

| | |
|---|---|
| **Source** | SNOMED CT-AU |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Side | 1..1 | |

# 12.61 Anatomical Location Description

## Identification

| | |
|---|---|
| **Label** | Description |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16319 |
| **OID** | 1.2.36.1.2001.1001.101.103.16319 |

## Definition

| | |
|---|---|
| **Definition** | Description of anatomical location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Anatomical Site (ANATOMICAL LOCATION) | 0..1 | |

# 12.62 Anatomical Location Image

## Identification

| | |
|---|---|
| **Label** | Image |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16199 |
| **OID** | 1.2.36.1.2001.1001.101.103.16199 |

## Definition

| | |
|---|---|
| **Definition** | Image or images used to identify a location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Context** | This element is intended to be an image, e.g. photo of the anatomical site such as a wound on the leg. |
| **Context Source** | NEHTA |
| **Data Type** | EncapsulatedData |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Anatomical Site (ANATOMICAL LOCATION) | 0..* | |

# 12.63 PHYSICAL PROPERTIES OF AN OBJECT

## Identification

| | |
|---|---|
| **Label** | Physical Details |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16166 |
| **OID** | 1.2.36.1.2001.1001.101.102.16166 |

## Definition

| | |
|---|---|
| **Definition** | Record of physical details such as weight and dimensions, of a body part, device, device, lesion or specimen. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result Group Specimen Detail (SPECIMEN) | 0..* | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | ~~Name (Physical Object Name)~~ | ~~0..0~~ | - |
| | Weight | 0..1 | |
| | DIMENSIONS | 0..1 | |
| | Description (Object Description) | 0..1 | |
| | Image | 0..1 | |

# 12.64 Weight

## Identification

| | |
|---|---|
| **Label** | Weight |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16327 |
| **OID** | 1.2.36.1.2001.1001.101.103.16327 |

## Definition

| | |
|---|---|
| **Definition** | Weight of the object. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Quantity |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) | 0..1 | |

# 12.65 DIMENSIONS

## Identification

| | |
|---|---|
| **Label** | DIMENSIONS |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16328 |
| **OID** | 1.2.36.1.2001.1001.101.102.16328 |

## Definition

| | |
|---|---|
| **Definition** | The dimensions of the object. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) | 0..1 | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | ~~Diameter~~ | ~~0..0~~ | - |
| | ~~Circumference~~ | ~~0..0~~ | - |
| | ~~Length~~ | ~~0..0~~ | - |
| | ~~Breadth~~ | ~~0..0~~ | - |
| | ~~Depth~~ | ~~0..0~~ | - |
| | ~~Area~~ | ~~0..0~~ | - |
| | Volume | 0..1 | |

# 12.66 Volume

## Identification

| | |
|---|---|
| **Label** | Volume |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16335 |
| **OID** | 1.2.36.1.2001.1001.101.103.16335 |

## Definition

| | |
|---|---|
| **Definition** | Volume of the object. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Quantity |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | DIMENSIONS | 0..1 | |

# 12.67 Object Description

## Identification

| | |
|---|---|
| **Label** | Description |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16621 |
| **OID** | 1.2.36.1.2001.1001.101.103.16621 |

## Definition

| | |
|---|---|
| **Definition** | A general description of the specimen preparation. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) | 0..1 | |

# 12.68 Image

## Identification

| | |
|---|---|
| **Label** | Image |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16199 |
| **OID** | 1.2.36.1.2001.1001.101.103.16199 |

## Definition

| | |
|---|---|
| **Definition** | A picture of the specimen. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | EncapsulatedData |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) | 0..1 | |

# 12.69 COLLECTION AND HANDLING

## Identification

| | |
|---|---|
| **Label** | COLLECTION AND HANDLING |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16167 |
| **OID** | 1.2.36.1.2001.1001.101.102.16167 |

## Definition

| | |
|---|---|
| **Definition** | Collection and handling requirements. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result Group Specimen Detail (SPECIMEN) | 0..1 | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~Potential Risk / Biohazard~~ | ~~0..0~~ | - |
|  | Sampling Preconditions | 0..1 | |
|  | ~~Number of Containers~~ | ~~0..0~~ | - |
|  | ~~Collection Procedure Details~~ | ~~0..0~~ | - |
|  | ~~Transport Medium~~ | ~~0..0~~ | - |
|  | ~~Testing Method~~ | ~~0..0~~ | - |
|  | ~~DEVICE~~ | ~~0..0~~ | - |

# 12.70 Sampling Preconditions

## Identification

| | |
|---|---|
| **Label** | Sampling Preconditions |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16171 |
| **OID** | 1.2.36.1.2001.1001.101.103.16171 |

## Definition

| | |
|---|---|
| **Definition** | Any conditions to be met before the sample should be taken. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Can also be used to document any known deviations from collection or handling instructions, e.g. patient was not fasted.<br><br>Examples include fasting, 'full bladder', 'sterile field' or any special instructions on the handling or immediate processing of the sample e.g. centrifuge on receipt. |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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*[10] with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | COLLECTION AND HANDLING | 0..1 | |

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

# 12.71 HANDLING AND PROCESSING

## Identification

| | |
|---|---|
| **Label** | HANDLING AND PROCESSING |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16528 |
| **OID** | 1.2.36.1.2001.1001.101.102.16528 |

## Definition

| | |
|---|---|
| **Definition** | Workflow of specimen processing/handling. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result Group Specimen Detail (SPECIMEN) | 1..1 | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Date and Time of Collection (Collection DateTime) | 1..1 | |
| | Collection Setting | 0..1 | |
| | Date and Time of Receipt (DateTime Received) | 0..1 | |
| | ~~Date and Time Processed (DateTime Processed)~~ | ~~0..0~~ | - |

# 12.72 Collection DateTime

## Identification

| | |
|---|---|
| **Label** | Date and Time of Collection |
| **Metadata Type** | Data Element |
| **Identifier** | DE-11013 |
| **OID** | 1.2.36.1.2001.1001.101.103.11013 |

## Definition

| | |
|---|---|
| **Definition** | The date and time that collection has been ordered to take place or has taken place. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Collected Date/Time |
| **Notes** | This provides a point in time reference for linking of result data to request data, and a point in time reference within a health record that the clinician may refer to. |
| **Data Type** | DateTime |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | HANDLING AND PROCESSING | 1..1 | |

# 12.73 Collection Setting

## Identification

| | |
|---|---|
| **Label** | Collection Setting |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16529 |
| **OID** | 1.2.36.1.2001.1001.101.103.16529 |

## Definition

| | |
|---|---|
| **Definition** | Identification of the setting at which the specimen was collected from a subject of care. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | The specimen is often collected by a healthcare provider, but may be collected directly by the patient or carer at home. This specifies the specimen collection location within the healthcare environment. It enables the laboratory to ask questions about the collection of the specimen, if required. The specimen collection setting may provide additional information relevant to the analysis of the result data. |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | HANDLING AND PROCESSING | 0..1 | |

# 12.74 DateTime Received

## Identification

| | |
|---|---|
| **Label** | Date and Time of Receipt |
| **Metadata Type** | Data Element |
| **Identifier** | DE-11014 |
| **OID** | 1.2.36.1.2001.1001.101.103.11014 |

## Definition

| | |
|---|---|
| **Definition** | The date and time that the sample was received at the laboratory. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Received Date/Time |
| **Notes** | This provides a point in time reference for linking of result data to request data, and a point in time reference within a health record that the clinician may refer to. |
| **Data Type** | DateTime |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | HANDLING AND PROCESSING | 0..1 | |

# 12.75 IDENTIFIERS

## Identification

| | |
|---|---|
| **Label** | IDENTIFIERS |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16186 |
| **OID** | 1.2.36.1.2001.1001.101.102.16186 |

## Definition

| | |
|---|---|
| **Definition** | Sample identifications. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result Group Specimen Detail (SPECIMEN) | 0..1 | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Specimen Identifier | 0..1 | |
|  | Parent Specimen Identifier | 0..1 | |
|  | Container Identifier | 0..1 | |
|  | ~~Specimen Collector Identifier~~ | ~~0..0~~ | - |
|  | ~~SPECIMEN COLLECTOR DETAILS~~ | ~~0..0~~ | - |

# 12.76 Specimen Identifier

## Identification

| | |
|---|---|
| **Label** | Specimen Identifier |
| **Metadata Type** | Data Element |
| **Identifier** | DE-11012 |
| **OID** | 1.2.36.1.2001.1001.101.103.11012 |

## Definition

| | |
|---|---|
| **Definition** | Unique identifier of the specimen, normally assigned by the laboratory. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | The assignment of an identification code to a specimen allows the tracking of the specimen through receipt, processing, analysis, reporting and storage within the laboratory.<br><br>This identifier may be placed on several vials of the same specimen type collected at the same time as in the case of blood vials. |
| **Data Type** | UniqueIdentifier |

## Usage

| | |
|---|---|
| **Conditions of Use** | It is desirable that each specimen has an identifier. |
| **Conditions of Use Source** | NEHTA |
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IDENTIFIERS | 0..1 | |

# 12.77 Parent Specimen Identifier

## Identification

| | |
|---|---|
| **Label** | Parent Specimen Identifier |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16187 |
| **OID** | 1.2.36.1.2001.1001.101.103.16187 |

## Definition

| | |
|---|---|
| **Definition** | Unique identifier of the parent specimen, where the specimen is split into sub-samples. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | UniqueIdentifier |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IDENTIFIERS | 0..1 | |

# 12.78 Container Identifier

## Identification

| | |
|---|---|
| **Label** | Container Identifier |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16188 |
| **OID** | 1.2.36.1.2001.1001.101.103.16188 |

## Definition

| | |
|---|---|
| **Definition** | Unique identifier given to the container in which the specimen is transported or processed. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | UniqueIdentifier |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IDENTIFIERS | 0..1 | |

# 12.79 Pathological Diagnosis

## Identification

| | |
|---|---|
| **Label** | Pathological Diagnosis |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16402 |
| **OID** | 1.2.36.1.2001.1001.101.103.16402 |

## Definition

| | |
|---|---|
| **Definition** | Single word, phrase or brief description representing the diagnostic statement as asserted by the reporting pathologist. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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*[11] with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | PATHOLOGY TEST RESULT | 0..* | |

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

# 12.80 Pathology Test Conclusion

## Identification

| | |
|---|---|
| **Label** | Conclusion |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16403 |
| **OID** | 1.2.36.1.2001.1001.101.103.16403 |

## Definition

| | |
|---|---|
| **Definition** | Concise and clinically contextualised narrative interpretation of the pathology test results. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | PATHOLOGY TEST RESULT | 0..1 | |

# 12.81 Test Result Representation

## Identification

| | |
|---|---|
| **Label** | Test Result Representation |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16159 |
| **OID** | 1.2.36.1.2001.1001.101.103.16159 |

## Definition

| | |
|---|---|
| **Definition** | Rich text representation of the entire result as issued by the diagnostic service. Multiple formats are allowed but they must be semantically equivalent. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | The report is a verbatim copy of the report as issued. The results reported may also, or instead, be supplied in a machine-readable structured form. As some structured pathology information is unable to be stored and displayed correctly by receiving systems at this time, some structured pathology information (such as microbiology results) are sent in the same way as free text or images.<br><br>Resistance to structured formatting has been expressed in some quarters. These concerns may be due to the perceived difficulty in ensuring the results are maintained in their entirety as intended by the reporting provider. The nature and intent of DCMs to constrain information and provide context may help to alleviate this problem. In the meantime the NEHTA pathology data group has chosen to represent the non numerical pathology results as a single test result report data element. This is similar to the approach taken by NEHTA Pathology Result Report Structured Document Template [NEHT2009s], which is HL7 based. |
| **Data Type** | EncapsulatedData |

## Usage

| | |
|---|---|
| **Conditions of Use** | Used for results unable to be sent and or received as structured information. |
| **Conditions of Use Source** | NEHTA |
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | PATHOLOGY TEST RESULT | 0..1 | |

# 12.82 Test Comment

## Identification

| | |
|---|---|
| **Label** | Test Comment |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16468 |
| **OID** | 1.2.36.1.2001.1001.101.103.16468 |

## Definition

| | |
|---|---|
| **Definition** | Additional narrative about the test not captured in other fields. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | PATHOLOGY TEST RESULT | 0..1 | |

# 12.83 TEST REQUEST DETAILS

## Identification

| | |
|---|---|
| **Label** | TEST REQUEST DETAILS |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16160 |
| **OID** | 1.2.36.1.2001.1001.101.102.16160 |

