nehta

Event Summary
Structured Content Specification
Version 1.2

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Approved for external use

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Document Information

Key information

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Product version history

Product version	Date	Release comments
1.0	31 Oct 2011	Initial draft.
1.1	30 Nov 2011	Final specification for submission to the Standards Australia process.
1.2	10 Apr 2015	This version implements changes authorised in September 2014 (by CCB-0345).

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
Interoperability Framework	Version 2.0, Issued 17 August 2007
Pathology Test Result Detailed Clinical Model Specification	Version 3.1, To be published
Imaging Examination Result Detailed Clinical Model Specification	Version 3.1, To be published
Adverse Reaction Detailed Clinical Model Specification	Version 3.2, To be published
Medication Instruction and Action Detailed Clinical Model Specification	Version 2.3, To be published
Miscellaneous Detailed Clinical Model Specification	Version 1.4, To be published
Medical History Detailed Clinical Model Specification	Version 1.0, To be published
Reason for Encounter Data Specification	Version 2.0
Event Summary Information Requirements	Version 1.2, Issued 10 April 2015

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Table of Contents

1 Introduction

This document is a Structured Content Specification (SCS) for an Event Summary.

Appendix C, *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. 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 *help@nehta.gov.au*.

1.1 Document Purpose

This document describes the structured content of Event Summary documents that are added to the personally controlled electronic health record (PCEHR) system.

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 Event Summaries.

It is also a key input to the *NEHTA Event Summary CDA® Implementation Guide [NEHT2015f]*, which describes how to implement NEHTA-compliant Event Summaries 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 an Event Summary 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.

This document is not to be used as a guide to presentation (or rendering) of the data. It contains no information as to how the data described by it should be displayed and no such information should be inferred.

1.4 Known Issues

Known issues with this document are described in Appendix B, *Known Issues*.

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2 Event Summary Structured Document

2.1 Purpose

To record information about significant health care events when there is no existing communication exchange (such as a shared health summary, discharge summary or specialist letter), at the discretion of the clinician, with the consent of the individual.

2.2 Use

May be used in conjunction with the assessment and treatment of itinerant patients where the healthcare provider is not (and is unlikely to become) the patient's usual provider, to record significant health care events or information relevant to the patient's ongoing care, for use in the PCEHR and related applications.

2.3 EVENT SUMMARY

Identification

Label	EVENT SUMMARY
Metadata Type	Structured Document
Identifier	SD-16473
OID	1.2.36.1.2001.1001.101.100.16473

Definition

Definition	A record, reported by a clinician, of one significant health care event involving the subject of care.
Definition Source	NEHTA
Synonymous Names	

Data Hierarchy

Note

Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. It is typically expected that such identifiers will be generated internally by systems and not displayed to users since they usually have no clinical significance.

Items below whose background is grey and whose text is struck through are data components that are included in the relevant Detailed Clinical Model Specification, but whose use is prohibited in this particular scenario.

	EVENT SUMMARY			
CONTEXT				
		SUBJECT OF CARE		1..1
		DOCUMENT AUTHOR		1..1
		ENCOUNTER		1..1
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			DateTime Health Event Ended	1..1
			~~HEALTHCARE FACILITY~~	~~0..0~~
		Document Instance Identifier		1..1
		~~RELATED INFORMATION~~		~~0..0~~

		Document Type			1..1
		DateTime Attested			1..1
CONTENT					
		Event Details (EVENT OVERVIEW)			0..1
			Event Details (CLINICAL SYNOPSIS)		1..1
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				Clinical Synopsis Description	1..1
				~~DateTime Recorded~~	~~0..0~~
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				~~SUBJECT~~	~~0..0~~
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				Detailed Clinical Model Identifier	1..1
			Event Overview Instance Identifier		0..1
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				~~Adverse Reaction Comment~~	~~0..0~~
				REACTION EVENT	0..1
					~~Specific Substance/Agent~~ ~~0..0~~
					Manifestation 1..*
					Reaction Type 0..1

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					~~Duration of Reaction~~	~~0..0~~
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					~~Duration of Exposure~~	~~0..0~~
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					~~Reporting Details~~	~~0..0~~
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				~~Reaction Reported~~		~~0..0~~
				~~Adverse Reaction Report~~		~~0..0~~
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				Detailed Clinical Model Identifier		1..1
			Adverse Reactions Instance Identifier			0..1
			~~RELATED INFORMATION~~			~~0..0~~
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				Therapeutic Good Identification	1..1
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				Directions	1..1
				~~Formula~~	~~0..0~~
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				~~Dose Description~~	~~0..0~~
				~~Structured Dose (AMOUNT OF MEDICATION)~~	~~0..0~~
				~~Timing (MEDICATION TIMING)~~	~~0..0~~
				~~Additional Instruction~~	~~0..0~~
				Clinical Indication	0..1
				~~Administration Details (MEDICATION ADMINISTRATION)~~	~~0..0~~
				Medication Instruction Comment	0..1
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				Change Type	1..1
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				Change Description	0..1
				Change or Recommendation Reason	0..1
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			Medication Orders Instance Identifier		0..1
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				Problem/Diagnosis Identification	1..1
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				~~Age at Resolution/Remission~~	~~0..0~~
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			Medical History Instance Identifier		0..1
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		IMMUNISATIONS			0..1
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				~~Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)~~	~~0..0~~
				~~Reason for Action~~	~~0..0~~
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				~~Expiry Date~~	~~0..0~~

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				Detailed Clinical Model Identifier		1..1
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		DIAGNOSTIC INVESTIGATIONS				0..1
			PATHOLOGY TEST RESULT			0..*
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				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
						Anatomical Location Name	0..1
						Side	0..1
						~~Numerical Identifier~~	~~0..0~~
						~~Anatomical Plane~~	~~0..0~~
					~~RELATIVE LOCATION~~		~~0..0~~
					Anatomical Location Description		0..1
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					DIMENSIONS		0..1
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						~~Circumference~~	~~0..0~~
						~~Length~~	~~0..0~~
						~~Breadth~~	~~0..0~~
						~~Depth~~	~~0..0~~
						~~Area~~	~~0..0~~
						Volume	0..1
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					~~NEEDLE BIOPSY CORE DETAILS~~		~~0..0~~
					COLLECTION AND HANDLING		0..1

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						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~~
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						Collection Setting	0..1
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						Parent Specimen Identifier	0..1
						Container Identifier	0..1
						~~Specimen Collector Identifier~~	~~0..0~~
						~~SPECIMEN COLLECTOR DETAILS~~	~~0..0~~
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				Clinical Information Provided			0..1
				Result Group (PATHOLOGY TEST RESULT GROUP)			0..*
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					Result (INDIVIDUAL PATHOLOGY TEST RESULT)		1..*
						Individual Pathology Test Result Name	1..1

