nehta

e-Referral

Structured Content Specification

Version 2.1 — 7 Dec 2011

Final

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Document Information

Document owner

Document Owner
The National Clinical Terminology and Information Service

Change history

Version	Date	Comments
1.0	28 Feb 2007	Initial public release as Referral Content Specification.
2.0	5 May 2011	Release as a Structured Content Specification.
2.1	7 Dec 2011	Final specification for submission to Standards Australia.

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 an e-Referral. It specifies the information structure of NEHTA-compliant e-Referrals 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 e-Referral 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 e-Referral.

It is also a key input to the NEHTA e-Referral CDA Implementation Guide [NEHT2011av], which describes how to implement NEHTA-compliant e-Referrals 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 e-Referral 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 e-Referral Structured Document

2.1 Purpose

For sending referrals from general medical practiitioners to specialist medical practitions in Australia.

2.2 E-REFERRAL

Identification

Label	E-REFERRAL
Metadata Type	Structured Document
Identifier	SD-21000
OID	1.2.36.1.2001.1001.101.100.21000

Definition

Definition	A referral of a subject of care from one health care provider to another.
Definition Source	NEHTA
Synonymous Names	

Data Hierarchy

	E-REFERRAL			
CONTEXT				
		SUBJECT OF CARE		1..1
		DOCUMENT AUTHOR		1..1
		DateTime Authored		1..1
		~~DateTime Health Event Started~~		~~0..0~~
		~~DateTime Health Event Ended~~		~~0..0~~
		~~HEALTHCARE FACILITY~~		~~0..0~~
		PATIENT NOMINATED CONTACTS		0..*
		DateTime Attested		1..1
CONTENT				
		REFERRAL DETAIL		1..1
			Referral DateTime	1..1
			Referral Reason	1..1

			Referral Validity Duration		1..1
			USUAL GP		0..1
			REFEREE		1..1
			~~INFORMATION PROVIDER~~		~~0..0~~
			~~SUBJECT~~		~~0..0~~
			~~Referral Detail Identifier~~		~~0..0~~
			~~LINK~~		~~0..0~~
			~~Detailed Clinical Model Identifier~~		~~0..0~~
		MEDICAL HISTORY			1..1
			PROBLEM/DIAGNOSIS		0..*
				Problem/Diagnosis (Problem/Diagnosis Identification)	1..1
				~~Clinical Description~~	~~0..0~~
				~~Severity~~	~~0..0~~
				Date of Onset	0..1
				~~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..1
				~~Age at Resolution/Remission~~	~~0..0~~
				~~Diagnostic Criteria~~	~~0..0~~
				~~Clinical Stage/Grade~~	~~0..0~~
				Comment (Problem/Diagnosis Comment)	0..1
				~~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~~
			~~EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES~~		~~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..1
				Start Date/Time (DateTime Started)	0..1
				~~DEVICE~~	~~0..0~~
				~~INFORMATION PROVIDER~~	~~0..0~~
				~~SUBJECT~~	~~0..0~~
				~~Procedure Identifier~~	~~0..0~~
				~~LINK~~	~~0..0~~
				~~Detailed Clinical Model Identifier~~	~~0..0~~
			~~EXCLUSION STATEMENT - PROCEDURES~~		~~0..0~~

			Other Medical History Item (MEDICAL HISTORY ITEM)		0..*
				Medical History Item Description	1..1
				Medical History Item Timeinterval	0..1
				Medical History Item Comment	0..1
				~~INFORMATION PROVIDER~~	~~0..0~~
				~~SUBJECT~~	~~0..0~~
				~~Medical History Item 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	1..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..0~~
				~~Administration Details (MEDICATION ADMINISTRATION)~~	~~0..0~~
				~~Comment (Medication Instruction Comment)~~	~~0..0~~
				~~DISPENSING~~	~~0..0~~
				~~Change Type~~	~~0..0~~
				~~Change or Recommendation? (Change Status)~~	~~0..0~~
				~~Change Description~~	~~0..0~~
				~~Change Reason (Change or Recommendation Reason)~~	~~0..0~~
				~~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~~
		ADVERSE REACTIONS			1..1
			EXCLUSION STATEMENT - ADVERSE REACTIONS		0..1
				Global Statement	1..1

				~~No Known Adverse Reaction to~~		~~0..0~~
				~~No Known Allergic Reaction to~~		~~0..0~~
				~~No Known Hypersensitivity Reaction to~~		~~0..0~~
				~~No Known Intolerance to~~		~~0..0~~
				~~INFORMATION PROVIDER~~		~~0..0~~
				~~SUBJECT~~		~~0..0~~
				~~Exclusion Statement - Adverse Reactions Identifier~~		~~0..0~~
				~~LINK~~		~~0..0~~
				~~Detailed Clinical Model Identifier~~		~~0..0~~
			ADVERSE REACTION			0..*
				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 Test Result 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..*
			Overall Result Status (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~~

2.3 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	Identifies the person about whom the healthcare event/encounter/clinical interaction has been captured and/or interchanged, that led to the creation of the document. In other words, the subject of the information.
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]. The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B: *Specification Guide for Use*. Additional obligation and occurrence constraints: • Participation Period is **PROHIBITED**. • LOCATION OF PARTICIPATION is **PROHIBITED**. • Entity Identifier is **ESSENTIAL**. • ADDRESS is **ESSENTIAL**. • ELECTRONIC COMMUNICATION DETAIL is **ESSENTIAL**. • Relationship to Subject of Care is **PROHIBITED**. • EMPLOYMENT DETAIL is **PROHIBITED**. • DEMOGRAPHIC DATA is **ESSENTIAL**. • Sex is **ESSENTIAL**. • DATE OF BIRTH DETAIL is **ESSENTIAL**. • Indigenous Status is **ESSENTIAL**. • ENTITLEMENT is **ESSENTIAL**.

	• Qualifications is **PROHIBITED**. Other additional constraints: • Participation Type **SHALL** have an implementation-specific value equivalent to “Subject of Care”. • Role **SHALL** have an implementation-specific value equivalent to “Patient”. • The value of one Entity Identifier **SHALL** be an Australian IHI. • 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
	E-REFERRAL	1..1	

2.4 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 health care provider who has made the e-Referral.
Definition Source	NEHTA
Synonymous Names	Referrer
Notes	The referrer who is responsible for the content of the letter, even if someone else did physically author or compose the referral.

Usage

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

	• Participation Type **SHALL** have an implementation-specific value equivalent to “Document Author”. • 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. • The value of one Entity Identifier **SHALL** be an Australian HPI-I. • The value of one EMPLOYER ORGANISATION.Entity Identifier **SHALL** be an Australian HPI-O. • AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	E-REFERRAL	1..1	

2.5 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 e-Referral by the authoring healthcare provider is started or done.
Definition Source	NEHTA
Synonymous Names	DateTime e-Referral Created DateTime Created DateTime Issued
Data Type	DateTime

Usage

Examples	1. 31/03/2004. 2. 03/2004. 3. 2004. 4. 31/03/2004 13:10.

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	E-REFERRAL	1..1	

2.6 PATIENT NOMINATED CONTACTS

Identification

Label	PATIENT NOMINATED CONTACTS
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	Details pertaining to the organisation or individual(s) nominated to act as the contact to receive information about the subject of care.
Definition Source	NEHTA
Synonymous Names	Nominated Contact
Notes	The subject of care themselves may not be the primary point of contact (e.g. dementia or paediatrics).

Usage

Conditions of Use	This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v]. The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B: *Specification Guide for Use*. Additional obligation and occurrence constraints: • Participation Period is **PROHIBITED**. • LOCATION OF PARTICIPATION is **PROHIBITED**. • EMPLOYMENT DETAIL is **PROHIBITED**. • DATE OF BIRTH DETAIL is **PROHIBITED**. • DEMOGRAPHIC DATA is **PROHIBITED**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**. Other additional constraints when the Patient Nominated Contact is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON): • Participation Type **SHALL** have an implementation-specific fixed value equivalent to “Patient Nominated Contacts”. • 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. • Relationship to Subject of Care is **ESSENTIAL**. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON. Other additional constraints when the Patient Nominated Contact is an Organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an ORGANISATION): • Participation Type **SHALL** have an implementation-specific fixed value equivalent to “Patient Nominated Contacts”. • 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. • Relationship to Subject of Care is **PROHIBITED**. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a ORGANISATION.
Conditions of Use Source	NEHTA
Misuse	The subject of care **SHALL** not be used as a nominated contact (s).