## Definition

| | |
|---|---|
| **Definition** | Details concerning a single pathology test requested. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Usually there is one test request for each result, however, in some circumstances multiple test requests may be represented using a single Pathology test result. |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | PATHOLOGY TEST RESULT | 0..* | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~Requester Order Identifier~~ | ~~0..0~~ | - |
|  | Test Requested Name | 0..* | |
|  | ~~REQUESTER~~ | ~~0..0~~ | - |
|  | ~~Receiver Order Identifier~~ | ~~0..0~~ | - |
|  | Laboratory Test Result Identifier | 0..1 | |

# 12.84 Test Requested Name

## Identification

| | |
|---|---|
| **Label** | Test Requested Name |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16404 |
| **OID** | 1.2.36.1.2001.1001.101.103.16404 |

## Definition

| | |
|---|---|
| **Definition** | Identification of pathology test requested, where the test requested differs from the test actually performed. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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*[12] with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | TEST REQUEST DETAILS | 0..* | |

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

# 12.85 Laboratory Test Result Identifier

## Identification

| | |
|---|---|
| **Label** | Laboratory Test Result Identifier |
| **Metadata Type** | Data Element |
| **Identifier** | DE-11018 |
| **OID** | 1.2.36.1.2001.1001.101.103.11018 |

## Definition

| | |
|---|---|
| **Definition** | The identifier given to the laboratory test result of a pathology investigation. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Lab Number |
| **Notes** | The assignment of an identification code to a result allows the linking of a result to a request within the laboratory. |
| **Data Type** | UniqueIdentifier |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | TEST REQUEST DETAILS | 0..1 | |

# 12.86 Pathology Test Result DateTime

## Identification

| | |
|---|---|
| **Label** | Pathology Test Result DateTime |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16605 |
| **OID** | 1.2.36.1.2001.1001.101.103.16605 |

## Definition

| | |
|---|---|
| **Definition** | The date and, optionally, time of the Pathology Test Result observation. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | If the *Pathology Test Result Duration* is non-zero, it is the time at which the Pathology Test Result observation was completed, i.e. the date (and time) of the trailing edge of the *Pathology Test Result Duration*. |
| **Data Type** | DateTime |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | PATHOLOGY TEST RESULT | 1..1 | |

# 13 Imaging Examination Result Data Group

## 13.1 Purpose

To record the findings and interpretation of an imaging examination, or series of examinations, performed.

## 13.2 Use

Use to record all results related to the diagnostic imaging aspects of any imaging examinations performed.

Use to record the imaging examination components (only) of a more complex procedure, including those that may have been undertaken under imaging guidance.

More complex procedures (such as echocardiaograms or Bone density scans) may be represented using templates or specialised DCMs where additional report content is appropriate.

Will normally be reported back to the requesting clinician as one component within the context of an overall COMPOSITION-based report.

## 13.3 Misuse

Not to be used to record non-imaging examination findings or activities. For example when imaging is performed as part of a procedure the information related to the procedure must be recorded using the Procedure DCM for the operative findings. This DCM will only be used to record the findings from the imaging.

Not to be used to record details about any parallel procedure undertaken. Use the specific procedure-related DCMs, for example Procedure DCM.

Not to be used to record details about medications administered during the imaging test. Use specific medication-related DCMs, for example Medication Action DCM.

# 13.4 IMAGING EXAMINATION RESULT

## Identification

| | |
|---|---|
| **Label** | IMAGING EXAMINATION RESULT |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16145 |
| **OID** | 1.2.36.1.2001.1001.101.102.16145 |

## Definition

| | |
|---|---|
| **Definition** | The result of an imaging examination which may be used to record a single valued test but will often be specialised or templated to represent multiple value or 'panel' tests. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | CAT<br>CT<br>Computed Tomography<br>Imaging<br>Magnetic Resonance Imaging<br>MRI<br>Nuclear Medicine Imaging<br>Radiology<br>Scan<br>Ultrasound<br>Xray<br>X-ray |
| **Scope** | This data group also acts as the parent for specialisations appropriate for more specific imaging laboratory tests, e.g. radiology, magnetic resonance imaging, ultrasound. |
| **Scope Source** | NEHTA |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is a reuse of the IMAGING EXAMINATION RESULT data group, which is described in Imaging Examination Result Detailed Clinical Model Specification [NEHT2011bd]. |
| **Conditions of Use Source** | NEHTA |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | DIAGNOSTIC INVESTIGATIONS | 0..* | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Examination Result Name (Imaging Examination Result Name) | 1..1 | |
|  | Modality (Imaging Modality) | 0..1 | |
|  | Anatomical Site (ANATOMICAL LOCATION) | 0..* | |
|  | Imaging Examination Result Status | 1..1 | |
|  | Clinical Information Provided | 0..1 | |
|  | Findings | 0..1 | |
|  | Result Group (IMAGING EXAMINATION RESULT GROUP) | 0..* | |
|  | ~~Radiological Diagnosis~~ | ~~0..0~~ | - |
|  | ~~Conclusion (Imaging Examination Conclusion)~~ | ~~0..0~~ | - |
|  | Examination Result Representation | 0..1 | |
|  | ~~Examination Comment~~ | ~~0..0~~ | - |
|  | ~~RECEIVING IMAGING SERVICE~~ | ~~0..0~~ | - |
|  | EXAMINATION REQUEST DETAILS | 0..* | |
|  | ~~Examination Procedure~~ | ~~0..0~~ | - |
|  | ~~COMPARED IMAGE DETAILS~~ | ~~0..0~~ | - |
|  | ~~INFORMATION PROVIDER~~ | ~~0..0~~ | - |
|  | ~~SUBJECT~~ | ~~0..0~~ | - |
|  | Imaging Examination Result DateTime | 1..1 | |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~Imaging Examination Result Duration~~ | ~~0..0~~ | - |
|  | ~~Imaging Examination Result Identifier~~ | ~~0..0~~ | - |
|  | ~~LINK~~ | ~~0..0~~ | - |
|  | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ | - |

# 13.5 Imaging Examination Result Name

## Identification

| | |
|---|---|
| **Label** | Examination Result Name |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16498 |
| **OID** | 1.2.36.1.2001.1001.101.103.16498 |

## Definition

| | |
|---|---|
| **Definition** | Identification of the imaging examination or procedure performed, typically including modality and anatomical location (including laterality). |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IMAGING EXAMINATION RESULT | 1..1 | |

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

# 13.6 Imaging Modality

## Identification

| | |
|---|---|
| **Label** | Modality |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16500 |
| **OID** | 1.2.36.1.2001.1001.101.103.16500 |

## Definition

| | |
|---|---|
| **Definition** | The imaging method used to perform the examination. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Context** | For identification/description of the diagnostic imaging modalities that are:<br>• Available for request; or<br>• Used in reporting. |
| **Context Source** | NEHTA |
| **Notes** | The imaging method, including the electro-magnetic energy type, applied to produce diagnostic quality images of body structures or internal organs performed during a diagnostic imaging procedure.<br>If the modality is specified by a code in the Examination result name, then this field is not required. |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br>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.<br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | 1. X-ray.<br>2. CT scan.<br>3. MRI.<br>4. PET scan. |

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

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IMAGING EXAMINATION RESULT | 0..1 | |

# 13.7 ANATOMICAL LOCATION

## Identification

| | |
|---|---|
| **Label** | Anatomical Site |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16150 |
| **OID** | 1.2.36.1.2001.1001.101.102.16150 |

## Definition

| | |
|---|---|
| **Definition** | Details about the anatomical locations to which this examination result refers. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Do not include anatomical locations described in IMAGING EXAMINATION RESULT GROUP. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IMAGING EXAMINATION RESULT | 0..* | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIFIC LOCATION | 0..1 | |
|  | ~~RELATIVE LOCATION~~ | ~~0..0~~ | - |
|  | Description (Anatomical Location Description) | 0..1 | |
|  | ~~Visual Markings/Orientation~~ | ~~0..0~~ | - |
|  | Image (Anatomical Location Image) | 0..* | |

# 13.8 SPECIFIC LOCATION

## Identification

| | |
|---|---|
| **Label** | SPECIFIC LOCATION |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16151 |
| **OID** | 1.2.36.1.2001.1001.101.102.16151 |

## Definition

| | |
|---|---|
| **Definition** | Specific and identified anatomical location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Anatomical Site (ANATOMICAL LOCATION) | 0..1 | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Name of Location (Anatomical Location Name) | 0..1 | |
| | Side | 0..1 | |
| | ~~Numerical Identifier~~ | ~~0..0~~ | - |
| | ~~Anatomical Plane~~ | ~~0..0~~ | - |

# 13.9 Anatomical Location Name

## Identification

| | |
|---|---|
| **Label** | Name of Location |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16153 |
| **OID** | 1.2.36.1.2001.1001.101.103.16153 |

## Definition

| | |
|---|---|
| **Definition** | The name of an anatomical location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodeableText |
| **Value Domain** | Body Structure Foundation Reference Set |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIFIC LOCATION | 0..1 | |

# 13.10 Body Structure Foundation Reference Set

## Identification

| | |
|---|---|
| **Label** | Body Structure Foundation Reference Set |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16152 |
| **OID** | 1.2.36.1.2001.1001.101.104.16152 |
| **External Identifier** | SNOMED CT-AU Concept Id: 32570061000036105 |

## Definition

| | |
|---|---|
| **Definition** | The set of values for named anatomical locations. |
| **Definition Source** | NEHTA |

## Value Domain

| | |
|---|---|
| **Source** | SNOMED CT-AU |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Name of Location (Anatomical Location Name) | 1..1 | |

# 13.11 Side

## Identification

| | |
|---|---|
| **Label** | Side |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16336 |
| **OID** | 1.2.36.1.2001.1001.101.103.16336 |

## Definition

| | |
|---|---|
| **Definition** | The laterality of an anatomical location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Laterality |
| **Data Type** | CodedText |
| **Value Domain** | Laterality Reference Set |

## Usage

| | |
|---|---|
| **Examples** | 1. Right.<br>2. Left.<br>3. Bilalteral. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIFIC LOCATION | 0..1 | |

# 13.12 Laterality Reference Set

## Identification

| | |
|---|---|
| **Label** | Laterality Reference Set |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16312 |
| **OID** | 1.2.36.1.2001.1001.101.104.16312 |
| **External Identifier** | SNOMED CT-AU Concept Id: 32570611000036103 |

## Definition

| | |
|---|---|
| **Definition** | The set of values for identifying laterality of an anatomical location. |
| **Definition Source** | NEHTA |

## Value Domain

| | |
|---|---|
| **Source** | SNOMED CT-AU |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Side | 1..1 | |

# 13.13 Anatomical Location Description

## Identification

| | |
|---|---|
| **Label** | Description |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16319 |
| **OID** | 1.2.36.1.2001.1001.101.103.16319 |

## Definition

| | |
|---|---|
| **Definition** | Description of anatomical location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Anatomical Site (ANATOMICAL LOCATION) | 0..1 | |

# 13.14 Anatomical Location Image

## Identification

| | |
|---|---|
| **Label** | Image |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16199 |
| **OID** | 1.2.36.1.2001.1001.101.103.16199 |

## Definition

| | |
|---|---|
| **Definition** | Image or images used to identify a location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Context** | This element is intended to be an image, e.g. photo of the anatomical site such as a wound on the leg. |
| **Context Source** | NEHTA |
| **Data Type** | EncapsulatedData |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Anatomical Site (ANATOMICAL LOCATION) | 0..* | |

# 13.15 Imaging Examination Result Status

## Identification

| | |
|---|---|
| **Label** | Imaging Examination Result Status |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16502 |
| **OID** | 1.2.36.1.2001.1001.101.103.16502 |

## Definition

| | |
|---|---|
| **Definition** | The status of the examination result as a whole. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodedText |
| **Value Domain** | *Not specified.*<br><br>In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[3] with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | 1. "Registered". No result yet available.<br><br>2. "Interim". This is an initial or interim result: data may be missing or verification not been performed.<br><br>3. "Final". The result is complete and verified by the responsible radiologist.<br><br>4. "Amended". The result has been modified subsequent to being Final, and is complete and verified by the radiologist.<br><br>5. "Cancelled / Aborted". The result is not available because the examination was not started or completed. |

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

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IMAGING EXAMINATION RESULT | 1..1 | |

# 13.16 Clinical Information Provided

## Identification

| | |
|---|---|
| **Label** | Clinical Information Provided |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16397 |
| **OID** | 1.2.36.1.2001.1001.101.103.16397 |

## Definition

| | |
|---|---|
| **Definition** | Description of clinical information available at the time of interpretation of results, or a link to the original clinical information provided in the examination request. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IMAGING EXAMINATION RESULT | 0..1 | |

# 13.17 Findings

## Identification

| | |
|---|---|
| **Label** | Findings |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16503 |
| **OID** | 1.2.36.1.2001.1001.101.103.16503 |

## Definition

| | |
|---|---|
| **Definition** | Narrative description of findings, including comparative findings. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IMAGING EXAMINATION RESULT | 0..1 | |