						Result Value (INDIVIDUAL PATHOLOGY TEST RESULT VALUE)				0..1
							Individual Pathology Test Result Value			1..1
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									Reference Range	1..1
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						Individual Pathology Test Result Reference Range Guidance				0..1
						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
								Anatomical Location Name		0..1
								Side		0..1
								~~Numerical Identifier~~		~~0..0~~
								~~Anatomical Plane~~		~~0..0~~
							~~RELATIVE LOCATION~~			~~0..0~~
							Anatomical Location Description			0..1
							~~Visual Markings/Orientation~~			~~0..0~~
							Anatomical Location Image			0..*
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							~~Name (Physical Object Name)~~	~~0..0~~
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							DIMENSIONS	0..1
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							~~Breadth~~	~~0..0~~
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							~~Area~~	~~0..0~~
							Volume	0..1
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							Image	0..1
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						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~~
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							Collection Setting	0..1
							Date and Time of Receipt (DateTime Received)	0..1

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							Parent Specimen Identifier	0..1
							Container Identifier	0..1
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							~~SPECIMEN COLLECTOR DETAILS~~	~~0..0~~
					Pathological Diagnosis			0..*
					Conclusion (Pathology Test Conclusion)			0..1
					Test Result Representation			0..1
					Test Comment			0..1
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					Pathology Test Result Instance Identifier			0..1

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				SPECIFIC LOCATION		0..1
					Anatomical Location Name	0..1
					Side	0..1
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				Anatomical Location Description		0..1
				~~Visual Markings/Orientation~~		~~0..0~~
				Anatomical Location Image		0..*
			~~Anatomical Region~~			~~0..0~~
			Imaging Examination Result Status			1..1
			Clinical Information Provided			0..1
			Findings			0..1
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					Individual Imaging Examination Result Name	1..1
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				Requested Service Description		1..1

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				Subject of Care Instruction Description	0..1
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			~~RELATED INFORMATION~~		~~0..0~~
			Section Type		1..1

2.4 SUBJECT OF CARE

Identification

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

Definition

Definition	Person who receives healthcare services.
Definition Source	NEHTA
Synonymous Names	Patient Individual
Scope	The person who is the focus of this document.
Scope Source	NEHTA

Usage

Conditions of Use	This is a reuse of the *PARTICIPATION* `data group`, which is described in *Participation Data Specification [NEHT2011v]*. Further constraints on this data group that apply to this reuse of it are listed below. Obligation and occurrence constraints: • Participation Period is **PROHIBITED**. • LOCATION OF PARTICIPATION is **PROHIBITED**. • Entity Identifier is **ESSENTIAL**. • ADDRESS 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**. • Qualifications is **PROHIBITED**. Other 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. • ADDRESS **SHALL** have an Address Purpose value of “Residential” or “Temporary Accommodation”. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON. Terms used in obligation and occurrence constraints are explained in Appendix C, *Specification Guide for Use*.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EVENT SUMMARY	1..1

2.5 DOCUMENT AUTHOR

Identification

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

Definition

Definition	Composer of the document.
Definition Source	NEHTA
Synonymous Names	Author
Scope	The healthcare provider who has attended to the subject of care and decides to upload their *Event Summary*.
Scope Source	NEHTA
Notes	The date, or date and time, that the authoring of the document was completed is recorded in the *Participation Period* of the *Author*.

Usage

Conditions of Use

This is a reuse of the *PARTICIPATION* `data group`, which is described in *Participation Data Specification [NEHT2011v]*. Further constraints on this data group that apply to this reuse of it are listed below.

Obligation and occurrence constraints:

- Participation Period is **ESSENTIAL**.
- LOCATION OF PARTICIPATION is **PROHIBITED**.
- Entity Identifier is **ESSENTIAL**.
- Relationship to Subject of Care is **PROHIBITED**.
- EMPLOYMENT DETAIL is **ESSENTIAL**.
- EMPLOYER ORGANISATION is **ESSENTIAL**.
- EMPLOYER ORGANISATION.Entity Identifier is **ESSENTIAL**.
- EMPLOYER ORGANISATION.ADDRESS is **ESSENTIAL**.
- EMPLOYER ORGANISATION.ELECTRONIC COMMUNICATION DETAIL is **ESSENTIAL**.
- DEMOGRAPHIC DATA is **PROHIBITED**.

Other constraints:

- Participation Type **SHALL** have an implementation-specific value equivalent to “Document Author”.

	• Role **SHOULD** have a value chosen from *1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 [ABS2009]*. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7® and is publicly available **MAY** be used. • The value of one Entity Identifier **SHALL** be an Australian HPI-I. • The value of ADDRESS.Address Purpose **SHALL** be “B” (Business). • The value of ELECTRONIC COMMUNICATION DETAIL.Electronic Communication Usage Code **SHALL** be “B” (Business). • 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. Terms used in obligation and occurrence constraints are explained in Appendix C, *Specification Guide for Use*.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EVENT SUMMARY	1..1

2.6 ENCOUNTER

Identification

Label	ENCOUNTER
Metadata Type	Data Group
Identifier	DG-16057
OID	1.2.36.1.2001.1001.101.102.16057

Definition

Definition	Encounter between a subject of care and a health system.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EVENT SUMMARY	1..1

Children

Data Type	Name	Occurrences
	DateTime Health Event Started	0..1
	DateTime Health Event Ended	1..1
	~~HEALTHCARE FACILITY~~	~~0..0~~

2.7 DateTime Health Event Started

Identification

Label	DateTime Health Event Started
Metadata Type	Data Element
Identifier	DE-15507
OID	1.2.36.1.2001.1001.101.103.15507

Definition

Definition	The date or date and time that the health event to which the *Event Summary* document relates was started.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for DateTime.

Relationships

Parents

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

2.8 DateTime Health Event Ended

Identification

Label	DateTime Health Event Ended
Metadata Type	Data Element
Identifier	DE-15510
OID	1.2.36.1.2001.1001.101.103.15510

Definition

Definition	The date or date and time that the health event to which the *Event Summary* document relates was completed.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for DateTime.