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	E-REFERRAL	0..*	

2.7 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 DateTime Document Sent DateTime Document Transmitted
Context	For use in a healthcare setting. 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. 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
	E-REFERRAL	1..1	

2.8 MEDICAL HISTORY

Identification

Label	MEDICAL HISTORY
Metadata Type	Section
Identifier	S-16117
OID	1.2.36.1.2001.1001.101.101.16117

Definition

Definition	The past and current medical history of the subject of care, this includes problem/diagnosis and medical or surgical procedures performed.
Definition Source	NEHTA
Synonymous Names	

Usage

Conditions of Use	Additional obligation and occurrence constraints: • Each instance of this section **SHALL** have at least one instance of 'PROBLEM/DIAGNOSIS' OR 'Procedure (PROCEDURE)' OR 'Other Medical History Item (MEDICAL HISTORY ITEM)'.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	E-REFERRAL	1..1	

Children

Data Type	Name	Occur-rences	Condi-tion
	PROBLEM/DIAGNOSIS	0..*	
	~~EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES~~	~~0..0~~	-
	Procedure (PROCEDURE)	0..*	

Data Type	Name	Occur-rences	Condi-tion
	~~EXCLUSION STATEMENT - PROCEDURES~~	~~0..0~~	-
	Other Medical History Item (MEDICAL HISTORY ITEM)	0..*	

2.9 MEDICATION ORDERS

Identification

Label	Medications
Metadata Type	Section
Identifier	S-16146
OID	1.2.36.1.2001.1001.101.101.16146

Definition

Definition	Therapeutic Goods which are/were prescribed for the subject of care or the subject of care has/had been taking.
Definition Source	NEHTA
Synonymous Names	
Notes	This section outlines the data groups and data elements for ceased and current medications for the referral.

Usage

Conditions of Use	Additional obligation and occurrence constraints: • 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
	E-REFERRAL	1..1	

Children

Data Type	Name	Occur-rences	Condi-tion
	EXCLUSION STATEMENT - MEDICATIONS	0..1	

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

2.10 ADVERSE REACTIONS

Identification

Label	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	

Usage

Conditions of Use	Additional obligation and occurrence constraints: • Each instance of this section either **SHALL** have exactly one instance of 'EXCLUSION STATEMENT - ADVERSE REACTIONS' OR **SHALL** have one or more instances of 'ADVERSE REACTION' but **SHALL NOT** have both.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	E-REFERRAL	1..1	

Children

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

2.11 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 the subject of care during the healthcare event, that are considered to be relevant to the subject's ongoing care.
Definition Source	NEHTA
Synonymous Names	Pathology/Diagnostic Imaging Results Investigations Performed

Usage

Conditions of Use	Additional obligation and occurrence constraints: • Each instance of this section **SHALL** have at least one instance of 'PATHOLOGY TEST RESULT' OR 'IMAGING EXAMINATION RESULT' OR 'Requested Service (REQUESTED SERVICE)'.
Conditions of Use Source	NEHTA
Misuse	Including diagnostic test results which are **NOT** considered to be relevant to the subject of care's ongoing care.

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	E-REFERRAL	0..1	

Children

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

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

3 Referral Detail Data Group

3.1 Purpose

Detailed information about the clinical referral.

3.2 REFERRAL DETAIL

Identification

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

Definition

Definition	This section captures detailed information about the clinical referral.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	E-REFERRAL	1..1	

Children

Data Type	Name	Occur-rences	Condi-tion
	Referral DateTime	1..1	
	Referral Reason	1..1	
	Referral Validity Duration	1..1	
	USUAL GP	0..1	
	REFEREE	1..1	
	~~INFORMATION PROVIDER~~	~~0..0~~	-
	~~SUBJECT~~	~~0..0~~	-
	~~Referral Detail Identifier~~	~~0..0~~	-

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

3.3 Referral DateTime

Identification

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

Definition

Definition	The date/time when the Referral document was sent.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

Conditions of Use	The exact referral dates **SHALL** be used.
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
	REFERRAL DETAIL	1..1	

3.4 Referral Reason

Identification

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

Definition

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

Usage

Examples	1. To rule out ischaemic heart disease. 2. To rule out organic brain lesions. 3. Thank you for seeing this 14 year old schoolboy who fell whilst playing football at school yesterday. On examination he has a swollen painful R ankle and cannot weight bear on it today. I suspect he has a fracture of his Right Tibia and fibula. 4. Thank you for seeing this 43 year old lady who has had 2 episodes of cholecystitis in the last month. She is currently well. Ultrasound of her abdomen done at the Public Hospital Emergency Department shows she has gall stones. She has Private Cover and wishes to see you to consider cholecystectomy at the Private Hospital.

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	REFERRAL DETAIL	1..1	

3.5 Referral Validity Duration

Identification

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

Definition

Definition	The length of time the referral is valid from the date of the first subject of care/specialist encounter.
Definition Source	NEHTA
Synonymous Names	
Notes	It captures the valid duration of the referral which may be constrained by, e.g. Medicare funding policy.
Data Type	Duration

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	REFERRAL DETAIL	1..1	

3.6 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	This is a person or an organisation and the types of sources include: • the clinician; • a healthcare provider; and • a GP Practice.

Usage

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

	• DEMOGRAPHIC DATA is **PROHIBITED**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**. Other additional constraints when the Usual GP is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON): • EMPLOYMENT DETAIL is **ESSENTIAL**. • Entity Identifier is **ESSENTIAL**. • EMPLOYER ORGANISATION is **ESSENTIAL**. • EMPLOYER ORGANISATION.Entity Identifier is **ESSENTIAL**. • Participation Type **SHALL** have an implementation-specific value equivalent to “Usual GP”. • Role **SHOULD** have a value chosen from 1220.0 – ANZSCO – 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. • The value of one Entity Identifier **SHALL** be an Australian HPI-I. • The value of one EMPLOYER ORGANISATION.Entity Identifier **SHALL** be an Australian HPI-O. • AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON. Other additional constraints when the Usual GP is an Organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an ORGANISATION): • Participation Type **SHALL** have an implementation-specific value equivalent to “Usual GP”. • Role **SHALL** have a value representing the type of Facility e.g. Clinic. • The value of one Entity Identifier **SHALL** be an Australian HPI-O. • AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as an ORGANISATION.
Conditions of Use Source	NEHTA
Misuse	This data group **SHALL** not be recorded if the “Usual GP” is same as the “Document Author / Referring GP”

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	REFERRAL DETAIL	0..1	

3.7 REFEREE

Identification

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

Definition

Definition	The specialist to whom the subject of care is being referred.
Definition Source	NEHTA
Synonymous Names	
Notes	Types of sources include: • the clinician; and • a healthcare provider.

Usage

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

	Other additional constraints when the Referee is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON): • EMPLOYMENT DETAIL is **ESSENTIAL**. • Participation Type **SHALL** have an implementation-specific value equivalent to “Referee”. • Role **SHOULD** have a value chosen from 1220.0 – ANZSCO – 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. • The value of one Entity Identifier **SHALL** be an Australian HPI-I. • The value of one EMPLOYER ORGANISATION.Entity Identifier **SHALL** be an Australian HPI-O. • AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON. Other additional constraints when the Referee is an Organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an ORGANISATION): • Participation Type **SHALL** have an implementation-specific value equivalent to “Referee”. • Role **SHALL** have a value representing the type of Facility e.g. Clinic. • The value of one Entity Identifier **SHALL** be an Australian HPI-O. • AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as an ORGANISATION.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	REFERRAL DETAIL	1..1	

4 Problem/Diagnosis Data Group

4.1 Purpose

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

4.2 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.

4.3 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.

4.4 PROBLEM/DIAGNOSIS

Identification

Label	PROBLEM/DIAGNOSIS
Metadata Type	Data Group
Identifier	DG-15530
OID	1.2.36.1.2001.1001.101.102.15530

Definition

Definition	The problems and/or diagnoses that form part of the past and current medical history of the subject of care.
Definition Source	NEHTA
Synonymous Names	
Notes	An account of relevant identified health related problems as reported by a healthcare provider. This can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status as assessed by a healthcare provider. This item is repeated for every instance of a problem/diagnosis.