# 13.18 IMAGING EXAMINATION RESULT GROUP

## Identification

| | |
|---|---|
| **Label** | Result Group |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16504 |
| **OID** | 1.2.36.1.2001.1001.101.102.16504 |

## Definition

| | |
|---|---|
| **Definition** | A group of structured results. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Results may be grouped by anatomical location or by some other name or code to describe what binds all the results together. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | IMAGING EXAMINATION RESULT | 0..* | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result Group Name (Imaging Examination Result Group Name) | 1..1 | |
| | Result (INDIVIDUAL IMAGING EXAMINATION RESULT) | 1..* | |
| | Result Group Anatomical Site (ANATOMICAL LOCATION) | 0..1 | |

# 13.19 Imaging Examination Result Group Name

## Identification

| | |
|---|---|
| **Label** | Result Group Name |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16567 |
| **OID** | 1.2.36.1.2001.1001.101.103.16567 |

## Definition

| | |
|---|---|
| **Definition** | The name of a group of structured results. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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*[4] with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result Group (IMAGING EXAMINATION RESULT GROUP) | 1..1 | |

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

# 13.20 INDIVIDUAL IMAGING EXAMINATION RESULT

## Identification

| | |
|---|---|
| **Label** | Result |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16505 |
| **OID** | 1.2.36.1.2001.1001.101.102.16505 |

## Definition

| | |
|---|---|
| **Definition** | Specific detailed result, including both the value of the result item and additional information that may be useful for clinical interpretation. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Results include whatever specific data items imaging services report as part of the clinical service; it may include measurements. These are often referred to as 'Structured Findings'. |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result Group (IMAGING EXAMINATION RESULT GROUP) | 1..* | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result Name (Individual Imaging Examination Result Name) | 1..1 | |
| | Result Value (Imaging Examination Result Value) | 0..1 | |
| | Result Value Normal Status (Imaging Examination Result Value Normal Status) | 0..1 | |
| | Result Value Reference Range Details (IMAGING EXAMINATION RESULT VALUE REFERENCE RANGE DETAILS) | 0..* | |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| T | Result Comment | 0..* | |

# 13.21 Individual Imaging Examination Result Name

## Identification

| | |
|---|---|
| **Label** | Result Name |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16568 |
| **OID** | 1.2.36.1.2001.1001.101.103.16568 |

## Definition

| | |
|---|---|
| **Definition** | The name of a specific detailed result. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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*[5] with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | 1. Cardiac ejection fraction.<br><br>2. Bone density. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result (INDIVIDUAL IMAGING EXAMINATION RESULT) | 1..1 | |

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

# 13.22 Imaging Examination Result Value

## Identification

| | |
|---|---|
| **Label** | Result Value |
| **Metadata Type** | Data Element |
| **Identifier** | DE-11023 |
| **OID** | 1.2.36.1.2001.1001.101.103.11023 |

## Definition

| | |
|---|---|
| **Definition** | Actual value of the result. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Most result values will be numerical measurements, but others may be coded concepts or free text. |
| **Data Type** | CodeableText<br>QuantityRange<br>Quantity |
| **Value Domain** | *Not specified.*<br><br>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*[6] with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | 1. 140.<br><br>2. ++.<br><br>3. Neg. |

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

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result (INDIVIDUAL IMAGING EXAMINATION RESULT) | 0..1 | |

# 13.23 Imaging Examination Result Value Normal Status

## Identification

| | |
|---|---|
| **Label** | Result Value Normal Status |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16572 |
| **OID** | 1.2.36.1.2001.1001.101.103.16572 |

## Definition

| | |
|---|---|
| **Definition** | An interpretation of an observation to indicate whether the result is considered normal or abnormal. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Often included by lab, even if the normal range itself is not included. |
| **Data Type** | CodeableText |
| **Value Domain** | Imaging Examination Result Value Normal Status Values |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result (INDIVIDUAL IMAGING EXAMINATION RESULT) | 0..1 | |

# 13.24 Imaging Examination Result Value Normal Status Values

## Identification

| | |
|---|---|
| **Label** | Result Value Normal Status Values |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16572 |
| **OID** | 1.2.36.1.2001.1001.101.104.16572 |

## Definition

| | |
|---|---|
| **Definition** | The set of values to indicate whether an observation result is considered normal or abnormal. |
| **Definition Source** | NEHTA |

## Value Domain

| | |
|---|---|
| **Source** | HL7 V3: ObservationInterpretationNormality code set |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result Value Normal Status (Imaging Examination Result Value Normal Status) | 1..1 | |

# 13.25 IMAGING EXAMINATION RESULT VALUE REFERENCE RANGE DETAILS

## Identification

| | |
|---|---|
| **Label** | Result Value Reference Range Details |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16325 |
| **OID** | 1.2.36.1.2001.1001.101.102.16325 |

## Definition

| | |
|---|---|
| **Definition** | Tagged reference ranges for this value in its particular measurement context. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Defines a range to be associated with any Quantity datum.<br><br>Each such range is particular to the patient and context, e.g. sex, age, and any other factor which affects ranges. |

## Usage

| | |
|---|---|
| **Conditions of Use** | May be used to represent normal, therapeutic, dangerous, critical etc ranges. |
| **Conditions of Use Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result (INDIVIDUAL IMAGING EXAMINATION RESULT) | 0..* | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result Value Reference Range Meaning (Imaging Examination Result Value Reference Range Meaning) | 1..1 | |
| | Result Value Reference Range (Imaging Examination Result Value Reference Range) | 1..1 | |

# 13.26 Imaging Examination Result Value Reference Range Meaning

## Identification

| | |
|---|---|
| **Label** | Result Value Reference Range Meaning |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16574 |
| **OID** | 1.2.36.1.2001.1001.101.103.16574 |

## Definition

| | |
|---|---|
| **Definition** | Term whose value indicates the meaning of this range. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Default value is "normal". |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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*[7] with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | 1. "Normal".<br><br>2. "Critical".<br><br>3. "Therapeutic". |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result Value Reference Range Details (IMAGING EXAMINATION RESULT VALUE REFERENCE RANGE DETAILS) | 1..1 | |

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

# 13.27 Imaging Examination Result Value Reference Range

## Identification

| | |
|---|---|
| **Label** | Result Value Reference Range |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16566 |
| **OID** | 1.2.36.1.2001.1001.101.103.16566 |

## Definition

| | |
|---|---|
| **Definition** | The data range for the associated meaning. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | QuantityRange |

## Usage

| | |
|---|---|
| **Examples** | 1. Critical. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result Value Reference Range Details (IMAGING EXAMINATION RESULT VALUE REFERENCE RANGE DETAILS) | 1..1 | |

# 13.28 Result Comment

## Identification

| | |
|---|---|
| **Label** | Result Comment |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16466 |
| **OID** | 1.2.36.1.2001.1001.101.103.16466 |

## Definition

| | |
|---|---|
| **Definition** | May include statements about significant, unexpected or unreliable values, or information about the source of the value where this may be relevant to the interpretation of the result. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result (INDIVIDUAL IMAGING EXAMINATION RESULT) | 0..* | |

# 13.29 ANATOMICAL LOCATION

## Identification

| | |
|---|---|
| **Label** | Result Group Anatomical Site |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16150 |
| **OID** | 1.2.36.1.2001.1001.101.102.16150 |

## Definition

| | |
|---|---|
| **Definition** | Details about the individual anatomical location to which these 'Result group' examination results refer, where finer-grained representation of Anatomical location is required. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Result Group (IMAGING EXAMINATION RESULT GROUP) | 0..1 | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | SPECIFIC LOCATION | 0..1 | |
| | ~~RELATIVE LOCATION~~ | ~~0..0~~ | - |
| | Description (Anatomical Location Description) | 0..1 | |
| | ~~Visual Markings/Orientation~~ | ~~0..0~~ | - |
| | Image (Anatomical Location Image) | 0..* | |

# 13.30 SPECIFIC LOCATION

## Identification

| | |
|---|---|
| **Label** | SPECIFIC LOCATION |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16151 |
| **OID** | 1.2.36.1.2001.1001.101.102.16151 |

## Definition

| | |
|---|---|
| **Definition** | Specific and identified anatomical location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result Group Anatomical Site (ANATOMICAL LOCATION) | 0..1 | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Name of Location (Anatomical Location Name) | 0..1 | |
|  | Side | 0..1 | |
|  | ~~Numerical Identifier~~ | ~~0..0~~ | - |
|  | ~~Anatomical Plane~~ | ~~0..0~~ | - |

# 13.31 Anatomical Location Name

## Identification

| | |
|---|---|
| **Label** | Name of Location |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16153 |
| **OID** | 1.2.36.1.2001.1001.101.103.16153 |

## Definition

| | |
|---|---|
| **Definition** | The name of an anatomical location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodeableText |
| **Value Domain** | Body Structure Foundation Reference Set |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIFIC LOCATION | 0..1 | |

# 13.32 Body Structure Foundation Reference Set

## Identification

| | |
|---|---|
| **Label** | Body Structure Foundation Reference Set |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16152 |
| **OID** | 1.2.36.1.2001.1001.101.104.16152 |
| **External Identifier** | SNOMED CT-AU Concept Id: 32570061000036105 |

## Definition

| | |
|---|---|
| **Definition** | The set of values for named anatomical locations. |
| **Definition Source** | NEHTA |

## Value Domain

| | |
|---|---|
| **Source** | SNOMED CT-AU |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Name of Location (Anatomical Location Name) | 1..1 | |

# 13.33 Side

## Identification

| | |
|---|---|
| **Label** | Side |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16336 |
| **OID** | 1.2.36.1.2001.1001.101.103.16336 |

## Definition

| | |
|---|---|
| **Definition** | The laterality of an anatomical location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Laterality |
| **Data Type** | CodedText |
| **Value Domain** | Laterality Reference Set |

## Usage

| | |
|---|---|
| **Examples** | 1. Right.<br>2. Left.<br>3. Bilalteral. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | SPECIFIC LOCATION | 0..1 | |

# 13.34 Laterality Reference Set

## Identification

| | |
|---|---|
| **Label** | Laterality Reference Set |
| **Metadata Type** | Value Domain |
| **Identifier** | VD-16312 |
| **OID** | 1.2.36.1.2001.1001.101.104.16312 |
| **External Identifier** | SNOMED CT-AU Concept Id: 32570611000036103 |

## Definition

| | |
|---|---|
| **Definition** | The set of values for identifying laterality of an anatomical location. |
| **Definition Source** | NEHTA |

## Value Domain

| | |
|---|---|
| **Source** | SNOMED CT-AU |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Side | 1..1 | |

# 13.35 Anatomical Location Description

## Identification

| | |
|---|---|
| **Label** | Description |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16319 |
| **OID** | 1.2.36.1.2001.1001.101.103.16319 |

## Definition

| | |
|---|---|
| **Definition** | Description of anatomical location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result Group Anatomical Site (ANATOMICAL LOCATION) | 0..1 | |

# 13.36 Anatomical Location Image

## Identification

| | |
|---|---|
| **Label** | Image |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16199 |
| **OID** | 1.2.36.1.2001.1001.101.103.16199 |

## Definition

| | |
|---|---|
| **Definition** | Image or images used to identify a location. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Context** | This element is intended to be an image, e.g. photo of the anatomical site such as a wound on the leg. |
| **Context Source** | NEHTA |
| **Data Type** | EncapsulatedData |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Result Group Anatomical Site (ANATOMICAL LOCATION) | 0..* | |

# 13.37 Examination Result Representation

## Identification

| | |
|---|---|
| **Label** | Examination Result Representation |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16509 |
| **OID** | 1.2.36.1.2001.1001.101.103.16509 |

## Definition

| | |
|---|---|
| **Definition** | Rich text representation of the entire result as issued by the diagnostic service. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Multiple formats are allowed but they must be semantically equivalent. |
| **Data Type** | EncapsulatedData |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IMAGING EXAMINATION RESULT | 0..1 | |

# 13.38 EXAMINATION REQUEST DETAILS

## Identification

| | |
|---|---|
| **Label** | EXAMINATION REQUEST DETAILS |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16511 |
| **OID** | 1.2.36.1.2001.1001.101.102.16511 |

## Definition

| | |
|---|---|
| **Definition** | Details concerning a single examination requested. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | Usually there is one examination request for each result, however in some circumstances multiple examination requests may be represented using a single Imaging examination result. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | IMAGING EXAMINATION RESULT | 0..* | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | ~~Requester Order Identifier~~ | ~~0..0~~ | - |
| | Examination Requested Name | 0..* | |
| | ~~REQUESTER~~ | ~~0..0~~ | - |
| | ~~Receiver Order Identifier~~ | ~~0..0~~ | - |
| | DICOM Study Identifier | 0..1 | |
| | Report Identifier | 0..1 | |
| | IMAGE DETAILS | 0..* | |