Relationships

Parents

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

2.9 Document Instance Identifier

Identification

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

Definition

Definition	A globally unique identifier for each instance of an *Event Summary* document.
Definition Source	NEHTA
Synonymous Names	
Context	A document can have multiple instances as it passes through its life cycle of creation, revisions before it is first sent, and revised versions thereafter. The value of this `data element` enables systems to identify all instances of a document uniquely, thus enabling efficient storage, query and audit trail of information about a subject of care.
Context Source	NEHTA
Notes	This `data element` is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EVENT SUMMARY	1..1

2.10 Document Type

Identification

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

Definition

Definition	Type of document.
Definition Source	NEHTA
Synonymous Names	
Notes	A document's type is identified by a unique identifier, not by a name.
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system, for example LOINC.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.100.16473

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EVENT SUMMARY	1..1

2.11 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 that the document author or document authoriser or approver confirms 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
Notes	Confirmation that a document is complete and genuine is usually by signature.
Data Type	DateTime

Usage

Conditions of Use	DateTime Attested **SHALL** include a date and a time component.
Conditions of Use Source	NEHTA
Examples	Please see DateTime in Appendix C, *Specification Guide for Use* for examples and usage information on specifying a date or time (or both).

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EVENT SUMMARY	1..1

2.12 EVENT OVERVIEW

Identification

Label	Event Details
Metadata Type	Section
Identifier	S-16672
OID	1.2.36.1.2001.1001.101.101.16672

Definition

Definition	Summary information concerning the event.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Event Details (CLINICAL SYNOPSIS)	1..1
	Event Overview Instance Identifier	0..1
	~~RELATED INFORMATION~~	~~0..0~~
	Section Type	1..1

2.13 Event Overview Instance Identifier

Identification

Label	Event Overview Instance Identifier
Metadata Type	Data Element
Identifier	DE-17010
OID	1.2.36.1.2001.1001.101.103.17010

Definition

Definition	A globally unique identifier for each instance of an *Event Overview* section.
Definition Source	NEHTA
Synonymous Names	
Notes	This `data element` is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Event Details (EVENT OVERVIEW)	0..1

2.14 Section Type

Identification

Label	Section Type
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition

Definition	Type of section.
Definition Source	NEHTA
Synonymous Names	
Notes	A section's type is identified by a unique identifier, not by a name.
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.101.16672

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Event Details (EVENT OVERVIEW)	1..1

2.15 ADVERSE REACTIONS

Identification

Label	Newly Identified Adverse Reactions
Metadata Type	Section
Identifier	S-20113
OID	1.2.36.1.2001.1001.101.101.20113

Definition

Definition	Information about adverse reactions of the patient (including allergies and intolerances), and any relevant reaction details. This includes statements about adverse reactions that need to be positively recorded as absent or excluded.
Definition Source	NEHTA
Synonymous Names	
Scope	Includes adverse reactions that the author became aware of during the health event.
Scope Source	NEHTA

Usage

Misuse	Use to record adverse reactions that are already included in the subject of care's medical record.

Relationships

Parents

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

Children

Data Type	Name	Occurrences
	~~EXCLUSION STATEMENT - ADVERSE REACTIONS~~	~~0..0~~
	ADVERSE REACTION	1..*
	Adverse Reactions Instance Identifier	0..1
	~~RELATED INFORMATION~~	~~0..0~~

Data Type	Name	Occurrences
	Section Type	1..1

2.16 Adverse Reactions Instance Identifier

Identification

Label	Adverse Reactions Instance Identifier
Metadata Type	Data Element
Identifier	DE-16963
OID	1.2.36.1.2001.1001.101.103.16963

Definition

Definition	A globally unique identifier for each instance of an *Adverse Reactions* section.
Definition Source	NEHTA
Synonymous Names	
Notes	This `data element` is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Newly Identified Adverse Reactions (ADVERSE REACTIONS)	0..1

2.17 Section Type

Identification

Label	Section Type
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition

Definition	Type of section.
Definition Source	NEHTA
Synonymous Names	
Notes	A section's type is identified by a unique identifier, not by a name.
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.101.20113

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Newly Identified Adverse Reactions (ADVERSE REACTIONS)	1..1

2.18 MEDICATION ORDERS

Identification

Label	Medications
Metadata Type	Section
Identifier	S-16146
OID	1.2.36.1.2001.1001.101.101.16146

Definition

Definition	Medicines that the subject of care is using.
Definition Source	NEHTA
Synonymous Names	
Scope	Medicines includes prescribed and over-the-counter medicines.
Scope Source	NEHTA
Notes	Inclusion of medicines will be at the discretion of the clinician; it is likely that medicines that are considered relevant to the event will be included.

Relationships

Parents

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

Children

Data Type	Name	Occurrences
	~~EXCLUSION STATEMENT - MEDICATIONS~~	~~0..0~~
	Known Medication (MEDICATION INSTRUCTION)	1..*
	Medication Orders Instance Identifier	0..1
	~~RELATED INFORMATION~~	~~0..0~~
	Section Type	1..1

2.19 Medication Orders Instance Identifier

Identification

Label	Medication Orders Instance Identifier
Metadata Type	Data Element
Identifier	DE-16964
OID	1.2.36.1.2001.1001.101.103.16964

Definition

Definition	A globally unique identifier for each instance of a *Medication Orders* section.
Definition Source	NEHTA
Synonymous Names	
Notes	This `data element` is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

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

2.20 Section Type

Identification

Label	Section Type
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition

Definition	Type of section.
Definition Source	NEHTA
Synonymous Names	
Notes	A section's type is identified by a unique identifier, not by a name.
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.101.16146

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Medications (MEDICATION ORDERS)	1..1

2.21 MEDICAL HISTORY

Identification

Label	Diagnoses/Interventions
Metadata Type	Section
Identifier	S-16117
OID	1.2.36.1.2001.1001.101.101.16117

Definition

Definition	Information about the subject of care's problems, diagnoses and medical or surgical procedures.
Definition Source	NEHTA
Synonymous Names	
Assumptions	Every entry in a person's medical history is either a procedure or a problem/diagnosis.
Assumptions Source	NEHTA
Notes	A *Medical History* `section` is allowed to contain *Procedure*, *Problem/Diagnosis*, and *Uncategorised Medical History Item* `data group`s. Having both categorised items (*Procedure* and *Problem/Diagnosis*) and uncategorised items (*Uncategorised Medical History Item*) would be unusual, because generally if a system is able to differentiate some items, it is able to differentiate them all. However a system may be able to categorise some, and not others – possibly because of legacy data, or partial classification in the underlying terminology. For this reason, the rules allow a mix of categorised and uncategorised items.

Usage

Conditions of Use	Each instance of this section **SHALL** contain at least one instance of: • PROBLEM/DIAGNOSIS, or • PROCEDURE, or • UNCATEGORISED MEDICAL HISTORY ITEM.
Conditions of Use Source	NEHTA
Misuse	Use to record vaccine administration record of the subject of care. The *Immunisations* section is used for this purpose.