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
	MEDICAL HISTORY	0..*	

Children

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

Data Type	Name	Occur-rences	Condi-tion
	~~Severity~~	~~0..0~~	-
	Date of Onset	0..1	
	~~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..1	
	~~Age at Resolution/Remission~~	~~0..0~~	-
	~~Diagnostic Criteria~~	~~0..0~~	-
	~~Clinical Stage/Grade~~	~~0..0~~	-
	Comment (Problem/Diagnosis Comment)	0..1	
	~~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~~	-

4.5 Problem/Diagnosis Identification

Identification

Label	Problem/Diagnosis
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
	PROBLEM/DIAGNOSIS	1..1	

4.6 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 subject of care 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
	Problem/Diagnosis (Problem/Diagnosis Identification)	1..1	

4.7 Date of Onset

Identification

Label	Date of Onset
Metadata Type	Data Element
Identifier	DE-15507
OID	1.2.36.1.2001.1001.101.103.15507

Definition

Definition	Estimated or actual date the problem/diagnosis began, in the opinion of the clinician.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	PROBLEM/DIAGNOSIS	0..1	

4.8 Date of Resolution/Remission

Identification

Label	Date of Resolution/Remission
Metadata Type	Data Element
Identifier	DE-15510
OID	1.2.36.1.2001.1001.101.103.15510

Definition

Definition	The date or estimated date that the problem/diagnosis resolved or went into remission, as indicated/identified by the clinician.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

Conditions of Use	Record only date, time **SHALL NOT** be recorded.
Conditions of Use Source	NEHTA
Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	PROBLEM/DIAGNOSIS	0..1	

4.9 Problem/Diagnosis Comment

Identification

Label	Comment
Metadata Type	Data Element
Identifier	DE-16545
OID	1.2.36.1.2001.1001.101.103.16545

Definition

Definition	Additional narrative about the problem or diagnosis not captured in other fields.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	PROBLEM/DIAGNOSIS	0..1	

5 Procedure (Action) Data Group

5.1 Purpose

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

5.2 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).

5.3 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.

5.4 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
	MEDICAL HISTORY	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..1	
	Start Date/Time (DateTime Started)	0..1	
	~~DEVICE~~	~~0..0~~	-
	~~INFORMATION PROVIDER~~	~~0..0~~	-
	~~SUBJECT~~	~~0..0~~	-
	~~Procedure Identifier~~	~~0..0~~	-
	~~LINK~~	~~0..0~~	-
	~~Detailed Clinical Model Identifier~~	~~0..0~~	-

5.5 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	

5.6 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	

5.7 Procedure Comment

Identification

Label	Comment
Metadata Type	Data Element
Identifier	DE-15595
OID	1.2.36.1.2001.1001.101.103.15595

Definition

Definition	Additional narrative about the procedure not captured in other fields.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Procedure (PROCEDURE)	0..1	

5.8 DateTime Started

Identification

Label	Start Date/Time
Metadata Type	Data Element
Identifier	DE-15507
OID	1.2.36.1.2001.1001.101.103.15507

Definition

Definition	The start date and/or time for the procedure.
Definition Source	NEHTA
Synonymous Names	Date Started Start Date Start Date and Time
Data Type	DateTime

Usage

Conditions of Use	For a procedure which has not yet started, this is the planned date/time started. For a procedure which has started, this is the actual date/time started.
Conditions of Use Source	NEHTA
Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Procedure (PROCEDURE)	0..1	

6 Medical History Item Data Group

6.1 Purpose

Allows recording of an entry in a medical history when it cannot be determined whether the entry is a Procedure or is a Problem/Diagnosis.

6.2 Misuse

Using this when the item can be identified as a Procedure or can be identified as a Problem/Diagnosis.

6.3 MEDICAL HISTORY ITEM

Identification

Label	Other Medical History Item
Metadata Type	Data Group
Identifier	DG-16627
OID	1.2.36.1.2001.1001.101.102.16627

Definition

Definition	A medical history entry which cannot be categorised into one of the categories such as Procedure and Problem/Diagnosis.
Definition Source	NEHTA
Synonymous Names	

Usage

Conditions of Use	This is a reuse of the MEDICAL HISTORY 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
	MEDICAL HISTORY	0..*	

Children

Data Type	Name	Occur-rences	Condi-tion
	Medical History Item Description	1..1	
	Medical History Item Timeinterval	0..1	
	Medical History Item Comment	0..1	
	~~INFORMATION PROVIDER~~	~~0..0~~	-

Data Type	Name	Occur-rences	Condi-tion
	~~SUBJECT~~	~~0..0~~	-
	~~Medical History Item Identifier~~	~~0..0~~	-
	~~LINK~~	~~0..0~~	-
	~~Detailed Clinical Model Identifier~~	~~0..0~~	-

6.4 Medical History Item Description

Identification

Label	Medical History Item Description
Metadata Type	Data Element
Identifier	DE-16628
OID	1.2.36.1.2001.1001.101.103.16628

Definition

Definition	A description of the problem, diagnosis, intervention or other medical history item.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	1. Hypercholesterolaemia. 2. Left Total Knee Replacement. 3. RLL pneumonia.

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Other Medical History Item (MEDICAL HISTORY ITEM)	1..1	

6.5 Medical History Item Timeinterval

Identification

Label	Medical History Item Timeinterval
Metadata Type	Data Element
Identifier	DE-16629
OID	1.2.36.1.2001.1001.101.103.16629

Definition

Definition	The date range during which the item applied or occurred.
Definition Source	NEHTA
Synonymous Names	
Data Type	TimeInterval

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Other Medical History Item (MEDICAL HISTORY ITEM)	0..1	

6.6 Medical History Item Comment

Identification

Label	Medical History Item Comment
Metadata Type	Data Element
Identifier	DE-16630
OID	1.2.36.1.2001.1001.101.103.16630

Definition

Definition	Free text comments providing additional information relevant to the item in question.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Other Medical History Item (MEDICAL HISTORY ITEM)	0..1	

7 Exclusion Statement - Medications Data Group

7.1 Purpose

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

7.2 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.

7.3 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 subject of care 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~~	-

7.4 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	

7.5 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	

8 Medication Instruction Data Group

8.1 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.

8.2 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.

8.3 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.

8.4 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 Medicine Potion 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 includes self-prescribed, clinician prescribed and nonprescription medicines.
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	

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

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

8.5 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). Therapeutic use means use in or in connection with: • preventing, diagnosing, curing or alleviating a disease, ailment, defect or injury; • influencing, inhibiting or modifying a physiological process; • testing the susceptibility of persons to a disease or ailment; • influencing, controlling or preventing conception; • testing for pregnancy; or • replacement or modification of parts of the anatomy. From [TGA1989a]. 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: 1. 293049011000036110, paracetamol 500 mg + codeine phosphate 30 mg tablet 2. 327004011000036118, paracetamol 500 mg + codeine phosphate 30 mg tablet, 20 3. 234184011000036115, Panadeine Forte tablet: uncoated, 20 tablets 4. 192727011000036112, Panadeine Forte (paracetamol 500 mg + codeine phosphate 30 mg) tablet: uncoated, 1 tablet 5. 278453011000036118, Panadeine Forte tablet: uncoated, 20 tablets, blister pack 6. 315236011000036113, bandage compression 10 cm x 3.5 m bandage: high stretch, 1 bandage 7. 186324011000036116, Eloflex (2480) (bandage compression 10 cm x 3.5 m) bandage: high stretch, 1 bandage 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	

8.6 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]. 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: • |929360061000036106 *Medicinal product reference set*| • |929360081000036101 *Medicinal product pack reference set*| • |929360071000036103 *Medicinal product unit of use reference set*| • |929360021000036102 *Trade product reference set*| • |929360041000036105 *Trade product pack reference set*| • |929360031000036100 *Trade product unit of use reference set*| • |929360051000036108 *Containered trade product pack reference set*|

Relationships

Parents

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

8.7 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)	1..1	

9 Exclusion Statement - Adverse Reactions Data Group

9.1 Purpose

To positively record the absence or exclusion of any adverse reactions within the health record.

9.2 Use

Use to record the positive exclusion or absence of adverse reactions within the health record. This data group avoids the need to use terminology to express negation about any item within the health record. It is important to note that the Exclusion Statement information is time-specific. Its validity may not extend beyond the point in time when the information is recorded. The patient should always be asked to verify previous statements on adverse reaction to a substance.

9.3 EXCLUSION STATEMENT - ADVERSE REACTIONS

Identification

Label	EXCLUSION STATEMENT - ADVERSE REACTIONS
Metadata Type	Data Group
Identifier	DG-16137
OID	1.2.36.1.2001.1001.101.102.16137

Definition

Definition	Statements about Adverse Reactions that need to be positively recorded as absent or excluded.
Definition Source	openEHR Foundation
Synonymous Names	Exclusion No Nil significant Nil relevant
Scope	To positively record the absence or exclusion of any adverse reactions within the health record.
Scope Source	openEHR Foundation

Usage

Conditions of Use	This is a reuse of the EXCLUSION STATEMENT - 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
	ADVERSE REACTIONS	0..1	

Children

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

Data Type	Name	Occurrences	Condition
	~~No Known Adverse Reaction to~~	~~0..0~~	-
	~~No Known Allergic Reaction to~~	~~0..0~~	-
	~~No Known Hypersensitivity Reaction to~~	~~0..0~~	-
	~~No Known Intolerance to~~	~~0..0~~	-
	~~INFORMATION PROVIDER~~	~~0..0~~	-
	~~SUBJECT~~	~~0..0~~	-
	~~Exclusion Statement - Adverse Reactions 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.
Definition Source	openEHR Foundation
Synonymous Names	
Context	This can be used 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

Conditions of Use	Captures any information that is needed to be explicitly recorded as being absent or excluded within the record.
Conditions of Use Source	openEHR Foundation
Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	EXCLUSION STATEMENT - ADVERSE REACTIONS	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 global statements about the exclusion.
Definition Source	openEHR Foundation

Value Domain

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

Relationships

Parents

Data Type	Name	Occurrences	Condition
	Global Statement	1..1	

10 Adverse Reaction Data Group

10.1 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).