# 13.39 Examination Requested Name

## Identification

| | |
|---|---|
| **Label** | Examination Requested Name |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16512 |
| **OID** | 1.2.36.1.2001.1001.101.103.16512 |

## Definition

| | |
|---|---|
| **Definition** | Identification of imaging examination or procedure requested, where the examination requested differs from the examination actually performed. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | EXAMINATION REQUEST DETAILS | 0..* | |

# 13.40 DICOM Study Identifier

## Identification

| | |
|---|---|
| **Label** | DICOM Study Identifier |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16513 |
| **OID** | 1.2.36.1.2001.1001.101.103.16513 |

## Definition

| | |
|---|---|
| **Definition** | Unique identifier of this study allocated by the imaging service. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | UniqueIdentifier |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | EXAMINATION REQUEST DETAILS | 0..1 | |

# 13.41 Report Identifier

## Identification

| | |
|---|---|
| **Label** | Report Identifier |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16514 |
| **OID** | 1.2.36.1.2001.1001.101.103.16514 |

## Definition

| | |
|---|---|
| **Definition** | The local identifier given to the imaging examination report. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Diagnostic imaging report identifier. |
| **Context** | Unique identification of a diagnostic imaging procedure/study report.<br><br>Unique system identifier that uniquely identifies a procedure or study report being created.<br><br>It is recommended that the Report Instance Identifier value should be globally unique.<br><br>The global uniqueness of the value of this Identifier may be achieved by:<br><br>System ID (instance ID generated by System) + state identifier + organisation identifier<br><br>If unique national healthcare provider organisation identifiers (e.g. HPI-O) are available, uniqueness of the value of this Identifier may be achieved by:<br><br>System ID (instance ID generated by System) + HPI-O + Report Identifier<br><br>For a single study, the "Study Identifier", "Report Identifier" and "Report Version Number" values provide the version tracking facility for related reports that belong to a specific study set. |
| **Context Source** | NEHTA |
| **Assumptions** | The value of "Report Identifier" is intended for machine/computer consumption. It does not need to be used/consumed by the human user, e.g. reporting provider or the recipient of a test report. |
| **Assumptions Source** | NEHTA |
| **Data Type** | UniqueIdentifier |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | EXAMINATION REQUEST DETAILS | 0..1 | |

# 13.42 IMAGE DETAILS

## Identification

| | |
|---|---|
| **Label** | IMAGE DETAILS |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16515 |
| **OID** | 1.2.36.1.2001.1001.101.102.16515 |

## Definition

| | |
|---|---|
| **Definition** | Images referred to, or provided, to assist clinical understanding of the examination. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | If attached image is in DICOM format, all the fields below should be populated so the values are available to software that does not process DICOM images. |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | EXAMINATION REQUEST DETAILS | 0..* | |

### Children

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Image Identifier | 0..1 | |
| | DICOM Series Identifier | 0..1 | |
| | View (Image View Name) | 0..1 | |
| | Position (Subject Position) | 0..1 | |
| | Image DateTime | 0..1 | |
| | Image | 0..1 | |

# 13.43 Image Identifier

## Identification

| | |
|---|---|
| **Label** | Image Identifier |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16516 |
| **OID** | 1.2.36.1.2001.1001.101.103.16516 |

## Definition

| | |
|---|---|
| **Definition** | Unique identifier of this image allocated by the imaging service (often the DICOM image instance UID). |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Diagnostic Image Identifier. |
| **Context** | The "image identifier" value uniquely identifies an image object (DICOM or non-DICOM image). This allows software to easily determine if an image is already present, rather than having to compare a large number of (DICOM/image) tags.<br><br>Example:<br><br>X-ray skull AP and lateral views study produces two images each with a unique image identifier assigned by the system.<br><br>Source - The DICOM Standard White Paper - DICOM Part 1: Introduction and Overview, National Electrical Manufacturers Association, Rosslyn, VA, USA, 2000. |
| **Context Source** | NEHTA |
| **Assumptions** | It is assumed that the Diagnostic Imaging information system or Picture Archive and Communicating System (PACS) generates a unique identifier for each diagnostic image produced from the test procedure performed.<br><br>To ensure global uniqueness, the "image identifier" value may have to be used/associated with the unique "Organisation identifier" value. |
| **Assumptions Source** | NEHTA |
| **Data Type** | UniqueIdentifier |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IMAGE DETAILS | 0..1 | |

# 13.44 DICOM Series Identifier

## Identification

| | |
|---|---|
| **Label** | DICOM Series Identifier |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16517 |
| **OID** | 1.2.36.1.2001.1001.101.103.16517 |

## Definition

| | |
|---|---|
| **Definition** | Unique identifier of this series allocated by the imaging service. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | UniqueIdentifier |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IMAGE DETAILS | 0..1 | |

# 13.45 Image View Name

## Identification

| | |
|---|---|
| **Label** | View |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16198 |
| **OID** | 1.2.36.1.2001.1001.101.103.16198 |

## Definition

| | |
|---|---|
| **Definition** | The name of the imaging view e.g. Lateral or Antero-posterior (AP). |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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*[8] with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IMAGE DETAILS | 0..1 | |

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

# 13.46 Subject Position

## Identification

| | |
|---|---|
| **Label** | Position |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16519 |
| **OID** | 1.2.36.1.2001.1001.101.103.16519 |

## Definition

| | |
|---|---|
| **Definition** | Description of the subject of care's position when the image was performed. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | Text |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IMAGE DETAILS | 0..1 | |

# 13.47 Image DateTime

## Identification

| | |
|---|---|
| **Label** | Image DateTime |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16520 |
| **OID** | 1.2.36.1.2001.1001.101.103.16520 |

## Definition

| | |
|---|---|
| **Definition** | Specific date/time the imaging examination was performed. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | DateTime |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IMAGE DETAILS | 0..1 | |

# 13.48 Image

## Identification

| | |
|---|---|
| **Label** | Image |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16199 |
| **OID** | 1.2.36.1.2001.1001.101.103.16199 |

## Definition

| | |
|---|---|
| **Definition** | An attached or referenced image of a current view. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | EncapsulatedData |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IMAGE DETAILS | 0..1 | |

# 13.49 Imaging Examination Result DateTime

## Identification

| | |
|---|---|
| **Label** | Imaging Examination Result DateTime |
| **Metadata Type** | Data Element |
| **Identifier** | DE-16589 |
| **OID** | 1.2.36.1.2001.1001.101.103.16589 |

## Definition

| | |
|---|---|
| **Definition** | The date and, optionally, time when the Imaging Examination Result became available. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | DateTime |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | IMAGING EXAMINATION RESULT | 1..1 | |

# 14 Requested Service (Action) Data Group

## 14.1 Purpose

Describes the types of service requested for, or provided to, the subject of care. If the service provision has not been confirmed then, the service date and/or provider may not be recorded.

## 14.2 Misuse

Use to specify medication prescriptions.

# 14.3 REQUESTED SERVICE

## Identification

| | |
|---|---|
| **Label** | Requested Service |
| **Metadata Type** | Data Group |
| **Identifier** | DG-20158 |
| **OID** | 1.2.36.1.2001.1001.101.102.20158 |

## Definition

| | |
|---|---|
| **Definition** | A request for a diagnostic investigation of the subject of care. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Arranged Service |
| **Notes** | This item does not include the results of diagnostic test orders.<br><br>If the service provision has not been confirmed then, the service date and/or provider may not be recorded. |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is a reuse of the REQUESTED SERVICE data group, which is described in Miscellaneous Detailed Clinical Model Specification [NEHT2011aq]. |
| **Conditions of Use Source** | NEHTA |
| **Misuse** | Requesting a service other than a diagnostic investigation. |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | DIAGNOSTIC INVESTIGATIONS | 0..* | |

**Children**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~Reason for Service~~ | ~~0..0~~ | - |
|  | Requested Service Description | 1..1 | |

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | ~~Intent of Request~~ | ~~0..0~~ | - |
|  | ~~Request Urgency~~ | ~~0..0~~ | - |
|  | DateTime Service Scheduled | 0..1 | |
|  | Service Commencement Window | 0..1 | |
|  | Service Booking Status | 1..1 | |
|  | ~~Supplementary Information to Follow~~ | ~~0..0~~ | - |
|  | ~~Supplementary Information Expected~~ | ~~0..0~~ | - |
|  | Subject of Care Instruction Description | 0..1 | |
|  | ~~DISTRIBUTION LIST~~ | ~~0..0~~ | - |
|  | ~~SERVICE REQUESTER~~ | ~~0..0~~ | - |
|  | SERVICE PROVIDER | 0..1 | |
|  | ~~Request Validity Period~~ | ~~0..0~~ | - |
|  | ~~INFORMATION PROVIDER~~ | ~~0..0~~ | - |
|  | ~~SUBJECT~~ | ~~0..0~~ | - |
|  | Requested Service DateTime | 1..1 | |
|  | ~~Requested Service Identifier~~ | ~~0..0~~ | - |
|  | ~~LINK~~ | ~~0..0~~ | - |
|  | ~~Detailed Clinical Model Identifier~~ | ~~0..0~~ | - |

# 14.4 Requested Service Description

## Identification

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

## Definition

| | |
|---|---|
| **Definition** | Describes the service arranged for, or provided to the subject of care. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Service Requested<br>Arranged Service Description |
| **Context** | For use in healthcare setting.<br><br>Used to identify diagnostic, clinical procedures or clinical management requested by the healthcare provider to be undertaken on/provided to the subject of care. |
| **Context Source** | NEHTA |
| **Data Type** | CodeableText |
| **Value Domain** | *Not specified.*<br><br>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.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. |

## Usage

| | |
|---|---|
| **Examples** | 1. Elective Orthopaedic surgery for TKR<br><br>2. Dialysis<br><br>3. Adjustment of heart failure/hypertensive medications<br><br>4. Adjust INR to therapeutic range, etc |

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

# Relationships

### Parents

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Requested Service (REQUESTED SERVICE) | 1..1 | |

# 14.5 DateTime Service Scheduled

## Identification

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

## Definition

| | |
|---|---|
| **Definition** | The datetime at which the arranged service is scheduled to be provided to the Subject of Care. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | DateTime |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Requested Service (REQUESTED SERVICE) | 0..1 | |

# 14.6 Service Commencement Window

## Identification

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

## Definition

| | |
|---|---|
| **Definition** | The datetime or date range at/during which the arranged service is scheduled to be provided to the Subject of Care. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Service Commences |
| **Notes** | Specifies the range of time within which the requesting provider is expecting the arranged service to be provided to the subject of care. |
| **Data Type** | TimeInterval |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Requested Service (REQUESTED SERVICE) | 0..1 | |

# 14.7 Service Booking Status

## Identification

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

## Definition

| | |
|---|---|
| **Definition** | An indication of the booking status of the arranged service. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Data Type** | CodedText |
| **Value Domain** | Service Booking Status Values |

## Usage

| | |
|---|---|
| **Examples** | |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Requested Service (REQUESTED SERVICE) | 1..1 | |

# 14.8 Service Booking Status Values

## Identification

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

## Definition

| | |
|---|---|
| **Definition** | The set of values for an indication of the booking status of the arranged service. |
| **Definition Source** | NEHTA |

## Value Domain

| | |
|---|---|
| **Source** | HL7 v3 CDA: Act.moodCode. |
| **Permissible Values** | APT Appointment<br>ARQ Appointment Request<br>EVN Event<br>INT Intent<br>PRMS Promise<br>PRP Proposal<br>RQO Request |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Service Booking Status | 1..1 | |

# 14.9 Subject of Care Instruction Description

## Identification

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

## Definition

| | |
|---|---|
| **Definition** | Describes the instructions/advice and information that have been given to the subject of care from a healthcare provider in relation to the requested service. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Patient instructions |
| **Data Type** | Text |

## Usage

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

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Requested Service (REQUESTED SERVICE) | 0..1 | |

# 14.10 SERVICE PROVIDER

## Identification

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

## Definition

| | |
|---|---|
| **Definition** | The provider (individual or organisation) that has been arranged to provide the service. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | Referred To Provider<br>Referred To |