Relationships

Parents

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

Children

Data Type	Name	Occurrences
	PROBLEM/DIAGNOSIS	0..*
	~~EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES~~	~~0..0~~
	PROCEDURE	0..*
	~~EXCLUSION STATEMENT - PROCEDURES~~	~~0..0~~
	UNCATEGORISED MEDICAL HISTORY ITEM	0..*
	Medical History Instance Identifier	0..1
	~~RELATED INFORMATION~~	~~0..0~~
	Section Type	1..1

2.22 Medical History Instance Identifier

Identification

Label	Medical History Instance Identifier
Metadata Type	Data Element
Identifier	DE-16965
OID	1.2.36.1.2001.1001.101.103.16965

Definition

Definition	A globally unique identifier for each instance of a *Medical History* section.
Definition Source	NEHTA
Synonymous Names	
Notes	This `data element` is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Diagnoses/Interventions (MEDICAL HISTORY)	0..1

2.23 Section Type

Identification

Label	Section Type
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition

Definition	Type of section.
Definition Source	NEHTA
Synonymous Names	
Notes	A section's type is identified by a unique identifier, not by a name.
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.101.16117

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Diagnoses/Interventions (MEDICAL HISTORY)	1..1

2.24 IMMUNISATIONS

Identification

Label	IMMUNISATIONS
Metadata Type	Section
Identifier	S-16638
OID	1.2.36.1.2001.1001.101.101.16638

Definition

Definition	Information about vaccines given to the subject of care.
Definition Source	NEHTA
Synonymous Names	
Scope	Includes information about vaccines that have been administered or reported to be administered during the event.
Scope Source	NEHTA

Usage

Misuse	Use to record information about vaccines that are already included in the subject of care's medical record.

Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Administered Immunisation (MEDICATION ACTION)	1..*
	~~Exclusion Statement - Immunisation (EXCLUSION STATEMENT - MEDICATIONS)~~	~~0..0~~
	Immunisations Instance Identifier	0..1
	~~RELATED INFORMATION~~	~~0..0~~
	Section Type	1..1

2.25 Immunisations Instance Identifier

Identification

Label	Immunisations Instance Identifier
Metadata Type	Data Element
Identifier	DE-16962
OID	1.2.36.1.2001.1001.101.103.16962

Definition

Definition	A globally unique identifier for each instance of an *Immunisations* section.
Definition Source	NEHTA
Synonymous Names	
Notes	This `data element` is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

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

2.26 Section Type

Identification

Label	Section Type
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition

Definition	Type of section.
Definition Source	NEHTA
Synonymous Names	
Notes	A section's type is identified by a unique identifier, not by a name.
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.101.16638

Relationships

Parents

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

2.27 DIAGNOSTIC INVESTIGATIONS

Identification

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

Definition

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

Usage

Conditions of Use	Each instance of this section **SHALL** contain at least one instance of: • PATHOLOGY TEST RESULT, or • IMAGING EXAMINATION RESULT, or • REQUESTED SERVICE.
Conditions of Use Source	NEHTA
Misuse	Use to record diagnostic tests or procedures performed on or requested for the subject of care that are not relevant to the healthcare event.

Relationships

Parents

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

Children

Data Type	Name	Occurrences
	PATHOLOGY TEST RESULT	0..*

Data Type	Name	Occurrences
	IMAGING EXAMINATION RESULT	0..*
	~~Diagnostic Investigation Synopsis (CLINICAL SYNOPSIS)~~	~~0..0~~
	REQUESTED SERVICE	0..*
	Diagnostic Investigations Instance Identifier	0..1
	~~RELATED INFORMATION~~	~~0..0~~
	Section Type	1..1

2.28 Diagnostic Investigations Instance Identifier

Identification

Label	Diagnostic Investigations Instance Identifier
Metadata Type	Data Element
Identifier	DE-17011
OID	1.2.36.1.2001.1001.101.103.17011

Definition

Definition	A globally unique identifier for each instance of a *Diagnostic Investigations* section.
Definition Source	NEHTA
Synonymous Names	
Notes	This `data element` is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

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

2.29 Section Type

Identification

Label	Section Type
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition

Definition	Type of section.
Definition Source	NEHTA
Synonymous Names	
Notes	A section's type is identified by a unique identifier, not by a name.
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.101.20117

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DIAGNOSTIC INVESTIGATIONS	1..1

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3 Event Details Detailed Clinical Model

This chapter describes a reuse of version 4.3 of the *Clinical Synopsis* Detailed Clinical Model (DCM).

See *Miscellaneous Detailed Clinical Model Specification [NEHT2015l]* for more information.

3.1 Purpose

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

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

3.2 Use

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

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

3.3 Misuse

Using when more specialised data components are available.

3.4 CLINICAL SYNOPSIS

Identification

Label	Event Details
Metadata Type	Data Group
Identifier	DG-15513
OID	1.2.36.1.2001.1001.101.102.15513

Definition

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Event Details (EVENT OVERVIEW)	1..1

Children

Data Type	Name	Occurrences
	~~Clinical Synopsis Topic~~	~~0..0~~
	Clinical Synopsis Description	1..1
	~~DateTime Recorded~~	~~0..0~~

Data Type	Name	Occurrences
	~~INFORMATION PROVIDER~~	~~0..0~~
	~~SUBJECT~~	~~0..0~~
	Clinical Synopsis Instance Identifier	1..1
	~~RELATED INFORMATION~~	~~0..0~~
	Detailed Clinical Model Identifier	1..1

3.5 Clinical Synopsis Description

Identification

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

Definition

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

Usage

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

Relationships

Parents

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

3.6 Clinical Synopsis Instance Identifier

Identification

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

Definition

Definition	A globally unique identifier for each instance of a *Clinical Synopsis* evaluation.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

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

3.7 Detailed Clinical Model Identifier

Identification

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

Definition

Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.102.15513

Relationships

Parents

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

4 Adverse Reaction Detailed Clinical Model

This chapter describes a reuse of version 5.2 of the *Adverse Reaction* Detailed Clinical Model (DCM).

See *Adverse Reaction Detailed Clinical Model Specification [NEHT2015g]* for more information.

4.1 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. Gentamicin), drug-drug interactions, food-drug interactions, drug-disease interactions and idiosyncratic reactions).

4.2 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:

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

It can also be used to record an individual's reflections on their adverse reactions.

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; 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.

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 or 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 or 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 or reporter, and
- a flag for absolute contraindication.

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 available.

4.3 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 or 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.