10.2 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.

10.3 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.

10.4 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
	ADVERSE REACTIONS	0..*	

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~~	-

10.5 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 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 2. Latex 3. Peanut 4. Penicillin 5. Bee venom

Relationships

Parents

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

10.6 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 subject of care.
Definition Source	NEHTA

Value Domain

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

Relationships

Parents

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

10.7 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~~	-

10.8 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. 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. 2. Dysphagia. 3. Tinnitus. 4. Nausea. 5. Rash.

Relationships

Parents

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

10.9 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	

11 Pathology Test Result Data Group

11.1 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.

11.2 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.

11.3 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.

11.4 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 Pathology Biochemistry Haematology Microbiology 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 Test Result 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~~	-

11.5 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.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[1] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

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

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

11.6 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. 2. Haematology.

Relationships

Parents

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

11.7 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	

11.8 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	

11.9 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.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[2] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Conditions of Use	This is the actual specimen being submitted to the laboratory for analysis.
Conditions of Use Source	NEHTA
Examples	1. Venous blood. 2. Prostate tissue, left base. 3. Urine. 4. Sputum. 5. Scraping. 6. Catheter tip. 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	

11.10 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.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[3] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Venepuncture 2. Biopsy 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

11.11 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..*	

11.12 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~~	-

11.13 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	

11.14 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	

11.15 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. 2. Left. 3. Bilalteral.

Relationships

Parents

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

11.16 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	

11.17 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	

11.18 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..*	

11.19 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	

11.20 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	

11.21 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	

11.22 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	

11.23 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	

11.24 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	

11.25 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~~	-

11.26 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. 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.* 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. 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

11.27 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~~	-

11.28 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	

11.29 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	

11.30 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	

11.31 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~~	-

11.32 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. 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	

11.33 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	

11.34 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	

11.35 Overall Pathology Test Result Status

Identification

Label	Overall Test Result 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 2. Final

Relationships

Parents

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

11.36 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 Test Result Status (Overall Pathology Test Result Status)	1..1	

11.37 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	

11.38 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	

11.39 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.* 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. 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

11.40 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	

11.41 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.* 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. 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. 2. Haemoglobin concentration. 3. Hepatitis B surface antibody titre. 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

11.42 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 QuantityRange Quantity
Value Domain	Result Value Values

Usage

Examples	1. 140. 2. ++. 3. Neg.

Relationships

Parents

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

11.43 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

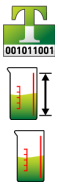
Definition	The set of values for the measured level/magnitude of the test result component.
Definition Source	NEHTA

Value Domain

Source	NEHTA

Relationships

Parents

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

11.44 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	

11.45 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	

11.46 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. 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	

11.47 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.* 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. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. "Normal". 2. "Critical". 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

11.48 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) 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	

11.49 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..*	

11.50 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	

11.51 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. 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 2. Final 3. Interim 4. Preliminary 5. Supplementary

Relationships

Parents

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

11.52 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	

11.53 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.* 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. 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. 2. Prostate tissue, left base. 3. Urine. 4. Sputum. 5. Scraping. 6. Catheter tip. 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	

11.54 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.* 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. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Venepuncture 2. Biopsy 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

11.55 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..*	

11.56 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~~	-

11.57 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	

11.58 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	

11.59 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. 2. Left. 3. Bilalteral.

Relationships

Parents

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

11.60 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	

11.61 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	

11.62 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..*	

11.63 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	

11.64 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	

11.65 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	

11.66 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	

11.67 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	

11.68 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	

11.69 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~~	-

11.70 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. 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.* 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. 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

11.71 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~~	-

11.72 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	

11.73 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	

11.74 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	

11.75 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~~	-

11.76 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. 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	

11.77 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	

11.78 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	

11.79 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.* 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. 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

11.80 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	

11.81 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. 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	

11.82 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	

11.83 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	

11.84 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.* 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. 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

11.85 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	

11.86 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	

12 Imaging Examination Result Data Group

12.1 Purpose

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

12.2 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.

12.3 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.

12.4 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 CT Computed Tomography Imaging Magnetic Resonance Imaging MRI Nuclear Medicine Imaging Radiology Scan Ultrasound Xray 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..*	
	Overall Result Status (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~~	-

12.5 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.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[1] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

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

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

12.6 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: • Available for request; or • 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. 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.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[2] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. X-ray. 2. CT scan. 3. MRI. 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	

12.7 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..*	

12.8 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~~	-

12.9 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	

12.10 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	

12.11 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. 2. Left. 3. Bilalteral.

Relationships

Parents

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

12.12 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	

12.13 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	

12.14 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..*	

12.15 Imaging Examination Result Status

Identification

Label	Overall 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.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[3] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. "Registered". No result yet available. 2. "Interim". This is an initial or interim result: data may be missing or verification not been performed. 3. "Final". The result is complete and verified by the responsible radiologist. 4. "Amended". The result has been modified subsequent to being Final, and is complete and verified by the radiologist. 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	

12.16 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	

12.17 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	

12.18 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	

12.19 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.* 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. 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

12.20 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
	Result Comment	0..*	

12.21 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.* 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. 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. 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

12.22 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 QuantityRange Quantity
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[6] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. 140. 2. ++. 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	

12.23 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	

12.24 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	

12.25 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. 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	

12.26 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.* 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. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. "Normal". 2. "Critical". 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

12.27 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	

12.28 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..*	

12.29 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..*	

12.30 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~~	-

12.31 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	

12.32 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	

12.33 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. 2. Left. 3. Bilalteral.

Relationships

Parents

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

12.34 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	

12.35 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	

12.36 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..*	

12.37 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	

12.38 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..*	

12.39 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..*	

12.40 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	

12.41 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. Unique system identifier that uniquely identifies a procedure or study report being created. It is recommended that the Report Instance Identifier value should be globally unique. The global uniqueness of the value of this Identifier may be achieved by: System ID (instance ID generated by System) + state identifier + organisation identifier If unique national healthcare provider organisation identifiers (e.g. HPI-O) are available, uniqueness of the value of this Identifier may be achieved by: System ID (instance ID generated by System) + HPI-O + Report Identifier 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	

12.42 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	

12.43 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. Example: X-ray skull AP and lateral views study produces two images each with a unique image identifier assigned by the system. 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. 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	

12.44 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	

12.45 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.* 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. 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

12.46 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	

12.47 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	

12.48 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	

12.49 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	

13 Requested Service (Action) Data Group

13.1 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.

13.2 Misuse

Use to specify medication prescriptions.

13.3 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. 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~~	-

13.4 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 Arranged Service Description
Context	For use in healthcare setting. 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.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[1] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Elective Orthopaedic surgery for TKR 2. Dialysis 3. Adjustment of heart failure/hypertensive medications 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	

13.5 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	

13.6 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	

13.7 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	

13.8 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 ARQ Appointment Request EVN Event INT Intent PRMS Promise PRP Proposal RQO Request

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Service Booking Status	1..1	

13.9 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	

13.10 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 Referred To

Usage

Conditions of Use	This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v]. The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in B: *Specification Guide for Use*. Additional obligation and occurrence constraints when the service provider is an individual (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON): • Participation Period is **PROHIBITED**. • LOCATION OF PARTICIPATION is **PROHIBITED**. • Entity Identifier is **ESSENTIAL**. • ADDRESS is **ESSENTIAL**. • Relationship to Subject of Care is **PROHIBITED**. • DEMOGRAPHIC DATA is **PROHIBITED**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**. Other additional constraints when the service provider is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON): • 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. • The value of one Entity Identifier **SHALL** be an Australian HPI-I. • AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON. Additional obligation and occurrence constraints when the service provider is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as a ORGANISATION): • Entity Identifier is **ESSENTIAL**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**. Other additional constraints when the service provider is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as a ORGANISATION): • Participation Type **SHALL** have an implementation-specific value equivalent to “Service Provider”. • Role **SHALL** have a value representing the type of Facility e.g. Hospital, Clinic. • The value of one Entity Identifier **SHALL** be an Australian HPI-O. • AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a ORGANISATION.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Requested Service (REQUESTED SERVICE)	0..1	

13.11 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. For supply of a service this is the date/time of completion of supply.
Data Type	DateTime