## Usage

| | |
|---|---|
| **Conditions of Use** | This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v].<br><br>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in B: *Specification Guide for Use*.<br><br>Additional obligation and occurrence constraints when the service provider is an individual (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON):<br><br>• Participation Period is **PROHIBITED**.<br><br>• LOCATION OF PARTICIPATION is **PROHIBITED**.<br><br>• Entity Identifier is **ESSENTIAL**.<br><br>• ADDRESS is **ESSENTIAL**.<br><br>• Relationship to Subject of Care is **PROHIBITED**.<br><br>• DEMOGRAPHIC DATA is **PROHIBITED**.<br><br>• ENTITLEMENT is **PROHIBITED**.<br><br>• Qualifications is **PROHIBITED**.<br><br>Other additional constraints when the service provider is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON):<br><br>• Participation Type **SHALL** have an implementation-specific value equivalent to “Service Provider”. |

| | |
|---|---|
| | • Role **SHOULD** have a value chosen from 1220.0 – ANZSCO – Australia and New Zealand Standard Classification of Occupations, First Edition, 2006 – METeOR 350899. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used.<br>• The value of one Entity Identifier **SHALL** be an Australian HPI-I.<br>• AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.<br>• PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.<br>Additional obligation and occurrence constraints when the service provider is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as a ORGANISATION):<br>• Entity Identifier is **ESSENTIAL**.<br>• ENTITLEMENT is **PROHIBITED**.<br>• Qualifications is **PROHIBITED**.<br>Other additional constraints when the service provider is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as a ORGANISATION):<br>• Participation Type **SHALL** have an implementation-specific value equivalent to “Service Provider”.<br>• Role **SHALL** have a value representing the type of Facility e.g. Hospital, Clinic.<br>• The value of one Entity Identifier **SHALL** be an Australian HPI-O.<br>• AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.<br>• PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a ORGANISATION. |
| **Conditions of Use Source** | NEHTA |

# Relationships

**Parents**

| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
| | Requested Service (REQUESTED SERVICE) | 0..1 | |

# 14.11 Requested Service DateTime

## Identification

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

## Definition

| | |
|---|---|
| **Definition** | The point in time at which the Requested Service action is completed. |
| **Definition Source** | NEHTA |
| **Synonymous Names** | |
| **Notes** | For a request to supply a service, this is the date/time of the request.<br>For supply of a service this is the date/time of completion of supply. |
| **Data Type** | DateTime |

## Usage

| | |
|---|---|
| **Examples** | |

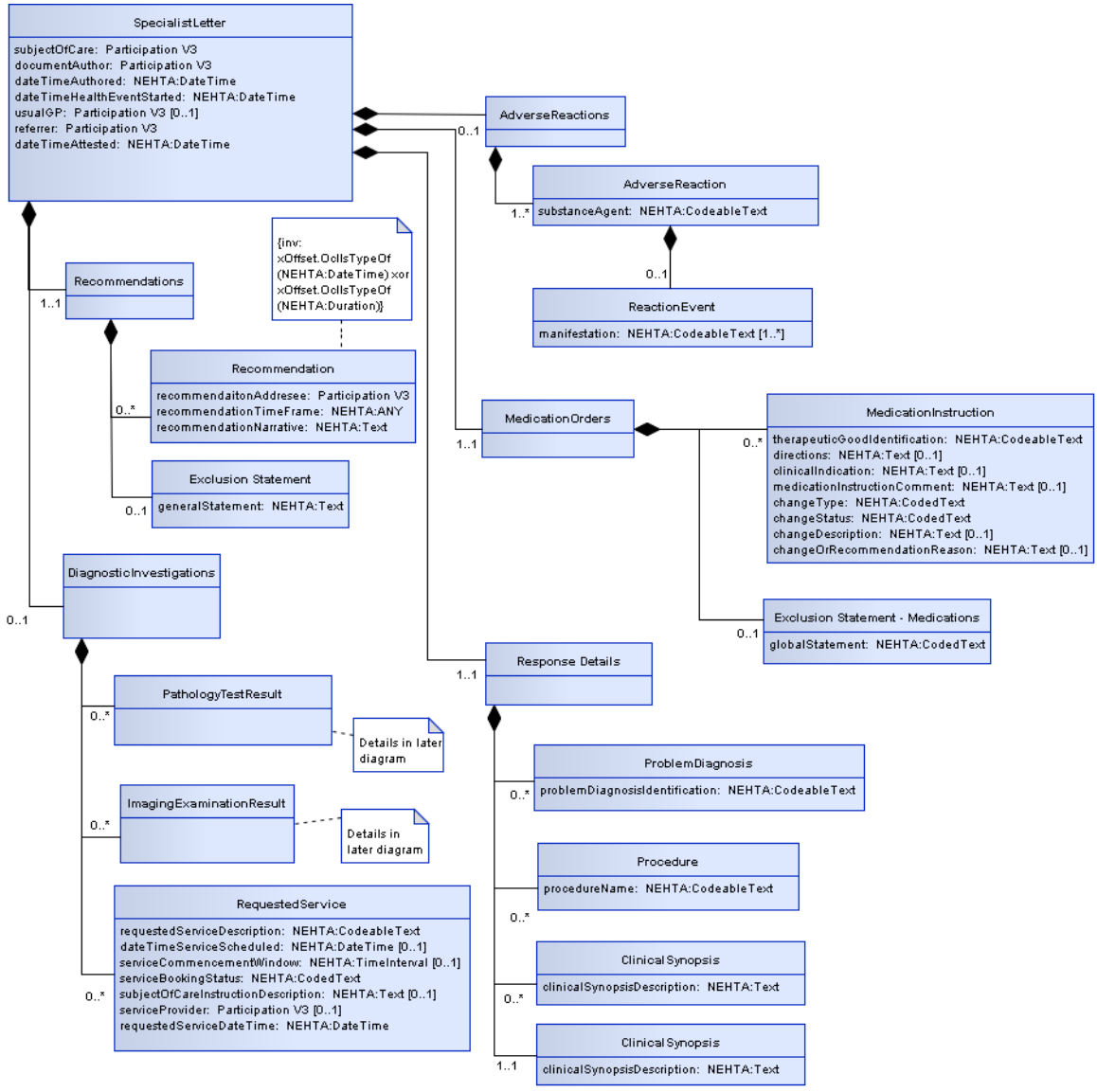
# Relationships

**Parents**

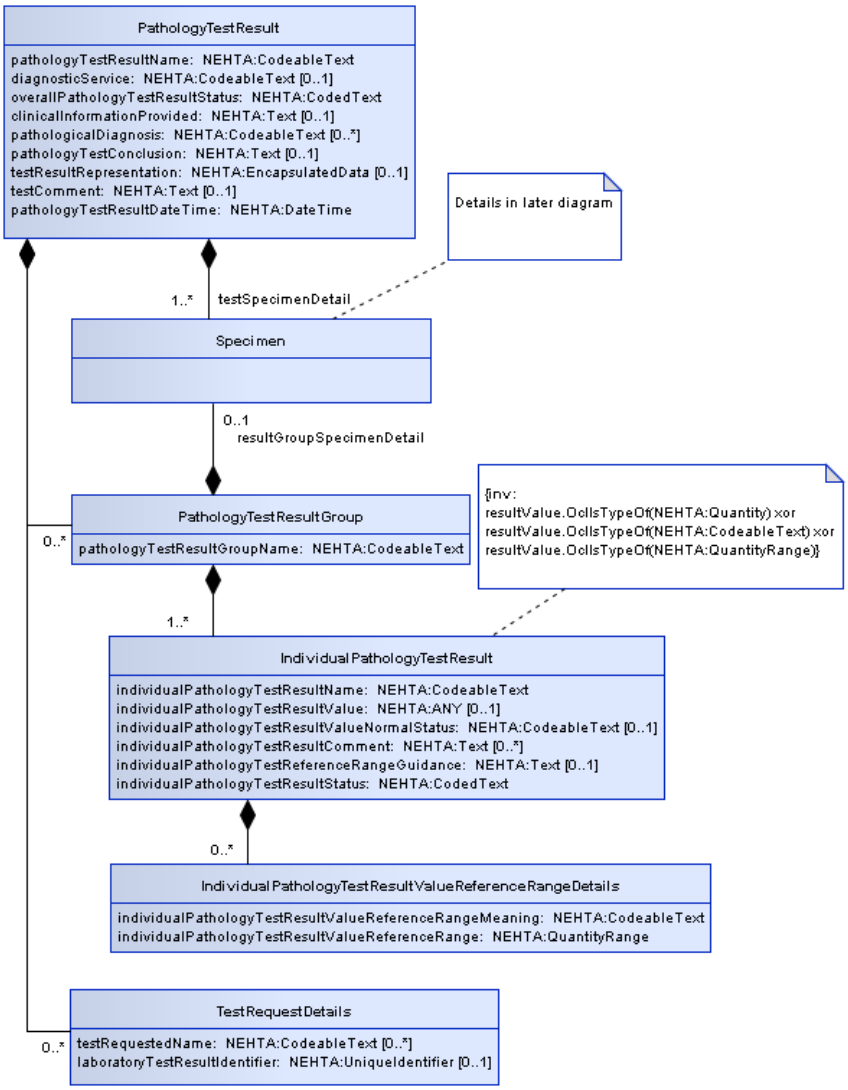
| Data Type | Name | Occur-rences | Condi-tion |
|---|---|---|---|
|  | Requested Service (REQUESTED SERVICE) | 1..1 | |

# 15 UML Class Diagram

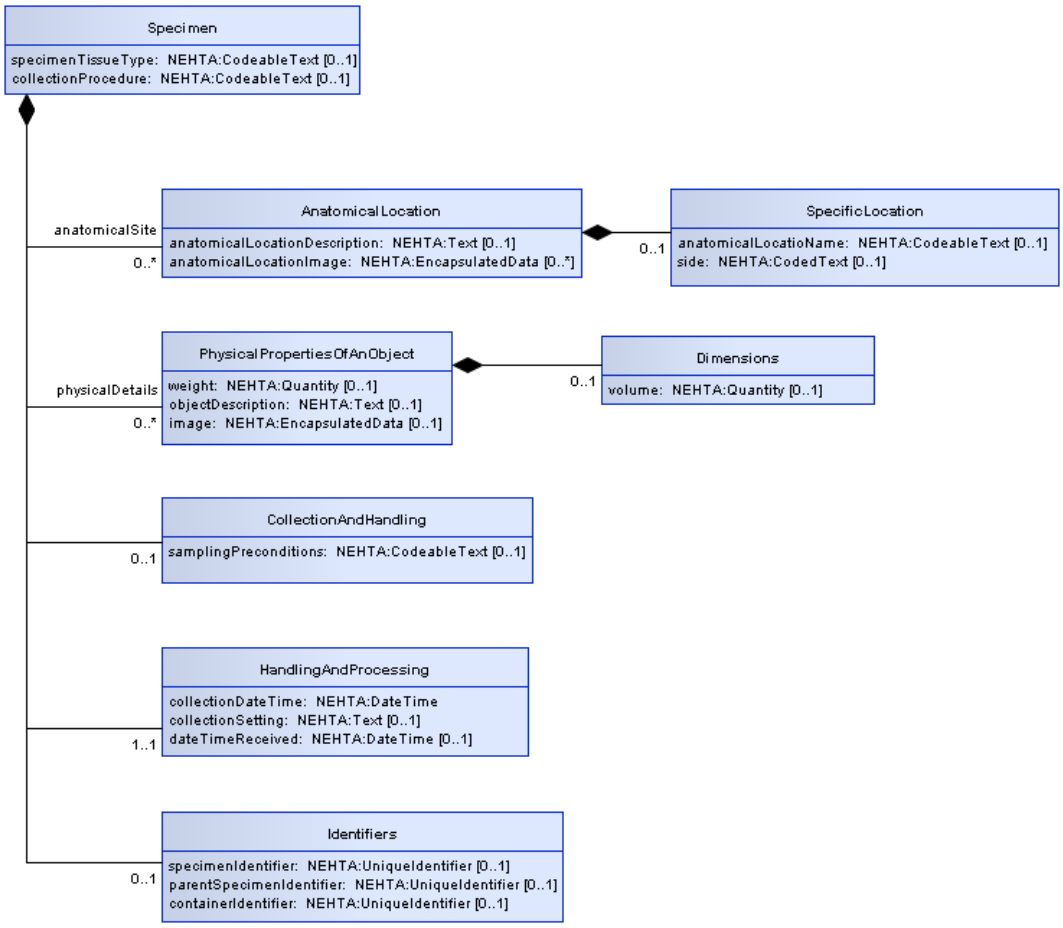
The following figure presents the data hierarchy using a UML 2.0 class diagram. The diagram displays data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes. Data groups are displayed as classes, their names are represented as association role names. Association role names are only displayed if they differ from the associated class name. The diagram shows the data hierarchy excluding the details of participation. The default multiplicity is 1..1.