4.4 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.
Definition Source	NEHTA
Scope	Substances and agents include medication at therapeutic or sub-therapeutic doses, food, plants, animals, venom from insect stings and glycoprotein from animals such as cats.
Scope Source	NEHTA

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Newly Identified Adverse Reactions (ADVERSE REACTIONS)	1..*

Children

Data Type	Name	Occurrences
	Substance/Agent	1..1
	~~Absolute Contraindication~~	~~0..0~~
	~~Adverse Reaction Comment~~	~~0..0~~
	REACTION EVENT	0..1
	~~Reaction Reported~~	~~0..0~~
	~~Adverse Reaction Report~~	~~0..0~~
	~~Supporting Clinical Record Information~~	~~0..0~~
	~~INFORMATION PROVIDER~~	~~0..0~~

Data Type	Name	Occurrences
	~~SUBJECT~~	~~0..0~~
	Adverse Reaction Instance Identifier	1..1
	~~RELATED INFORMATION~~	~~0..0~~
	Detailed Clinical Model Identifier	1..1

4.5 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	Occurrences (child within parent)
	ADVERSE REACTION	1..1

4.6 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 or 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 9 reference sets. From SNOMED CT-AU: • 142321000036106 |*Adverse reaction agent reference set*| • 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	Occurrences (child within parent)
	Substance/Agent	1..1

4.7 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	Occurrences (child within parent)
	ADVERSE REACTION	0..1

Children

Data Type	Name	Occurrences
	~~Specific Substance/Agent~~	~~0..0~~
	Manifestation	1..*
	Reaction Type	0..1
	~~Adverse Reaction Certainty~~	~~0..0~~
	~~Reaction Description~~	~~0..0~~
	~~Reaction Onset Date~~	~~0..0~~
	~~Duration of Reaction~~	~~0..0~~
	~~Additional Reaction Detail (ANATOMICAL LOCATION)~~	~~0..0~~
	~~Exposure Description~~	~~0..0~~

Data Type	Name	Occurrences
	~~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~~
	~~Adverse Reaction Event Comment~~	~~0..0~~

4.8 Manifestation

Identification

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

Definition

Definition	Presentation or exhibition of signs and symptoms of the adverse reaction expressed as a single word, phrase or brief description.
Definition Source	NEHTA
Synonymous Names	Reaction
Notes	The clinical manifestation (signs, symptoms, severity or certainty) of the adverse reaction are relevant as they contribute 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	Occurrences (child within parent)
	REACTION EVENT	1..*

4.9 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

Definition

Definition	The set of values for recording clinical manifestation of an adverse reaction.
Definition Source	NEHTA

Value Domain

Source	SNOMED CT-AU
Permissible Values	The permissible values are the members of the following SNOMED CT reference sets: • 142341000036103 |*Clinical manifestation reference set*| • 32570071000036102 |*Clinical finding foundation reference set*|

Relationships

Parents

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

4.10 Reaction Type

Identification

Label	Reaction Type
Metadata Type	Data Element
Identifier	DE-15554
OID	1.2.36.1.2001.1001.101.103.15554

Definition

Definition	The type of reaction, as determined by the clinician.
Definition Source	NEHTA
Synonymous Names	
Context	This field is used to identify the type of adverse reaction as determined by: • the signs and symptoms experienced by the subject of care; • information provided by a relevant individual; • previously documented history; and • clinical assessment by a healthcare provider.
Context Source	NEHTA
Data Type	CodedText
Value Domain	Adverse Reaction Type Values

Usage

Examples	1) Allergic reaction 2) Drug interaction 3) Food intolerance 4) Hypersensitivity reaction 5) Medication side-effect

Relationships

Parents

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

4.11 Adverse Reaction Type Values

Identification

Label	Adverse Reaction Type Values
Metadata Type	Value Domain
Identifier	VD-15554
OID	1.2.36.1.2001.1001.101.104.15554
External Identifier	SNOMED CT-AU Concept Id: 11000036103 |*Adverse reaction type reference set*|

Definition

Definition	The set of values for the type of adverse reaction.
Definition Source	NEHTA

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

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

4.12 Adverse Reaction Instance Identifier

Identification

Label	Adverse Reaction Instance Identifier
Metadata Type	Data Element
Identifier	DE-16697
OID	1.2.36.1.2001.1001.101.103.16697

Definition

Definition	A globally unique identifier for each instance of an *Adverse Reaction* evaluation.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	ADVERSE REACTION	1..1

4.13 Detailed Clinical Model Identifier

Identification

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

Definition

Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.102.15517

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	ADVERSE REACTION	1..1

5 Known Medication Detailed Clinical Model

This chapter describes a reuse of version 3.3 of the *Medication Instruction* Detailed Clinical Model (DCM).

See *Medication Instruction and Action Detailed Clinical Model Specification [NEHT2015h]* for more information.

5.1 Purpose

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

5.2 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 or administered); or in a summary document such as a 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 Prednisolone reducing dose regimen, 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 clinicians collectively expect the individual to be taking.

The information recorded may separate dose, route and timing to achieve a computable and shareable 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 structured 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 reusable in other contexts, especially the paired Medication Action (for recording dispensing, administration etc.) the content has been specified in reusable data groups. For example: the AMOUNT OF MEDICATION data group contains detail about medication dose; the TIMING data group contains detail about structured dose timing; the MEDICATION ADMINISTRATION data group contains structure around administration for both the order and the action; and the CHEMICAL DESCRIPTION OF MEDICATION data group describes the specific ingredients within a medicine. All of these data groups together are required to make up the total maximal dataset for a reusable medication instruction.

5.3 Misuse

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

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

5.4 MEDICATION INSTRUCTION

Identification

Label	Known 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 Prescribed Item Therapeutic
Scope	For use in the healthcare setting. Captures detailed information on the medication being used by or prescribed for the subject of care for their personal healthcare. This only includes legal substances. Such information covers not only aspects of the medication itself, but information relating to the ordering, dispensing, administration and review of medications. The specifications herein are presented grouped according to these process states. Recording legal substances such as over-the-counter medications, complementary and alternative medications, and prescribed medications.
Scope Source	NEHTA

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Medications (MEDICATION ORDERS)	1..*

Children

Data Type	Name	Occurrences
	Therapeutic Good Identification	1..1
	~~Additional Therapeutic Good Detail~~	~~0..0~~

Data Type	Name	Occurrences
	Directions	1..1
	~~Formula~~	~~0..0~~
	~~Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)~~	~~0..0~~
	~~Dose Description~~	~~0..0~~
	~~Structured Dose (AMOUNT OF MEDICATION)~~	~~0..0~~
	~~Timing (MEDICATION TIMING)~~	~~0..0~~
	~~Additional Instruction~~	~~0..0~~
	Clinical Indication	0..1
	~~Administration Details (MEDICATION ADMINISTRATION)~~	~~0..0~~
	Medication Instruction Comment	0..1
	~~DISPENSING~~	~~0..0~~
	Change Type	1..1
	Change Status	1..1
	Change Description	0..1
	Change or Recommendation Reason	0..1
	~~Indication for Authorised Use~~	~~0..0~~
	~~Medication Instruction ID~~	~~0..0~~
	~~Concession Benefit~~	~~0..0~~
	~~DateTime Medication Instruction Written~~	~~0..0~~
	~~Administrative Manufacturer Code~~	~~0..0~~
	~~INFORMATION PROVIDER~~	~~0..0~~
	~~SUBJECT~~	~~0..0~~
	~~Medication Instruction Narrative~~	~~0..0~~
	~~DateTime Medication Instruction Expires~~	~~0..0~~