Usage

Examples	

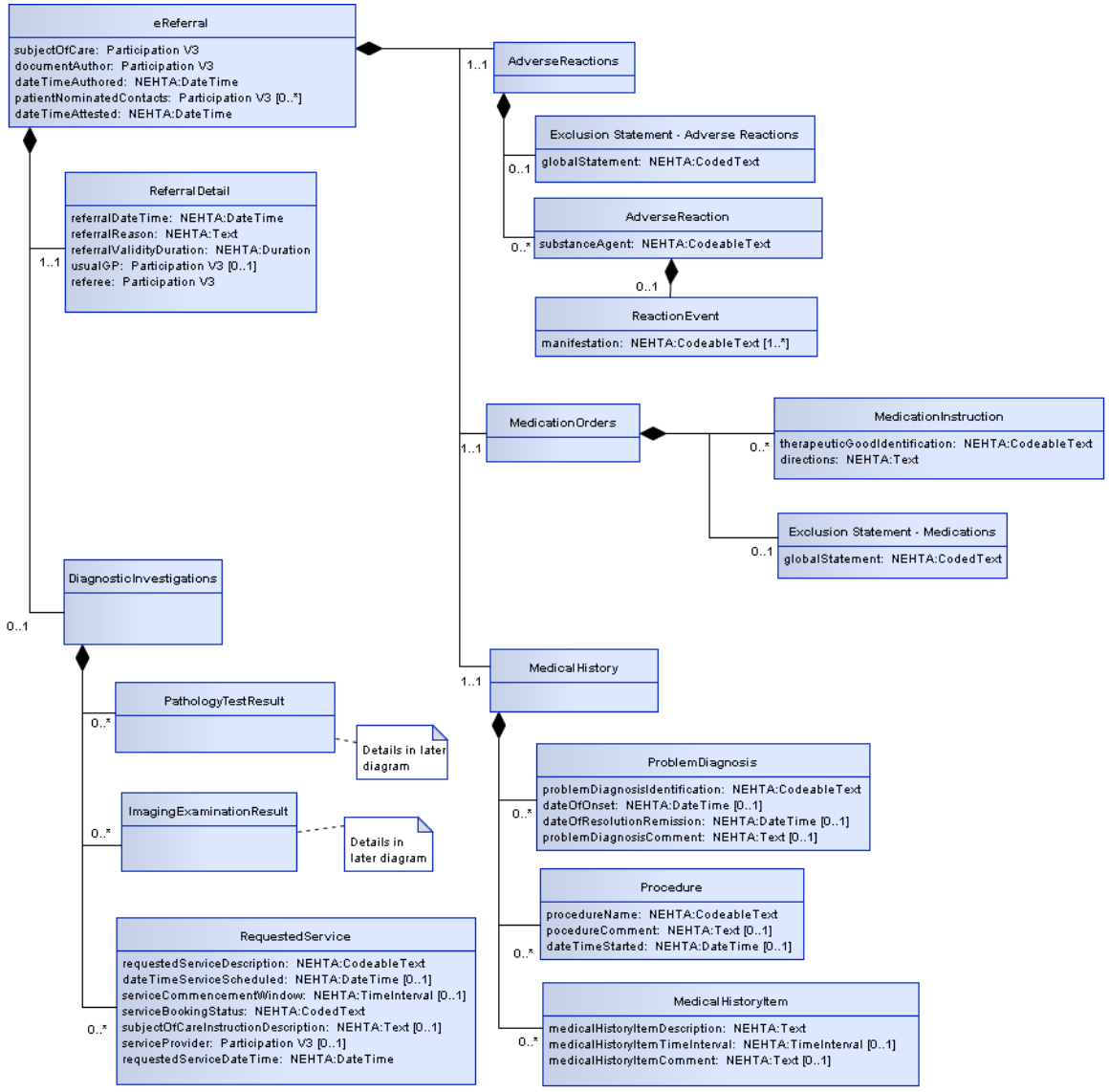
Relationships

Parents

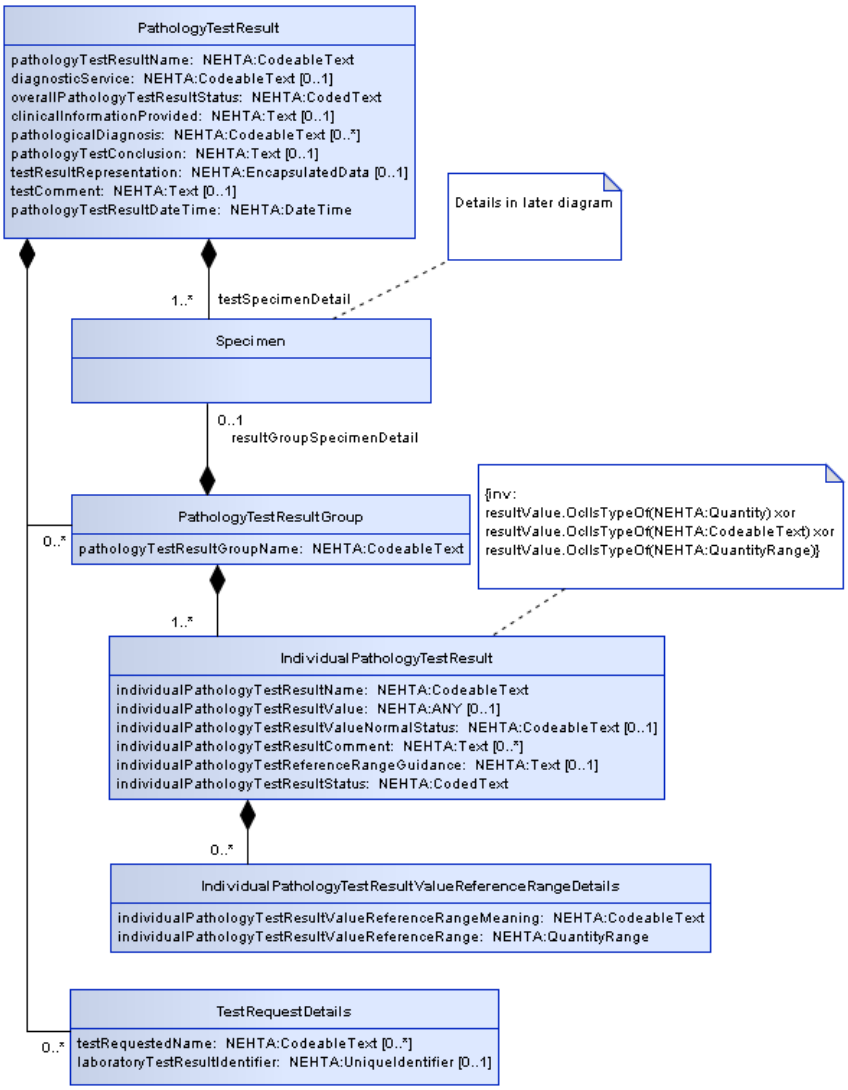
Data Type	Name	Occur-rences	Condi-tion
	Requested Service (REQUESTED SERVICE)	1..1	