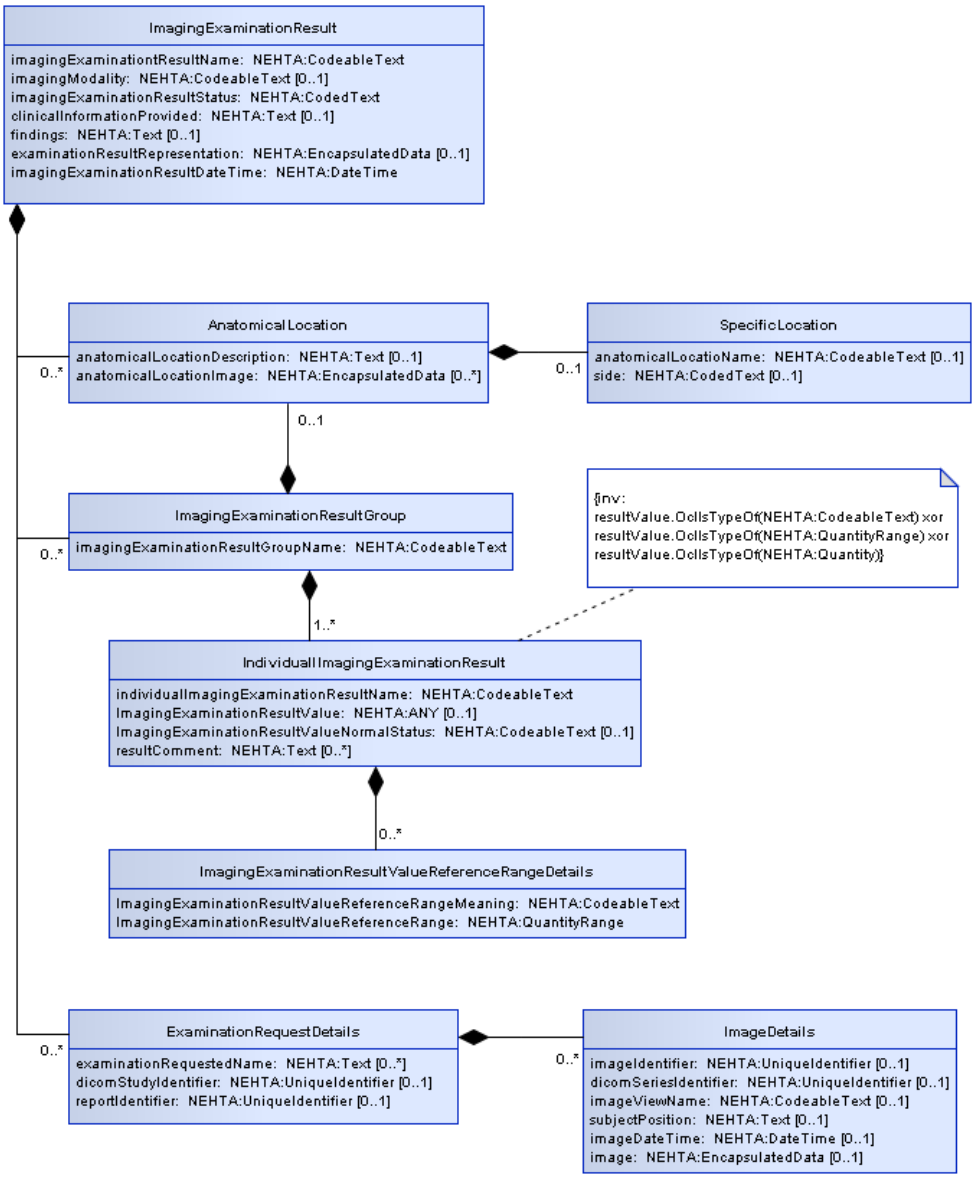

UML class diagram of the Specialist Letter data hierarchy.




UML class diagram of the Pathology Test Result for the Specialist Letter data hierarchy.




UML class diagram of the Specimen for the Specialist Letter data hierarchy.




UML class diagram of the Imaging Examination Result for the Specialist Letter data hierarchy.

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# Appendix A. Known Issues

This appendix 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 Status | As a NEHTA Managed Specification, the contents of this document are the result of extensive clinical collaboration and editorial review, and the specification is considered to be “Final”. Nonetheless, as software implementations and standards review of this specification progress, normative updates may be required. |
| 'Global Statement Values' Data Element | The list of permissible values is a sample set to initiate discussion and collaboration to develop the correct set of values. |
| 'Clinical Manifestation values' | The Clinical Manifestation Values has not been defined. Until it is defined use the Clinical finding foundation reference set (SNOMED CT-AU Concept ID: 32570071000036102). |
| Clinical Indication | The data element is a candidate for terminology. In the future its data type is to be changed to 'codeable text'. |
| Change Description | The data element is a candidate for terminology. In the future its data type is to be changed to 'codeable text'. |
| Additional Recipients | The information model doesn't cater for recipients other than referrer and usual GP. |
| Links to external resources | If a link (usually in references section) spans across several lines, certain PDF readers have problems to open it. |
| Exclusion Statement | The Exclusion Statement detailed clinical models are the subject of on-going development and review and may well change in the future. |
| Attachments | In the future this component will be mapped to Attachments DCM. |

# Appendix B. Specification Guide for Use

## B.1 Overview

Each Detailed Clinical Model (DCM) and Structured Content Specification (SCS) is designed to be a shared basis for data interpretation. It specifies rigorous business and technical definitions of data which systems may need to share. It is intended to be a logical specification of the data to be persisted within or communicated between systems. It is also the foundation for conformance, compliance and accreditation testing of implemented systems. NEHTA's CDA implementation guides are guides to the implementation of HL7 CDA R2 messages based upon these DCMs and SCSs.

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

Each SCS specifies the data for a single type of clinical document or information exchange, such as a discharge summary. It is assembled using DCMs which have been constrained to eliminate data components not relevant to the particular context. For example, procedure in a discharge summary uses only some of the data components required by procedure in a specialist report.

## B.2 The Structured Content Specification Metamodel

The NEHTA Structured Content Metamodel (see Figure 1) is used to specify the overall structure of a Structured Content Specification.

A DCM can be considered as a Data Group with no parent.

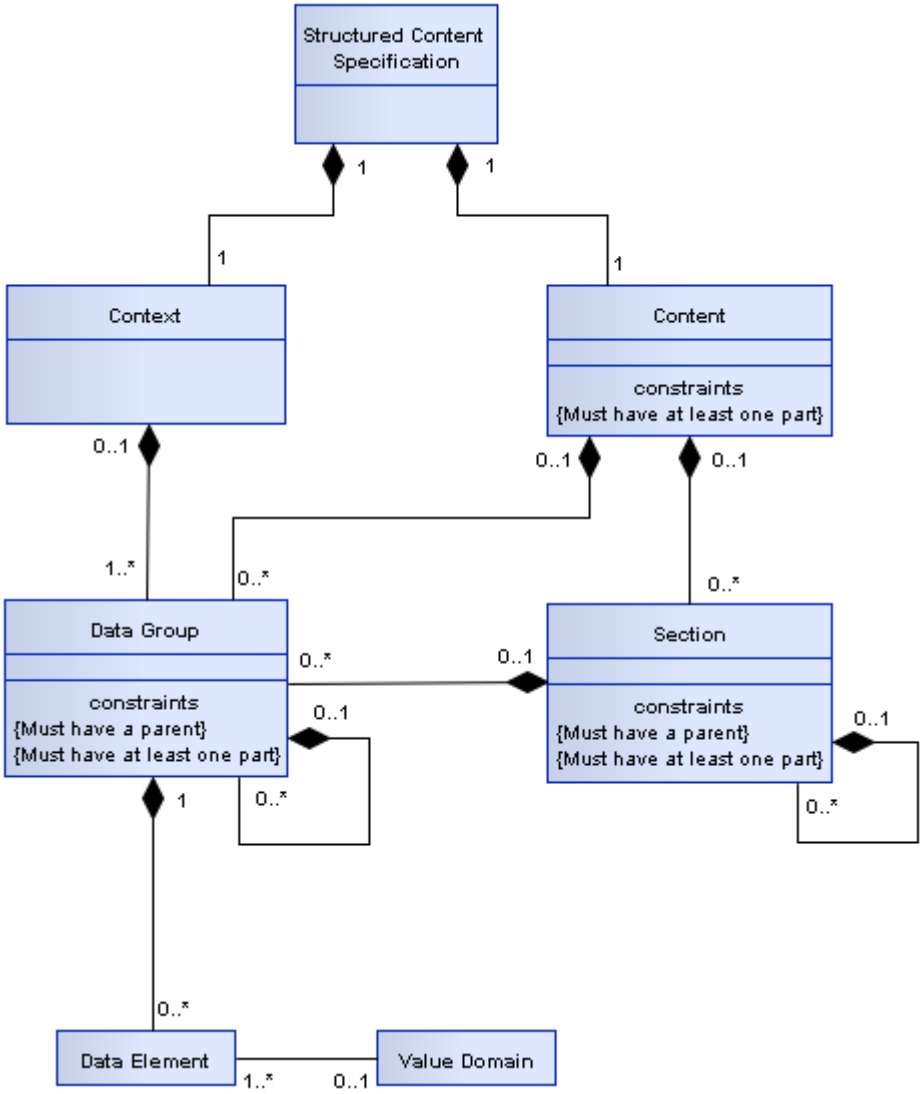


**Figure 1: SCS Metamodel**

There are two main components used to organise information within a Structured Content Specification (SCS) as follows:

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

Content: This contains information, which changes between different SCSs, but is always structured as shown, and consists of the following components:

- Section
- Data Group
- Data Element
- Value Domain

These components are described in more detail below.

# Context

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

# Content

The Content contains a collection of health information pertinent to a subject of care which is derived from the healthcare event described in the document. The detail **MAY** be organised into one or more sections, each of which contains one or more data groups and/or possible data elements.

# Section

The contents of the structured document Content **MAY** be subdivided into one or more sections. A section is an organising container that gives a reader a clue as to the expected content. The primary purpose of a section is to organise information in the manner that is suitable for the primary purpose for which it is collected, and that provides a way to navigate through the data components within the document, thereby enabling more efficient querying. It **SHOULD** also support safe re-use for secondary purposes, e.g. clinical coding or inclusion in a summarised form in an electronic health record. A section is context-specific to the document in which it resides.

# Data Group

Each data group is used to represent one concept. A data group consists of other data groups and/or data elements. Some data groups are reused across detailed clinical models.

## Participation

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

A Participant has been defined to align with the concepts of the NEHTA interoperability framework. It equates to an *Entity* that is related to the action described in an SCS as an *Actor*. A participant can be a human, an organisation or an IT system.

[NEHT2011v] defines the full Participation specification.

# Choice

Choice represents a decision to be made at run-time between a disjunctive mandatory set of data groups defined at design-time, i.e. one and only one member of the set **SHALL** be chosen.

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

# Data Element

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

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

# Value Domain

A value domain constrains the permissible values for a data element. The values **MAY** be a subset of values based on a generic data type.

Value domains are reusable components and therefore, the same value domain can be referred to by different data elements in different contexts. Value domains are often specified as a reference set. A reference set (or a subset) is a constrained list of SNOMED CT-AU, AMT or LOINC concepts that are appropriate to a particular context. It **SHOULD** be noted that many of these reference sets have been developed specifically for the context in which they appear. An assessment of fitness for purpose **SHOULD** therefore be undertaken before using any of the reference sets in another context.

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

<table>
<tr><th>Data Element</th><th>Data Type</th><th>Example of Value Domain</th></tr>
<tr><td>Sex</td><td>CodedText</td><td>[SA2006a] and [SA2006b] derive their values from METeOR 270263 which includes values such as:<br><table><tr><th>Value</th><th>Meaning</th></tr><tr><td>1</td><td>Male</td></tr><tr><td>2</td><td>Female</td></tr><tr><td>3</td><td>Intersex or Indeterminate</td></tr><tr><td>9</td><td>Not Stated/Inadequately Described</td></tr></table></td></tr>
<tr><td>Diagnosis</td><td>CodeableText</td><td>A SNOMED CT-AU reference set which references concepts such as 'Bronchitis' (Concept ID: 32398004)</td></tr>
<tr><td>Therapeutic Good Identification</td><td>CodeableText</td><td>An AMT reference set which references concepts such as 'Ibuprofen Blue (Herron) (ibuprofen 200 mg) tablet: film-coated, 1 tablet' (Concept ID: 54363011000036107)</td></tr>
<tr><td>To Be Advised</td><td>CodeableText</td><td>A LOINC subset which references concepts such as 'Cholesterol [Moles/volume] in Serum or Plasma' (ID: 14647-2)</td></tr>
</table>

**Table 1: Value Domain Examples**

# B.3 Icon Legend

These legends describe all icons that are used within the various NEHTA information specifications.