Data Type	Name	Occurrences
	Medication Instruction Instance Identifier	1..1
	~~RELATED INFORMATION~~	~~0..0~~
	Detailed Clinical Model Identifier	1..1

5.5 Therapeutic Good Identification

Identification

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

Definition

Definition	The medicine, vaccine or other therapeutic good being ordered for, administered to or used by the subject of care.
Definition Source	NEHTA
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; or • influencing, inhibiting or modifying a physiological process; or • testing the susceptibility of persons to a disease or ailment; or • influencing, controlling or preventing conception; or • testing for pregnancy; or • replacement or modification of parts of the anatomy. From the *Therapeutic Goods Act 1989* [TGA1989a]. The formal definition of a therapeutic good is given in Section 3 of the *Therapeutic Goods Act 1989*.
Data Type	CodeableText
Value Domain	Medicines Terminology

Usage

Conditions of Use	Where the therapeutic good can be identified by an Australian Medicines Terminology (AMT) concept, the value of this data element **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), the strength and, where appropriate, the dose form.
Conditions of Use Source	NEHTA
Examples	Some examples of AMT ConceptIDs and their AMT Preferred Terms are: 1) 23641011000036102 |*paracetamol 500 mg + codeine phosphate 30 mg tablet*| 2) 28329011000036108 |*paracetamol 500 mg + codeine phosphate 30 mg tablet, 20*| 3) 13362011000036106 |*Panadeine Forte tablet: uncoated, 20*| 4) 6647011000036101 |*Panadeine Forte tablet: uncoated*| 5) 20138011000036107 |*Panadeine Forte tablet: uncoated, 20, blister pack*| 6) 51295011000036108 |*bandage compression 10 cm x 3.5 m bandage: high stretch*| 7) 48667011000036100 |*Eloflex (2480) 10 cm x 3.5 m bandage: high stretch*| 8) 926706011000036104 |*Engerix-B Paediatric 10 microgram/0.5 mL injection: suspension, 0.5 mL syringe*|
Misuse	Detailing the formula of a compounded (extemporaneous) medication.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	1..1

5.6 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 v3 Model - Editorial Rules v2.0 [NEHT2014ag]*.

Value Domain

Source	Australian Medicines Terminology
Permissible Values	The permissible values are the members of the following seven 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	**Occurrences** (child within parent)
001011001	Therapeutic Good Identification	1..1

5.7 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	
Notes	It is essential that when the *Directions* `data element` is used together with structured information components such as *Ingredients and Form* and *Structured Dose* in clinical records or prescriptions, the contents of *Directions* not contradict the contents of these structured information components.
Data Type	Text

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	1..1

5.8 Clinical Indication

Identification

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

Definition

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

Usage

Examples	1) Long-term maintenance treatment of bronchospasm and dyspnoea.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	0..1

5.9 Medication Instruction Comment

Identification

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

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	0..1

5.10 Change Type

Identification

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

Definition

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

Usage

Examples	1) New prescription 2) Change of previous 3) Cancellation

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	1..1

5.11 Change Type Values

Identification

Label	Change Type Values
Metadata Type	Value Domain
Identifier	VD-16592
OID	1.2.36.1.2001.1001.101.104.16592
External Identifier	SNOMED CT-AU Concept Id: 15071000036100 |*Change type reference set*|

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

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

5.12 Change Status

Identification

Label	Change Status
Metadata Type	Data Element
Identifier	DE-16595
OID	1.2.36.1.2001.1001.101.103.16595

Definition

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

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for CodedText.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	1..1

5.13 Change Status Values

Identification

Label	Change Status Values
Metadata Type	Value Domain
Identifier	VD-16626
OID	1.2.36.1.2001.1001.101.104.16626
External Identifier	SNOMED CT-AU Concept Id: 669181000168104 |*Change status reference set*|

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

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

5.14 Change Description

Identification

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

Definition

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

Usage

Examples	1) Correction of prescription error. 2) Cessation of medication. 3) Change of dose. 4) Addition of drug. 5) Substitution of drug.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	0..1

5.15 Change or Recommendation Reason

Identification

Label	Change or Recommendation Reason
Metadata Type	Data Element
Identifier	DE-10177
OID	1.2.36.1.2001.1001.101.103.10177

Definition

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

Usage

Examples	1) Optimise drug therapy. 2) Intolerable side effect of dizziness.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	0..1

5.16 Medication Instruction Instance Identifier

Identification

Label	Medication Instruction Instance Identifier
Metadata Type	Data Element
Identifier	DE-16713
OID	1.2.36.1.2001.1001.101.103.16713

Definition

Definition	A globally unique object identifier for each instance of a *Medication Instruction* instruction.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	1..1

5.17 Detailed Clinical Model Identifier

Identification

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

Definition

Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.102.16211

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	1..1

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6 Problem/Diagnosis Detailed Clinical Model

This chapter describes a reuse of version 5.2 of the *Problem/Diagnosis* Detailed Clinical Model (DCM).

See *Medical History Detailed Clinical Model Specification [NEHT2015i]* for more information.

6.1 Purpose

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

6.2 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 or present, primary or secondary, active or inactive etc. These qualifiers can be documented separately and included in the Status data group, because their use varies in different settings.

6.3 Misuse

Not to be used to record differential diagnoses - use the Differential Diagnosis archetype (to be published).

Not to be used to record reason for encounter - use the Reason for Encounter archetype.

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 archetype.

Not to be used to record procedures - use the Procedure archetype.

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.