14 UML Class Diagram

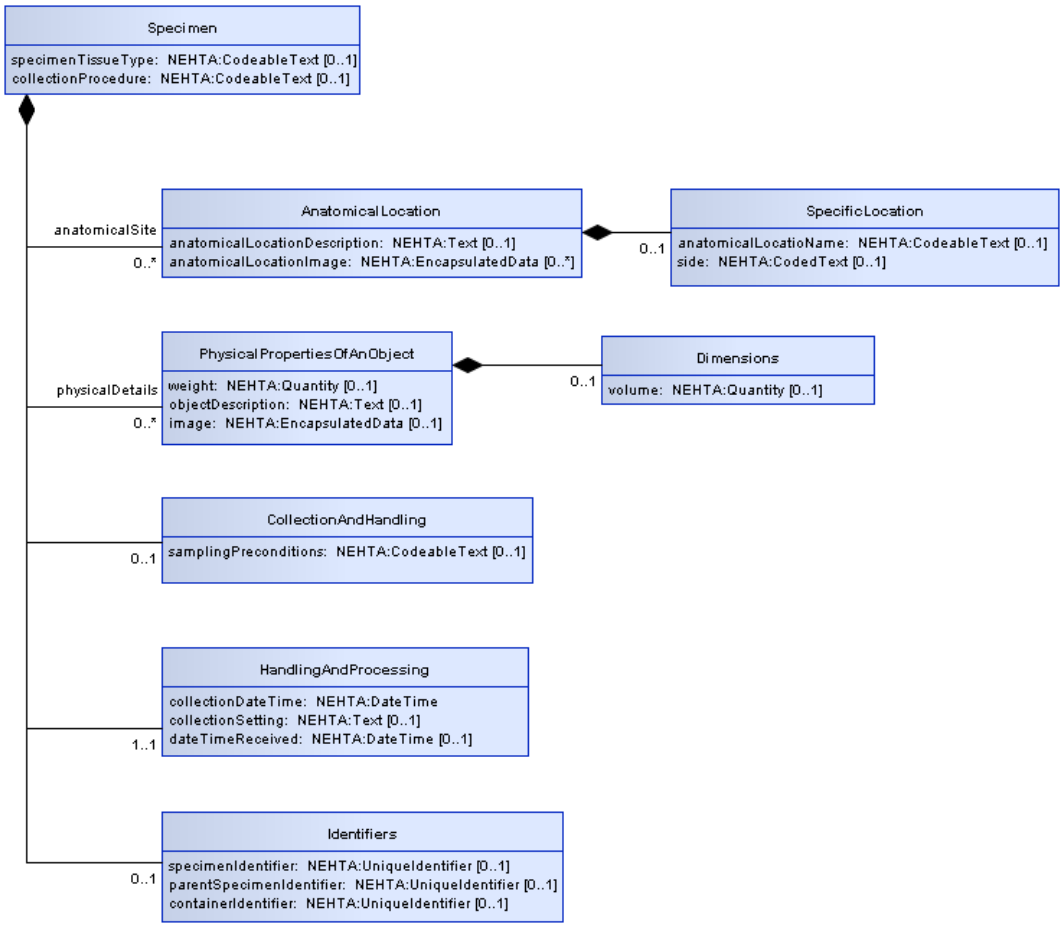
The following figure presents the data hierarchy using a UML 2.0 class diagram. The diagram displays data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes. Data groups are displayed as classes, their names are represented as 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.



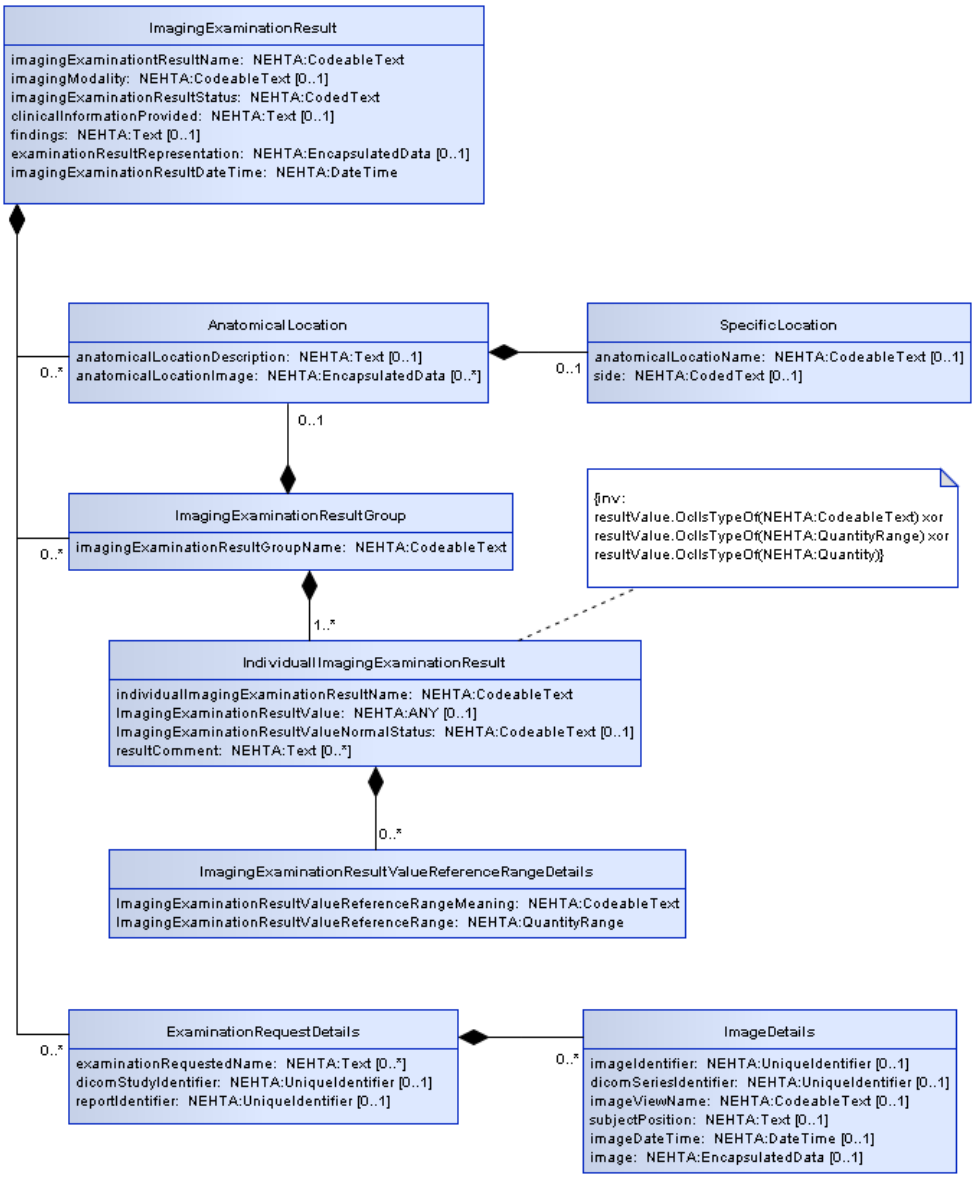
UML class diagram of the e-Referral data hierarchy.



UML class diagram of the Pathology Test Result for the e-Referral data hierarchy.



UML class diagram of the Specimen for the e-Referral data hierarchy.



UML class diagram of the Imaging Examination Result for the e-Referral data hierarchy.

Reference List

[DHA2011b] Australian Department of Health and AgeingNational E-Health Transition Authority Ltd, 9 September 2011, *Concept of Operations: Relating to the introduction of a Personally Controlled Electronic Health Record System*, Version 1.0. http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/PCEHRS-Intro-toc/$File/Concept%20of%20Operations%20-%20Final.pdf

[HL7CDAR2] Health Level Seven, Inc., January 2010, *HL7 Clinical Document Architecture*, Release 2, accessed 18 November 2010. http://www.hl7.org/implement/standards/cda.cfm

[NEHT2005a] National E-Health Transition Authority, 25 May 2005, *NEHTA Acronyms, Abbreviations & Glossary of Terms*, Version 1.2, accessed 09 November 2009. http://www.nehta.gov.au/component/docman/doc_download/8-clinical-information-glossary-v12

[NEHT2009r] National E-Health Transition Authority, 30 June 2009, *Australian Medicines Terminology Editorial Rules*, Version 3.0, accessed 9 June 2010. http://www.nehta.gov.au/component/docman/doc_download/742-australian-medicines-terminology-editorial-rules-v30

[NEHT2009s] National E-Health Transition Authority, 30 June 2009, *Pathology Result Report Structured Document Template*, Version 1.0, accessed 26 August 2010. http://www.nehta.gov.au/component/docman/doc_download/776-pathology-result-report-structured-document-template-v10-20090630

[NEHT2010c] National E-Health Transition Authority, September 2010, *Data Types in NEHTA Specifications: A Profile of the ISO 21090 Specification*, Version 1.0, accessed 13 September 2010. http://www.nehta.gov.au/component/docman/doc_download/1121-data-types-in-nehta-specifications-v10

[NEHT2011ad] National E-Health Transition Authority, 01 September 2011, *Miscellaneous Detailed Clinical Model Specification*, Version 1.0, accessed 01 September 2011. http://nehta.gov.au/component/docman/doc_download/1355-miscellaneous-detailed-clinical-model-specification-v10

[NEHT2011ag] National E-Health Transition Authority, To Be Published, *Miscellaneous Detailed Clinical Model Specification*, Version 1.1, accessed To Be Published.

[NEHT2011aq] National E-Health Transition Authority, To Be Published, *Miscellaneous Detailed Clinical Model Specification*, Version 1.2, accessed To Be Published.

[NEHT2011av] National E-Health Transition Authority, *e-Referral CDA Implementation Guide*, Version 2.1.

[NEHT2011aw] National E-Health Transition Authority, *e-Referral Structured Content Specification*, Version 2.1.

[NEHT2011ay] National E-Health Transition Authority, *Medication Instruction And Action Detailed Clinical Model Specification*, Version 2.1.

[NEHT2011az] National E-Health Transition Authority, *Problem Diagnosis Detailed Clinical Model Specification*, Version 3.1.

[NEHT2011ba] National E-Health Transition Authority, *Procedure Detailed Clinical Model Specification*, Version 3.1.

[NEHT2011bb] National E-Health Transition Authority, *Adverse Reaction Detailed Clinical Model Specification*, Version 3.1.