# Metadata Types Legend

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

| Icon | Metadata Types |
|---|---|
|  | Structured Document |
|  | Section |
|  | Data Group |
|  | Participation |
|  | Choice |

**Table 2: Metadata Types Legend**

# Data Types Legend

The following table explains each of the icons used to represent the data types bound to each data element in the SCSs. These data types are a profile of the **ISO 21090-2011** data types as specified in [NEHT2010c].

| Icon | Data type | Explanation |
|---|---|---|
|  | Boolean<br><br>(ISO 21090: BL) | A primitive data type, sometimes called the logical data type, having one of two values: *true* and *false*. Many systems represent true as *non-zero* (often 1, or -1) and false as *zero*.<br><br>**Usage/Examples**<br><br>• An actual value entered by a user might be 'yes' or could be chosen by a mouse click on an icon such as ☑. |

CodeableText

(ISO 21090: CD)

Coded text *with* exceptions; flexible data type to support various ways of holding text, both free text and coded text. Commonly used to support compliance for early adopters of the Structured Content Specifications. Whilst it is recommended that the values in this data type come from the bound value domain, it allows other value domains to also be used (with or without translations to the bound value domain) or free text alternatives. This is a recognition that it **MAY** not be possible to define an entire value domain for a complex concept (e.g. *Diagnosis*) or that there **MAY** be competing code sets in existence. Note that within exchange specifications and/or message profiles this data type **MAY** be constrained to mandate compliance with the bound value domain.

**Usage/Examples**

- AIHW Separation Mode specifies the status at separation of a person from an organisation. An early adopter **MAY** have a similar concept (coded or otherwise) that maps to this data element but does not strictly comply with the AIHW values.
- A SNOMED CT-AU coded/complex expression that embodies single or multiple concepts. The SNOMED CT-AU concepts behind these CodeableText components are specified in the Structured Content Specification value domains.

CodedText

(ISO 21090: CD)

Coded text *without* exceptions; text with code mappings. Values in this data type **SHALL** come from the bound value domain, with no exceptions. Often used for reference sets with only a small number of applicable values, e.g. Gender and Document Status.

**Usage/Examples**

[SA2006b] specifies the following value domain representing a type of address:

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

DateTime

(ISO 21090: TS)

Used for specifying a single date and/or time. Has the ability to indicate a level of precision, but not whether the date/time is estimated. String representations of known dates **SHALL** conform to the nonextended format within the **ISO 21090-2011** standard, i.e. YYYYMMDDHHMMSS.UUUU[+]-ZZzz.

**Usage/Examples**

- Partial dates: 2008, 20081001.
- To indicate 1:20 pm on May the 31st, 1999 for a time zone which is 5 hours behind Coordinated Universal Time (UTC): 19990531132000-0500.

| | | |
|---|---|---|
|  | Duration<br><br>(ISO 21090: PQ.TIME) | The period of time during which something continues. Consists of a value and a unit which represents the time value, e.g. hours, months. Compound durations are not allowed, e.g. 10 days 3 weeks 5 hours.<br><br>**Usage/Examples**<br><br>• 3 hours<br><br>• 6 months<br><br>• 1 year |
|  | Any<br><br>(ISO 21090: ANY) | Represents a data element where the data type to be used is conditional upon another data component. The values that can be required will vary considerably depending on the context. Note that this is an abstract data type that is the basis for all data types and **SHOULD NOT** be used in an actual implementation. |
|  | EncapsulatedData<br><br>(ISO 21090: ED) | Data that is primarily intended for human interpretation or for further machine processing outside the scope of this specification. This includes unformatted or formatted written language, multimedia data, or structured information as defined by a different standard (e.g., XML signatures).<br><br>**Usage/Examples**<br><br>• JPEG images<br><br>• HTML documents<br><br>• [RFC1521] MIME types |
|  | Integer<br><br>(ISO 21090: INT) | The mathematical data type comprising the exact integral values (according to [NEHT2010c]).<br><br>**Usage/Examples**<br><br>• 1<br><br>• -50<br><br>• 125 |
|  | Link<br><br>(ISO 21090: TEL) | This is a general link, reference or pointer to an object, data or application that exists logically or is stored electronically in a computer system.<br><br>**Usage/Examples**<br><br>• URL (Uniform Resource Locator) – the World Wide Web address of a site on the internet, such as the URL for the Google internet search engine – *'http://www.google.com'*.<br><br>• An absolute or relative path within a file/directory structure – e.g. in the Windows® operating system, the "link" or absolute path to a particular letter could be *C:\Documents and Settings\GuestUser\MyDocuments\letter.doc* |

| | |
|---|---|
|  Quantity<br><br>(ISO 21090: PQ) | Used for recording many real world measurements and observations. Includes the magnitude value and the units.<br><br>**Usage/Examples**<br><br>• 100 centimetres<br><br>• 25.5 grams |
|  QuantityRatio<br><br>(ISO 21090: RTO) | The relative magnitudes of two *Quantity* values (usually expressed as a quotient).<br><br>**Usage/Examples**<br><br>• 25 mg/500 ml<br><br>• 200 mmol per litre |
|  QuantityRange<br><br>(ISO 21090: IVL) | Two *Quantity* values that define the minimum and maximum values, i.e. lower and upper bounds. This is typically used for defining the valid range of values for a particular measurement or observation. Unbounded quantity ranges can be defined by not including a minimum and/or a maximum quantity value.<br><br>**Usage/Examples**<br><br>• -20 to 100 Celsius<br><br>• 30-50 mg<br><br>• >10 kg |
|  RealNumber<br><br>(ISO 21090: REAL) | A computational approximation to the standard mathematical concept of real numbers. These are often called floating point numbers.<br><br>**Usage/Examples**<br><br>• 1.075<br><br>• -325.1<br><br>• 3.14157 |
|  Text<br><br>(ISO 21090: ST) | Character strings (with optional language). Unless otherwise constrained by an implementation, can be any combination of alpha, numeric or symbols from the Unicode character set. Sometimes referred to as free text.<br><br>**Usage/Examples**<br><br>“The patient is a 37 year old man who was referred for cardiac evaluation after complaining of occasional palpitations, racing heart beats and occasional dizziness.” |
|  TimeInterval<br><br>(ISO 21090:TS) | An interval in time, with (optionally) a start date/time and (optionally) an end date/time and/or a duration/width.<br><br>**Usage/Examples**<br><br>• 01/01/2008 – 31/12/2008<br><br>• 1:30 a.m. – 6:00 p.m., duration/width = 16.5 hours |

| | | |
|---|---|---|
|  | UniqueIdentifier<br><br>(ISO 21090: II) | A general unique value to identify a physical or virtual object or concept.<br><br>In using this data type, the attributes of the UniqueIdentifier data type **SHOULD** be populated from the identifiers as defined in AS 4846 (2006) [SA2006a] and AS 5017 (2006) [SA2006b] as follows:<br><br>*root*: a globally unique object identifier that identifies the combination of geographic area, issuer and type. If no such globally unique object identifier exists, it **SHALL** be created.<br><br>*extension*: a unique identifier within the scope of the root that is directly equivalent to the identifier designation element.<br><br>*identifierName*: a human readable name for the namespace represented by the root that is populated with the issuer or identifier type values, or a concatenation of both as appropriate. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used as such.<br><br>*identifierScope*: the geographic span or coverage that applies to or constrains the identifier. It is directly equivalent to the geographic area element. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used as such.<br><br>Also, the following constraints apply on the UniqueIdentifier data type:<br><br>The *root* attribute **SHALL** be used.<br><br>For an entity identifier the *root* attribute **SHALL** be an OID that consists of a node in a hierarchically-assigned namespace, formally defined using the ITU-T's ASN.1 standard.<br><br>For an entity identifier the *root* attribute **SHALL NOT** be a UUID.<br><br>The *extension* attribute **SHALL** be used.<br><br>**Usage/Examples**<br><br>IHIs, HPI-Is, HPI-Os and patient hospital medical record numbers are examples of identifiers that **MAY** be carried by this data type. |

**Table 3: Data Types Legend**

# Keywords Legend

Where used in this document and in DCMs and SCSs, the keywords **SHALL, SHOULD, MAY, SHALL NOT** and **SHOULD NOT** are to be interpreted as described in [RFC2119].

The following table defines these keywords

| 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 component, but the full implications **SHALL** be understood and carefully weighed before choosing a different course. |

| | |
|---|---|
| **MAY** | This word, or the adjective 'optional', means that a component is truly optional. One implementer **MAY** choose to include the component because a particular implementation requires it, or because the implementer determines that it enhances the implementation while another implementer **MAY** omit the same component. An implementation which does not include a particular option **SHALL** 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 **SHALL** 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. |
| **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. |

**Table 4: Keywords Legend**

# Obligation Legend

Obligation in DCMs or SCSs specifies whether or not a data component **SHALL** be populated in the logical record architecture of a message. NEHTA intends that all data components will be implemented.

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

The following table defines the obligations.

| Keyword | Interpretation |
|---|---|
| **Essential** | Indicates that the data component is considered a mandatory component of information and **SHALL** be populated.<br><br>**Usage/Examples:**<br><br>The Participant component for a Subject of Care **SHALL** include an Entity Identifier data component in order to hold the IHI. |
| **Optional** | Indicates that the data component is not considered a mandatory component of information and **MAY** be populated.<br><br>**Usage/Examples:**<br><br>This is only needed when a DCM incorrectly asserts that a data component is Essential. It will be used with a note stating that the DCM needs revision. |
| **Prohibited** | Indicates that the data component is considered a forbidden component of information and **SHALL NOT** be populated.<br><br>**Usage/Examples:**<br><br>Within a Participation data group depicting a Subject of Care, the Participation Healthcare Role **SHALL NOT** be completed. |

| | |
|---|---|
| **Conditional** | Indicates that a data component is considered Essential only on satisfaction of a given condition. Individual data components specify the obligation of the data component when the condition is not met.<br><br>When a condition is met, the data component is considered to be essential and **SHALL** be populated.<br><br>When a condition is not met, the data component may be considered as Prohibited, or the data component may be considered Optional.<br><br>**Usage/Examples:**<br><br>Within a Pathology Result Report, the *Specimen Detail* data group is Essential if the requested test is to be performed on a specimen, otherwise it **SHALL NOT** be populated. |

**Table 5: Obligations Legend**

Where Essential child data components are contained within Optional parent data components, the child data components only need to be populated when the parent is populated.

# B.4 Information Model Specification Parts Legends

This section illustrates the format and parts used to define each Section, Data Group and Data Element within NEHTA's information model specifications and identifies when each part is applicable.

## Data Hierarchy

The top-level component contains a data hierarchy. Each row contains information about a single data component. The entries are nested to represent inclusion of one component in another. Each entry contains three occupied cells. One contains an icon to indicate its data type. One contains the label and description of the component (if the label is different from the name, the name is displayed in brackets after the label). One contains the multiplicity range for the data component.

In a SCS a component may be prohibited, that is it occurs in the referenced DCM but it **SHALL** not be included in documents created according to the SCS. This is represented by a multiplicity range of 0..0, the text of the entry is also in a ~~strike-through~~ font and it has a grey background.

## Chapter Name

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

## Identification Section Legend

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

| | |
|---|---|
| **Label** | A suggested display name for the component. (Source NEHTA.) |

| | |
|---|---|
| **Metadata Type** | The metadata type of the component, e.g. section, data group or data element. (Source NEHTA.) |
| **Identifier** | A NEHTA assigned internal identifier of the concept represented by the component. (Source NEHTA.) |
| **OID** | An object identifier that uniquely identifies the concept represented by the data component. (Source NEHTA.) |
| **External Identifier** | An identifier of the concept represented by the data component which is assigned by an organisation other than NEHTA. (Source NEHTA.) |

**Table 6: Identification Section Legend**

# Definition Section Legend

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

| | |
|---|---|
| **Definition** | The meaning, description and/or explanation of the data component. (Source NEHTA.)<br><br>For data groups used in a particular context the definition **MAY** be a refinement of the generic data group definition. |
| **Definition Source** | The authoritative source for the Definition statement. |
| **Synonymous Names** | A list of any names the data component **MAY** also be known as. (Source NEHTA.)<br><br>Implementers **MAY** prefer to use synonymous names to refer to the component in specific contexts. |
| **Scope** | Situations in which the data component may be used, i.e. the extent and capacity within which this data component may be used, including the circumstances under which the collection of specified data are required or recommended.<br><br>For example, Medication Instruction (data group) has a scope which includes all prescribable therapeutic goods, both medicines and non-medicines.<br><br>This attribute is not relevant to data elements or value domains. (Source NEHTA.) |
| **Scope Source** | The authoritative source for the Scope statement. |
| **Context** | The environment in which the data component is meaningful, i.e. the circumstance, purpose and perspective under which this data component is defined or used.<br><br>For example, Street Name has a context of Address. (Source NEHTA.) |
| **Assumptions** | Suppositions and notions used in defining the data component. (Source NEHTA.) |
| **Assumptions Source** | The authoritative source for the Assumptions statement. |
| **Notes** | Informative text that further describes the data component, or assists in the understanding of how the data component can be used. (Source NEHTA.) |
| **Notes Source** | The authoritative source for the Notes statement. |
| **Data Type** | The data type of the data element, e.g. DateTime or Text. (Source NEHTA.) |

| | |
|---|---|
| | The Data type is applicable only to data elements.<br><br>The valid data types are specified in the Data Types Legend. |
| **Value Domain** | The name and identifier of the terminologies, code sets and classifications to define the data element value range, or a statement describing what values to use in the absence of a defined value domain for the related data element.<br><br>In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the HL7 code set registration procedure with an appropriate object identifier (OID), and **SHALL** be publicly available.<br><br>When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. (Source NEHTA.)<br><br>The Value Domain is applicable only to CodedText and CodeableText data elements. |