6.4 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	A health condition that, as determined by a clinician, may have impact on the physical, mental or social well-being of a person. A diagnosis is determined by scientific evaluation of pathological and pathophysiological findings identified from the patient's clinical history, family history, physical examination and diagnostic investigations.
Definition Source	NEHTA
Synonymous Names	
Scope	The problems and diagnoses that form part of the past and current medical history of the subject of care.
Scope Source	NEHTA
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.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Diagnoses/Interventions (MEDICAL HISTORY)	0..*

Children

Data Type	Name	Occurrences
	Problem/Diagnosis Identification	1..1
	~~Clinical Description~~	~~0..0~~
	~~Severity~~	~~0..0~~
	Date of Onset	0..1

Data Type	Name	Occurrences
	~~Age at Onset~~	~~0..0~~
	~~ANATOMICAL LOCATION~~	~~0..0~~
	~~Occurrence Summary (PROBLEM/DIAGNOSIS OCCURRENCE SUMMARY)~~	~~0..0~~
	~~RELATED ITEMS~~	~~0..0~~
	~~Date of Resolution/Remission~~	~~0..0~~
	~~Age at Resolution/Remission~~	~~0..0~~
	~~Diagnostic Criteria~~	~~0..0~~
	~~Clinical Stage/Grade~~	~~0..0~~
	Problem/Diagnosis Comment	0..1
	~~Link to Supporting Clinical Evidence~~	~~0..0~~
	~~Status~~	~~0..0~~
	~~INFORMATION PROVIDER~~	~~0..0~~
	~~SUBJECT~~	~~0..0~~
	Problem/Diagnosis Instance Identifier	1..1
	~~RELATED INFORMATION~~	~~0..0~~
	Detailed Clinical Model Identifier	1..1

6.5 Problem/Diagnosis Identification

Identification

Label	Problem/Diagnosis Identification
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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for CodeableText.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	1..1

6.6 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 |*Problem/Diagnosis reference set*|

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	**Occurrences** (child within parent)
	Problem/Diagnosis Identification	1..1

6.7 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 or diagnosis began, as indicated or identified by the clinician.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

Conditions of Use	*Date of Onset* **SHALL NOT** include a time component.
Conditions of Use Source	NEHTA
Examples	Please see DateTime in Appendix C, *Specification Guide for Use* for examples and usage information on specifying a date or time (or both).

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

6.8 Problem/Diagnosis Comment

Identification

Label	Problem/Diagnosis 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

6.9 Problem/Diagnosis Instance Identifier

Identification

Label	Problem/Diagnosis Instance Identifier
Metadata Type	Data Element
Identifier	DE-16702
OID	1.2.36.1.2001.1001.101.103.16702

Definition

Definition	A globally unique object identifier for each instance of a *Problem/Diagnosis* evaluation.
Definition Source	NEHTA
Synonymous Names	
Notes	This `data element` is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	1..1

6.10 Detailed Clinical Model Identifier

Identification

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

Definition

Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.102.15530

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	1..1

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7 Procedure Detailed Clinical Model

This chapter describes a reuse of version 4.2 of the *Procedure (Action)* Detailed Clinical Model (DCM).

See *Medical History Detailed Clinical Model Specification [NEHT2015i]* for more information.

7.1 Purpose

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

7.2 Use

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

The scope of this archetype 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.

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 follow-up.

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

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.

7.3 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 a specific DCM 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.

7.4 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
Scope	The procedures that form part of the past and current medical history of the subject of care.
Scope Source	NEHTA

Usage

Misuse	Recording details about related activities such as use of imaging guidance during the procedure or collection of tissue samples for analysis - use specific DCMs for these purposes. Recording a whole operation or procedure report. Recording an observation such as a pathology test result or an imaging test.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Diagnoses/Interventions (MEDICAL HISTORY)	0..*

Children

Data Type	Name	Occurrences
	Procedure Name	1..1
	~~Procedure Description~~	~~0..0~~

Data Type	Name	Occurrences
	~~Procedure Reason~~	~~0..0~~
	~~ANATOMICAL LOCATION~~	~~0..0~~
	~~Procedure Detail~~	~~0..0~~
	~~Multimedia~~	~~0..0~~
	Procedure Comment	0..1
	~~DEVICE~~	~~0..0~~
	~~INFORMATION PROVIDER~~	~~0..0~~
	~~SUBJECT~~	~~0..0~~
	Procedure DateTime	1..1
	Procedure Instance Identifier	1..1
	~~RELATED INFORMATION~~	~~0..0~~
	Detailed Clinical Model Identifier	1..1

7.5 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for CodeableText.

Relationships

Parents

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

7.6 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 |*Procedure foundation reference set*|

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

7.7 Procedure Comment

Identification

Label	Procedure 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

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

7.8 Procedure DateTime

Identification

Label	Procedure DateTime
Metadata Type	Data Element
Identifier	DE-16475
OID	1.2.36.1.2001.1001.101.103.16475

Definition

Definition	The date range during which the *Procedure* action occurred.
Definition Source	NEHTA
Synonymous Names	
Data Type	TimeInterval

Usage

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

Relationships

Parents

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

7.9 Procedure Instance Identifier

Identification

Label	Procedure Instance Identifier
Metadata Type	Data Element
Identifier	DE-16561
OID	1.2.36.1.2001.1001.101.103.16561

Definition

Definition	A globally unique identifier for each instance of a *Procedure* action.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

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

7.10 Detailed Clinical Model Identifier

Identification

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

Definition

Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.102.15514

Relationships

Parents

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

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8 Uncategorised Medical History Item Detailed Clinical Model

This chapter describes a reuse of version 2.0 of the *Uncategorised Medical History Item* Detailed Clinical Model (DCM).

See *Medical History Detailed Clinical Model Specification [NEHT2015i]* for more information.

8.1 Purpose

To record an entry in a medical history when it cannot be determined whether the entry is a *Procedure* or is a *Problem/Diagnosis*.

8.2 Use

Use to record an item that is known to be a Procedure or a Problem/Diagnosis but that cannot be explicitly categorised as one or the other. This covers cases where the source system cannot automatically classify an entry as a Problem/Diagnosis or a Procedure, including cases where:

- the coding system used for medical history item cannot structurally support adequate concept classification; and
- the medical history item is maintained as free text and thus has never been classified.

Since it is not known whether an *Uncategorised Medical History Item* entry is conceptually a procedure or a problem/diagnosis, exclusion statements cannot be used when an *Uncategorised Medical History Item* entry is present, as the entry may, in fact, be a procedure or a problem/diagnosis.

8.3 Misuse

Misuses of this DCM include:

- using it when the item is known to be neither a Procedure nor a Problem/Diagnosis; and
- using it when the item can be identified as either a Procedure or a Problem/Diagnosis.

8.4 UNCATEGORISED MEDICAL HISTORY ITEM

Identification

Label	UNCATEGORISED 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 that has not been categorised as either *Procedure* or *Problem/Diagnosis*.
Definition Source	NEHTA
Synonymous Names	
Scope	For exchanging medical history items from clinical information systems that do not separate procedure and problem/diagnosis data in their data store.
Scope Source	NEHTA
Assumptions	Every entry in a person's medical history is either a procedure or a problem/diagnosis.
Assumptions Source	NEHTA

Usage

Misuse	Misuses of this data group include: • using it when the item is known to be neither a *Procedure* nor *Problem/Diagnosis*; and • using it when the item can be identified as either a *Procedure* or *Problem/Diagnosis*.