[NEHT2011bc] National E-Health Transition Authority, *Pathology Test Result Detailed Clinical Model Specification*, Version 2.1.

[NEHT2011bd] National E-Health Transition Authority, *Imaging Examination Result Detailed Clinical Model Specification*, Version 2.1.

[NEHT2011o] National E-Health Transition Authority, May 2011, *Data Specifications and Structured Document Templates - Guide for Use*, Version 1.2.

[NEHT2011v] National E-Health Transition Authority, 20 July 2011, *Participation Data Specification*, Version 3.2, accessed 22 July 2011.
http://www.nehta.gov.au/component/docman/doc_download/1341-participation-data-specification-v32

[RFC1521] Network Working Group, 1993, *RFC1521 - MIME (Multipurpose Internet Mail Extensions) Part One*, accessed 7 June 2010.
http://www.faqs.org/rfcs/rfc1521.html

[RFC2119] Network Working Group, 1997, *RFC2119 - Key words for use in RFCs to Indicate Requirement Levels*, accessed 13 April 2010.
http://www.faqs.org/rfcs/rfc2119.html

[SA2006a] Standards Australia, 2006, *AS 4846 (2006) – Healthcare Provider Identification*, accessed 12 November 2009.
http://infostore.saiglobal.com/store/Details.aspx?ProductID=318554

[SA2006b] Standards Australia, 2006, *AS 5017 (2006) – Healthcare Client Identification*, accessed 12 November 2009.
http://infostore.saiglobal.com/store/Details.aspx?ProductID=320426

[TGA1989a] Commonwealth of Australia, 1989, *THERAPEUTIC GOODS ACT 1989 - SECT 3*.
http://www.austlii.edu.au/au/legis/cth/consol_act/tga1989191/s3.html#therapeutic_goods

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).
PROCEDURE.Start DateTime	For a medical history this should be treated as End DateTime. In the future releases this item will may be mapped as a TimeInterval. This is to facilitate the recording of start date, End date or a Time Interval.
Links to External Resources	If a link (usually in references section) spans across several lines, certain PDF readers have problems to open it.
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.

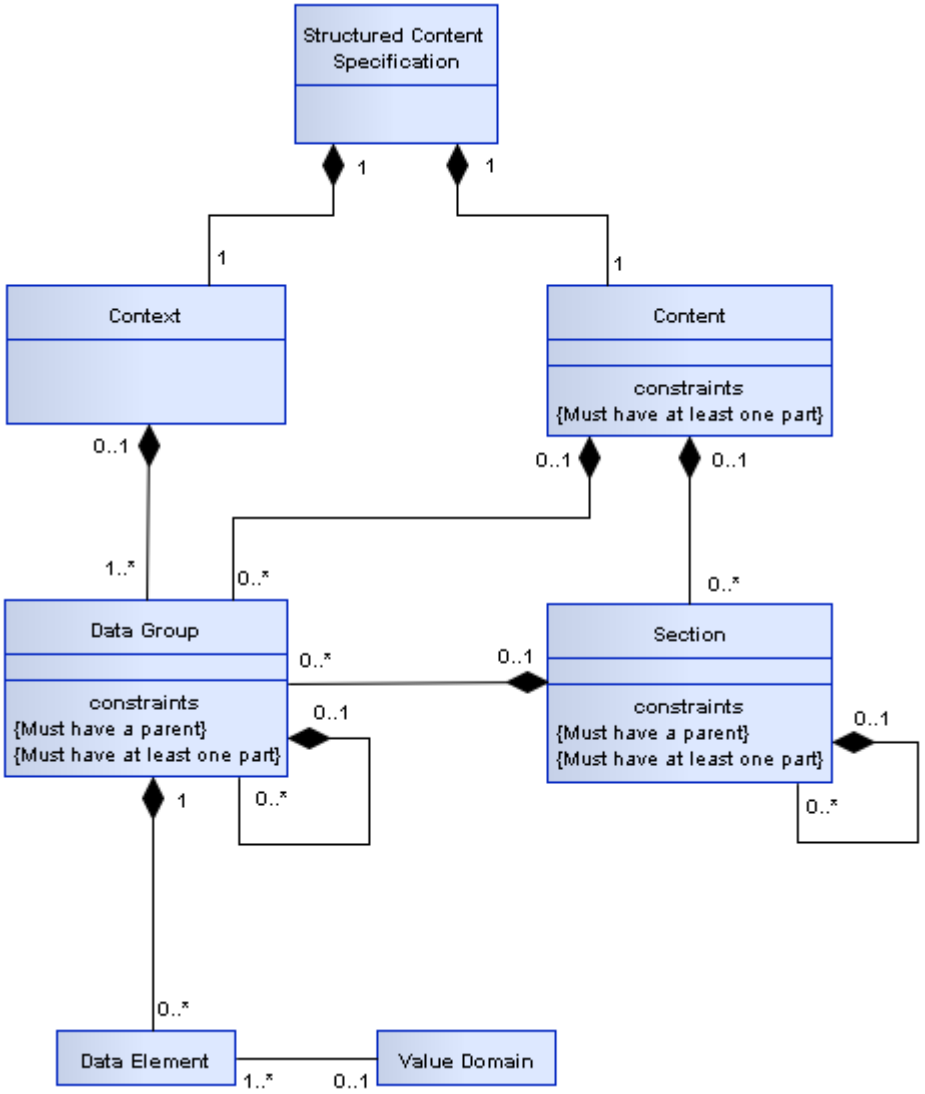


Figure 1: SCS Metamodel

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:
<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 (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*. **Usage/Examples** • An actual value entered by a user might be 'yes' or could be chosen by a mouse click on an icon such as ☑.

CodeableText

(ISO 21090: CD)

Coded text *with* exceptions; 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 (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. **Usage/Examples** • 3 hours • 6 months • 1 year
	Any (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 (ISO 21090: ED)	Data that is primarily intended for human interpretation or for further machine processing outside the scope of this specification. This includes unformatted or formatted written language, multimedia data, or structured information as defined by a different standard (e.g., XML signatures). **Usage/Examples** • JPEG images • HTML documents • [RFC1521] MIME types
	Integer (ISO 21090: INT)	The mathematical data type comprising the exact integral values (according to [NEHT2010c]). **Usage/Examples** • 1 • -50 • 125
	Link (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. **Usage/Examples** • URL (Uniform Resource Locator) – the World Wide Web address of a site on the internet, such as the URL for the Google internet search engine – *'http://www.google.com'*. • An absolute or relative path within a file/directory structure – e.g. in the Windows® operating system, the "link" or absolute path to a particular letter could be *C:\Documents and Settings\GuestUser\MyDocuments\letter.doc*

 Quantity (ISO 21090: PQ)	Used for recording many real world measurements and observations. Includes the magnitude value and the units. **Usage/Examples** • 100 centimetres • 25.5 grams
 QuantityRatio (ISO 21090: RTO)	The relative magnitudes of two *Quantity* values (usually expressed as a quotient). **Usage/Examples** • 25 mg/500 ml • 200 mmol per litre
 QuantityRange (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. **Usage/Examples** • -20 to 100 Celsius • 30-50 mg • >10 kg
 RealNumber (ISO 21090: REAL)	A computational approximation to the standard mathematical concept of real numbers. These are often called floating point numbers. **Usage/Examples** • 1.075 • -325.1 • 3.14157
 Text (ISO 21090: ST)	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. **Usage/Examples** “The patient is a 37 year old man who was referred for cardiac evaluation after complaining of occasional palpitations, racing heart beats and occasional dizziness.”
 TimeInterval (ISO 21090:TS)	An interval in time, with (optionally) a start date/time and (optionally) an end date/time and/or a duration/width. **Usage/Examples** • 01/01/2008 – 31/12/2008 • 1:30 a.m. – 6:00 p.m., duration/width = 16.5 hours