**Table 7: Definition Section Legend**

# Value Domain Section Legend

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

| | |
|---|---|
| **Source** | The name of the terminology or vocabulary from which the value domain's permissible values are sourced, e.g. SNOMED CT-AU, LOINC. |
| **Version Number** | Version number of the value domain source. |
| **Permissible Values** | List of permissible values in the value domain. |

**Table 8: Value Domain Section Legend**

# Usage Section Legend

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

| | |
|---|---|
| **Examples** | One or more demonstrations of the data that is catered for by the data element. (Source NEHTA.)<br><br>Where a data element has an associated value domain examples representative of that domain are used where possible. Where the value domain is yet to be determined an indicative example is provided.<br><br>Implementation guides **MAY** contain specific examples for how data elements **SHALL** be populated and how they relate to each other.<br><br>The Value Domain is applicable only to CodedText and CodeableText data elements. |
| **Conditions of Use** | Prerequisites, provisos and/or restrictions for use of the component. (Source NEHTA.) |

| | |
|---|---|
| **Conditions of Use Source** | The authoritative source for the Conditions of Use statement. |
| **Misuse** | Incorrect, inappropriate and/or wrong uses of the component. (Source NEHTA.) |
| **Default Value** | A common denomination, or at least a usable denomination, from the Value Domain where available and/or applicable, typically assigned at the creation of an instance of the component. (Source NEHTA.) |

**Table 9: Usage Section Legend**

# Relationships Section Legend

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

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

| Data Type | Name | Occurrences | Condition |
|---|---|---|---|
| Icon illustrating the Metadata type or Data type | Component Name | The maximum and minimum number of instances of this child component that **SHALL** occur. | The conditions that **SHALL** be met to include this child data element. Only applicable for elements with a Conditional obligation. |

**Table 10: Children Legend**

The following table illustrates the layout of the Parent relationships table. Note that the relationships described by this table are from the parent to the child component.

| Data Type | Name | Occurrences | Condition |
|---|---|---|---|
| Icon illustrating the Metadata or Data type | Component Name | The maximum and minimum number of instances of the component described on this page that **SHALL** occur. | The conditions that **SHALL** be met to include the data element. Only applicable for elements with a Conditional obligation. |

**Table 11: Parent Legend**

# Appendix C. Mappings from Requirements

This appendix lists data elements from the requirements sections in the NEHTA Specialist Letter Core Information Components [NEHT2011al] document and matches them to their associated data elements in this Structured Content Specification (SCS) augmented with NEHTA Participation Data Specification [NEHT2011v].

Some cells in the mapping table are empty. This is used to indicate that the cell has the same value as the cell immediately above it.

| Requirement Section | Data Item | SCS Data Element |
|---|---|---|
| Patient | Component | SUBJECT OF CARE |
| | Person Name | SUBJECT OF CARE.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.PERSON NAME |
| | Person Identifier | SUBJECT OF CARE.PARTICIPANT.Entity Identifier |
| | Date of Birth | SUBJECT OF CARE.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.DEMOGRAPHIC DATA.DATE OF BIRTH DETAIL.Date of Birth |
| | Date of Birth accuracy Indicator | SUBJECT OF CARE.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.DEMOGRAPHIC DATA.DATE OF BIRTH DETAIL.DATE OF BIRTH ACCURACY INDICATOR |
| | Sex | SUBJECT OF CARE.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.DEMOGRAPHIC DATA.Sex |
| | Address | SUBJECT OF CARE.PARTICIPANT.ADDRESS |
| | Communication Details | SUBJECT OF CARE.PARTICIPANT.ELECTRONIC COMMUNICATION DETAIL |
| Specialist | Component | DOCUMENT AUTHOR |
| | Person Name | DOCUMENT AUTHOR.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.PERSON NAME |
| | Person Identifier | DOCUMENT AUTHOR.PARTICIPANT.Entity Identifier |
| | Specialty | DOCUMENT AUTHOR.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.EMPLOYMENT DETAIL.Occupation |
| | Organisation Name | DOCUMENT AUTHOR.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.EMPLOYMENT DETAIL.EMPLOYER ORGANISATION.PERSON OR ORGANISATION OR DEVICE.ORGANISATION.Organisation Name |
| | Organisation Identifier | DOCUMENT AUTHOR.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.EMPLOYMENT DETAIL.EMPLOYER ORGANISATION.Entity Identifier |
| | Address | DOCUMENT AUTHOR.PARTICIPANT.ADDRESS |
| | Communication Details | DOCUMENT AUTHOR.PARTICIPANT.ELECTRONIC COMMUNICATION DETAIL |

| Requirement Section | Data Item | SCS Data Element |
|---|---|---|
| Referring GP | Component | REFERRER |
| | Person Name | REFERRER.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.PERSON NAME |
| | Person Identifier | REFERRER.PARTICIPANT.Entity Identifier |
| | Organisation Name | REFERRER.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.EMPLOYMENT DETAIL.EMPLOYER ORGANISATION.PERSON OR ORGANISATION OR DEVICE.ORGANISATION.Organisation Name |
| | Organisation Identifier | REFERRER.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.EMPLOYMENT DETAIL.EMPLOYER ORGANISATION.Entity Identifier |
| | Address | REFERRER.PARTICIPANT.ADDRESS |
| | Communication Details | REFERRER.PARTICIPANT.ELECTRONIC COMMUNICATION DETAIL |
| Usual GP | Component | USUAL GP |
| | Person Name | USUAL GP.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.PERSON NAME |
| | Person Identifier | USUAL GP.PARTICIPANT.Entity Identifier |
| | Organisation Name | USUAL GP.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.EMPLOYMENT DETAIL.EMPLOYER ORGANISATION.PERSON OR ORGANISATION OR DEVICE.ORGANISATION.Organisation Name |
| | Organisation Identifier | USUAL GP.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.EMPLOYMENT DETAIL.EMPLOYER ORGANISATION.Entity Identifier |
| | Address | USUAL GP.PARTICIPANT.ADDRESS |
| | Communication Details | USUAL GP.PARTICIPANT.ELECTRONIC COMMUNICATION DETAIL |
| Recipients | | *Additional recipients are currently not represented (this is a known issue - please also refer to the 'known issues' section)* |
| | Recipient Type | |
| | Person Name | |
| | Person Identifier | |
| | Organisation Name | |
| | Organisation Identifier | |
| | Healthcare Role | |
| | Relationship to Patient | |
| | Address | |
| | Communication Details | |
| Response Details | Component | Response Details (RESPONSE DETAILS) |

| Requirement Section | Data Item | SCS Data Element |
|---|---|---|
| | Date Patient Seen | DateTime Subject of Care Seen (DateTime Health Event Started) |
| | Diagnosis and/or Procedures | Response Details (RESPONSE DETAILS).Diagnosis (PROBLEM/DIAGNOSIS).Diagnosis Name (Problem/Diagnosis Identification) |
| | | Response Details (RESPONSE DETAILS).Procedure (PROCEDURE).Procedure Name |
| | | Response Details (RESPONSE DETAILS).Other Diagnosis/Procedure Entry (CLINICAL SYNOPSIS).Other Diagnosis or Procedure Name (Clinical Synopsis Description) |
| | Response Narrative | Response Details (RESPONSE DETAILS).Response Narrative (CLINICAL SYNOPSIS).Clinical Synopsis.Narrative (Clinical Synopsis Description) |
| Recommendations | Component | Recommendations (RECOMMENDATIONS) |
| | Recommendation | Recommendations (RECOMMENDATIONS).Recommendation (RECOMMENDATION) |
| | Recommendation To | Recommendations (RECOMMENDATIONS).Recommendation (RECOMMENDATION).Addressee (RECOMMENDATION ADDRESSEE) |
| | Recommendation Note | Recommendations (RECOMMENDATIONS).Recommendation (RECOMMENDATION).Recommendation Narrative |
| | Recommendation Timeframe | Recommendations (RECOMMENDATIONS).Recommendation (RECOMMENDATION).Time Frame (Recommendation Time Frame) |
| | Recommendation Exclusion Statement | Recommendations Exclusion (EXCLUSION STATEMENT).General Statement |
| Medicines List | Component | Medications (MEDICATIONS ORDERS) |
| | Medicine | Medications (MEDICATIONS ORDERS).Medication (MEDICATION INSTRUCTION) |
| | Medicine Status | Medications (MEDICATIONS ORDERS).Medication (MEDICATION INSTRUCTION).Change or Recommendation?(Change Status) |
| | Item Description | Medications (MEDICATIONS ORDERS).Medication (MEDICATION INSTRUCTION).Medicine (Therapeutic Good Identification) |
| | Dose Instructions | Medications (MEDICATIONS ORDERS).Medication (MEDICATION INSTRUCTION).Directions |
| | Reason for Medicine | Medications (MEDICATIONS ORDERS).Medication (MEDICATION INSTRUCTION).Clinical Indication |
| | Additional Comments | Medications (MEDICATIONS ORDERS).Medication (MEDICATION INSTRUCTION).Comment (Medication Instruction Comment) |
| | Changes Description | Medications (MEDICATIONS ORDERS).Medication (MEDICATION INSTRUCTION).Change Description |

| Requirement Section | Data Item | SCS Data Element |
|---|---|---|
| | Reason for Change | Medications (MEDICATIONS ORDERS).Medication (MEDICATION INSTRUCTION).Change Reason (Change or Recommendations Reason) |
| | Medicines Exclusion Statement | Medications (MEDICATIONS ORDERS).EXCLUSION STATEMENT - MEDICATIONS.Global Statement |
| Newly Identified Allergies and Adverse Reactions | Component | Newly Identified Allergies and Adverse Reactions (ADVERSE REACTIONS) |
| | Allergies / Adverse Reaction | Newly Identified Allergies and Adverse Reactions (ADVERSE REACTIONS).ADVERSE REACTION |
| | Agent Description | Newly Identified Allergies and Adverse Reactions (ADVERSE REACTIONS).ADVERSE REACTION.Substance/Agent |
| | Reaction Description | Newly Identified Allergies and Adverse Reactions (ADVERSE REACTIONS).ADVERSE REACTION.REACTION EVENT.Manifestation |
| Diagnostic Investigations | Component | DIAGNOSTIC INVESTIGATIONS |
| | Investigation Type | Derived from type of data group = PATHOLOGY TEST RESULT or type of data group = IMAGING EXAMINATION RESULT or value of Requested Service.Requested Service Description |
| | Investigation Name | Derived from type of data group = PATHOLOGY TEST RESULT or type of data group = IMAGING EXAMINATION RESULT or value of Requested Service.Requested Service Description |
| | Investigation Date | DIAGNOSTIC INVESTIGATIONS.IMAGING EXAMINATION RESULT.Imaging Examination Result DateTime |
| | | DIAGNOSTIC INVESTIGATIONS.PATHOLOGY TEST RESULT.Test Specimen Detail (SPECIMEN).HANDLING AND PROCESSING.Date and Time of Collection (Collection DateTime) |
| | Result Status | DIAGNOSTIC INVESTIGATIONS.PATHOLOGY TEST RESULT.Overall Test Result Status (Overall Pathology Test Result Status) |
| | | DIAGNOSTIC INVESTIGATIONS.IMAGING EXAMINATION RESULT.Imaging Examination Result Status |
| | | DIAGNOSTIC INVESTIGATIONS.Requested Service.Service Booking Status |
| | Link | DIAGNOSTIC INVESTIGATIONS.PATHOLOGY TEST RESULT.Test Result Representation *Note that a URL can be put into this data element.* |
| | | DIAGNOSTIC INVESTIGATIONS.IMAGING EXAMINATION RESULT.Examination Result Representation *Note that a URL can be put into this data element.* |
| | Data | DIAGNOSTIC INVESTIGATIONS.PATHOLOGY TEST RESULT.Test Result Representation. |

| Requirement Section | Data Item | SCS Data Element |
|---|---|---|
| | | DIAGNOSTIC INVESTIGATIONS.IMAGING EXAMINATION RESULT.Examination Result Representation. |
| Attachments | Component | *In the future this component will be mapped to Attachments DCM.* |
| Document Control | Component | *This is described in the CDA Implementation Guide* |

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