	UniqueIdentifier (ISO 21090: II)	A general unique value to identify a physical or virtual object or concept. In using this data type, the attributes of the UniqueIdentifier data type **SHOULD** be populated from the identifiers as defined in AS 4846 (2006) [SA2006a] and AS 5017 (2006) [SA2006b] as follows: *root*: a globally unique object identifier that identifies the combination of geographic area, issuer and type. If no such globally unique object identifier exists, it **SHALL** be created. *extension*: a unique identifier within the scope of the root that is directly equivalent to the identifier designation element. *identifierName*: a human readable name for the namespace represented by the root that is populated with the issuer or identifier type values, or a concatenation of both as appropriate. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used as such. *identifierScope*: the geographic span or coverage that applies to or constrains the identifier. It is directly equivalent to the geographic area element. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used as such. Also, the following constraints apply on the UniqueIdentifier data type: The *root* attribute **SHALL** be used. 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. For an entity identifier the *root* attribute **SHALL NOT** be a UUID. The *extension* attribute **SHALL** be used. **Usage/Examples** 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. **Usage/Examples:** 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. **Usage/Examples:** 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. **Usage/Examples:** 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. When a condition is met, the data component is considered to be essential and **SHALL** be populated. When a condition is not met, the data component may be considered as Prohibited, or the data component may be considered Optional. **Usage/Examples:** Within a Pathology Result Report, the *Specimen Detail* data group is Essential if the requested test is to be performed on a specimen, otherwise it **SHALL NOT** be 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.) 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.) 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. For example, Medication Instruction (data group) has a scope which includes all prescribable therapeutic goods, both medicines and non-medicines. 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. 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. 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. In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the HL7 code set registration procedure with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. (Source NEHTA.) 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.) 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. Implementation guides **MAY** contain specific examples for how data elements **SHALL** be populated and how they relate to each other. 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 xref NEHTA e-Referral Structured Content Specification [NEHT2011aw] 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		SUBJECT OF CARE
	Person Identifier	SUBJECT OF CARE.PARTICIPANT.Entity Identifier
	Person Name	SUBJECT OF CARE.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.PERSON NAME
	Date of Birth	SUBJECT OF CARE.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.DEMOGRAPHIC DATA.DATE OF BIRTH DETAIL
	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
	Indigenous Status	SUBJECT OF CARE.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.DEMOGRAPHIC DATA.Indigenous Status
Benefits Card Details		SUBJECT OF CARE.PARTICIPANT.ENTITLEMENT
	Benefits Card Detail	SUBJECT OF CARE.PARTICIPANT.ENTITLEMENT
	Benefit Type	SUBJECT OF CARE.PARTICIPANT.ENTITLEMENT.Entitlement Type
	Benefit Number	SUBJECT OF CARE.PARTICIPANT.ENTITLEMENT.Entitlement Number
Patient's Nominated Contacts		PATIENT NOMINATED CONTACTS
	Name	PATIENT NOMINATED CONTACTS.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.PERSON NAME
	Address	PATIENT NOMINATED CONTACTS.PARTICIPANT.Address
	Communication Details	PATIENT NOMINATED CONTACTS.PARTICIPANT.ELECTRONIC COMMUNICATION DETAIL
	Relationship to Patient	PATIENT NOMINATED CONTACTS.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.Relationship to Subject of Care
Referrer		DOCUMENT AUTHOR

Requirement Section	Data Item	SCS Data Element
	Person Identifier	DOCUMENT AUTHOR.PARTICIPANT.Entity Identifier
	Person Name	DOCUMENT AUTHOR.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.PERSON NAME
	Healthcare Role	DOCUMENT AUTHOR.PARTICIPANT.Role
	Organisation Identifier	DOCUMENT AUTHOR.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.EMPLOYMENT DETAIL.EMPLOYER ORGANISATION.Entity Identifier
	Organisation Name	DOCUMENT AUTHOR.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.EMPLOYMENT DETAIL.EMPLOYER ORGANISATION.Organisation Name
	Address	DOCUMENT AUTHOR.PARTICIPANT.Address
	Communication Details	DOCUMENT AUTHOR.PARTICIPANT.ELECTRONIC COMMUNICATION DETAIL
Usual GP		REFERRAL DETAIL.USUAL GP
	Person Identifier	REFERRAL DETAIL.USUAL GP.PARTICIPANT.Entity Identifier
	Person Name	REFERRAL DETAIL.USUAL GP.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.PERSON NAME
	Healthcare Role	REFERRAL DETAIL.USUAL GP.PARTICIPANT.Role
	Organisation Identifier	*When Usual GP is a Person* REFERRAL DETAIL.USUAL GP.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.EMPLOYMENT DETAIL.EMPLOYER ORGANISATION.Entity Identifier
		When Usual GP is an Organisation REFERRAL DETAIL.USUAL GP.PARTICIPANT.Entity Identifier
	Organisation Name	*When Usual GP is a Person* REFERRAL DETAIL.USUAL GP.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.EMPLOYMENT DETAIL.EMPLOYER ORGANISATION.Organisation Name
		When Usual GP is an Organisation REFERRAL DETAIL.USUAL GP.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.ORGANISATION.Organisation Name
	Communication Details	REFERRAL DETAIL.USUAL GP.PARTICIPANT.ELECTRONIC COMMUNICATION DETAIL
Referee		REFERRAL DETAIL.REFEREE
	Organisation Identifier	*When Referee is a Person* REFERRAL DETAIL.REFEREE.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.EMPLOYMENT DETAIL.EMPLOYER ORGANISATION.Entity Identifier
		When Referee is an Organisation REFERRAL DETAIL.REFEREE.PARTICIPANT.Entity Identifier
	Organisation Name	*When Referee is a Person* REFERRAL DETAIL.REFEREE.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.EMPLOYMENT DETAIL.EMPLOYER ORGANISATION.Organisation Name

Requirement Section	Data Item	SCS Data Element
		When Referee is an Organisation REFERRAL DETAIL.REFEREE.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.ORGANISATION.Organisation Name
	Person Identifier	REFERRAL DETAIL.REFEREE.PARTICIPANT.Entity Identifier
	Person Name	REFERRAL DETAIL.REFEREE.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.PERSON NAME
	Specialty	REFERRAL DETAIL.REFEREE.PARTICIPANT.Role
	Address	REFERRAL DETAIL.REFEREE.PARTICIPANT.Address
	Communication Details	REFERRAL DETAIL.REFEREE.PARTICIPANT.ELECTRONIC COMMUNICATION DETAIL
Referral Details		REFERRAL DETAIL
	Date of Referral	REFERRAL DETAIL.Referral DateTime
	Reason For Referral	REFERRAL DETAIL.Referral Reason
	Referral Validity Duration	REFERRAL DETAIL.Referral Validity Duration
Current and Past Medical History (Section)		MEDICAL HISTORY
	Current and Past Medical History (Group)	MEDICAL HISTORY
	Medical History Description	MEDICAL HISTORY.PROBLEM/DIAGNOSIS.Problem/Diagnosis (Problem/Diagnosis Identification)
		MEDICAL HISTORY.Procedure (PROCEDURE).Procedure Name
		MEDICAL HISTORY.Other Medical History Item (MEDICAL HISTORY ITEM).Medical History Item Description
	Medical History Comments	MEDICAL HISTORY.PROBLEM/DIAGNOSIS.Comment (Problem/Diagnosis Comment)
		MEDICAL HISTORY.Procedure (PROCEDURE).Comment (Procedure Comment)
		MEDICAL HISTORY.Other Medical History Item (MEDICAL HISTORY ITEM).Medical History Item Comment
	Medical History DateTime Range	MEDICAL HISTORY.PROBLEM/DIAGNOSIS.Date of Onset
		MEDICAL HISTORY.PROBLEM/DIAGNOSIS.Date of Resolution/Remission
		MEDICAL HISTORY.Procedure (PROCEDURE).DateTime Started
		MEDICAL HISTORY.Other Medical History Item (MEDICAL HISTORY ITEM).Medical History Item Timeinterval
Current Medications		Medications (MEDICATION ORDERS)

Requirement Section	Data Item	SCS Data Element
	Current Medications Exclusion Statement	Medications (MEDICATION ORDERS).EXCLUSION STATEMENT - MEDICATIONS.Global Statement
	Current Medication	Medications (MEDICATION ORDERS).Medication (MEDICATION INSTRUCTION)
	Item Description	Medications (MEDICATION ORDERS).Medication (MEDICATION INSTRUCTION).Medicne (Therapeutic Good Identification)
	Dose Instructions	Medications (MEDICATION ORDERS).Medication (MEDICATION INSTRUCTION).Directions
Allergies / Adverse Reactions		ADVERSE REACTIONS
	Allergies / Adverse Reactions Exclusion Statement	ADVERSE REACTIONS.EXCLUSION STATEMENT - ADVERSE REACTIONS.Global Statement
	Allergies / Adverse reaction	ADVERSE REACTIONS.ADVERSE REACTION
	Agent Description	ADVERSE REACTIONS.ADVERSE REACTION.Substance/Agent
	Reaction Description	ADVERSE REACTIONS.ADVERSE REACTION.REACTION EVENT.Manifestation
Diagnostic Investigations		DIAGNOSTIC INVESTIGATIONS
	Diagnostic Investigation	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	DIAGNOSTIC INVESTIGATIONS.PATHOLOGY TEST RESULT.Test Result Name (Pathology Test Result Name)
		DIAGNOSTIC INVESTIGATIONS.IMAGING EXAMINATION RESULT.Examination Result Name (Imaging Examination Result Name)
	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

Requirement Section	Data Item	SCS Data Element
		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.
		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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