Relationships

Parents

Data Type	Name	**Occurrences** (child within parent)
	Diagnoses/Interventions (MEDICAL HISTORY)	0..*

Children

Data Type	Name	Occurrences
	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~~
	Uncategorised Medical History Item Instance Identifier	1..1
	~~RELATED INFORMATION~~	~~0..0~~
	Detailed Clinical Model Identifier	1..1

8.5 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 or procedure as a 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	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	1..1

8.6 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 problem or diagnosis applied or the procedure occurred.
Definition Source	NEHTA
Synonymous Names	
Data Type	TimeInterval

Usage

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

Relationships

Parents

Data Type	Name	**Occurrences** (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	0..1

8.7 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	Additional narrative about the problem, diagnosis or procedure.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	0..1

8.8 Uncategorised Medical History Item Instance Identifier

Identification

Label	Uncategorised Medical History Item Instance Identifier
Metadata Type	Data Element
Identifier	DE-16479
OID	1.2.36.1.2001.1001.101.103.16479

Definition

Definition	A globally unique identifier for each instance of an Uncategorised Medical History Item evaluation.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	1..1

8.9 Detailed Clinical Model Identifier

Identification

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

Definition

Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.102.16627

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	1..1

9 Administered Immunisation Detailed Clinical Model

This chapter describes a reuse of version 4.1 of the *Medication Action* Detailed Clinical Model (DCM).

See *Medication Instruction and Action Detailed Clinical Model Specification [NEHT2015h]* for more information.

9.1 Purpose

To record activities undertaken with regard to a medicine, vaccine or other therapeutic good, and link to the instruction if appropriate.

9.2 Use

Use to record the planning, issuing of a prescription, dispensing, administration, cessation, suspension, completion of a medicine, vaccine or other therapeutic good. This will usually be in response to a medication order but may be administered immediately without an order at times, thus requiring recording of the administration alone (e.g. in an emergency). Such a record may be made to indicate the administration of a dose, dispensing of a certain quantity or as a record of ceasing a medication. The state of the medication instruction is altered by the action taken, as indicated in the pathway definition.

There is a date and time at which this action took place (as there is for all actions) and use of this DCM indicates that some action has actually occurred.

9.3 Misuse

Not to be used for recording an instruction or order (use *Medication Instruction* DCM).

9.4 MEDICATION ACTION

Identification

Label	Administered Immunisation
Metadata Type	Data Group
Identifier	DG-16210
OID	1.2.36.1.2001.1001.101.102.16210

Definition

Definition	The act of administering a dose of a vaccine to a person for the purpose of preventing or minimising the effects of a disease by producing immunity or to counter the effects of an infectious organism.
Definition Source	NEHTA
Synonymous Names	Medication Item
Scope	It is specifically used for the vaccine administration record and is intended to enable recording of the vaccine administered to the subject of care.
Scope Source	NEHTA

Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Therapeutic Good Identification	1..1
	~~Additional Therapeutic Good Detail~~	~~0..0~~
	~~Medication Action Instructions~~	~~0..0~~
	~~Formula~~	~~0..0~~
	~~Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)~~	~~0..0~~
	~~Reason for Action~~	~~0..0~~
	~~Quantity of Medication (AMOUNT OF MEDICATION)~~	~~0..0~~

Data Type	Name	Occurrences
	~~Medication Action Comment~~	~~0..0~~
	~~Sequence Number~~	~~0..0~~
	~~Administration (MEDICATION ADMINISTRATION)~~	~~0..0~~
	~~Brand Substitution Occurred~~	~~0..0~~
	~~Batch Identifier~~	~~0..0~~
	~~Expiry Date~~	~~0..0~~
	~~DISPENSED TO~~	~~0..0~~
	~~Number of this Dispense~~	~~0..0~~
	~~Maximum Number of Repeats~~	~~0..0~~
	~~Claim Category~~	~~0..0~~
	~~Administrative Item Code~~	~~0..0~~
	~~Administrative Manufacturer Code~~	~~0..0~~
	~~Administrative System Identifier~~	~~0..0~~
	~~INFORMATION PROVIDER~~	~~0..0~~
	~~SUBJECT~~	~~0..0~~
	Medication Action DateTime	1..1
	Medication Action Instance Identifier	1..1
	~~RELATED INFORMATION~~	~~0..0~~
	Detailed Clinical Model Identifier	1..1

9.5 Therapeutic Good Identification

Identification

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

Definition

Definition	The vaccine that was administered to or used by the subject of care.
Definition Source	NEHTA
Synonymous Names	Item Name
Context	This includes only vaccines.
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; or • influencing, inhibiting or modifying a physiological process; or • testing the susceptibility of persons to a disease or ailment; or • influencing, controlling or preventing conception; or • testing for pregnancy; or • replacement or modification of parts of the anatomy. From the *Therapeutic Goods Act 1989* [TGA1989a]. The formal definition of a therapeutic good is given in Section 3 of the *Therapeutic Goods Act 1989*.
Data Type	CodeableText
Value Domain	Medicines Terminology

Usage

Conditions of Use	Where the therapeutic good can be identified by an Australian Medicines Terminology (AMT) concept, the value of this data element **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), the strength and, where appropriate, the dose form.

Conditions of Use Source	NEHTA
Examples	Some examples of AMT ConceptIDs and their AMT Preferred Terms are: 1) 73810011000036102 |*Polio Sabin Multidose oral liquid: solution, 1 vial*| 2) 73802011000036101 |*Twinrix injection: suspension, 1 mL syringe*| 3) 923052011000036100 |*Prevenar-13 30.8 microgram/0.5 mL injection: suspension, 0.5 mL syringe*|
Misuse	Detailing the formula of a compounded (extemporaneous) medication.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Administered Immunisation (MEDICATION ACTION)	1..1

9.6 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 v3 Model - Editorial Rules v2.0 [NEHT2014ag]*.

Value Domain

Source	Australian Medicines Terminology
Permissible Values	The permissible values are the members of the following seven 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	Occurrences (child within parent)
	Therapeutic Good Identification	1..1

9.7 Medication Action DateTime

Identification

Label	Medication Action DateTime
Metadata Type	Data Element
Identifier	DE-16591
OID	1.2.36.1.2001.1001.101.103.16591

Definition

Definition	Date, and optionally time, that the medication action is completed.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Administered Immunisation (MEDICATION ACTION)	1..1

9.8 Medication Action Instance Identifier

Identification

Label	Medication Action Instance Identifier
Metadata Type	Data Element
Identifier	DE-16637
OID	1.2.36.1.2001.1001.101.103.16637

Definition

Definition	A globally unique identifier for each instance of *Medication Action* action.
Definition Source	NEHTA
Synonymous Names	
Notes	This `data element` is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Administered Immunisation (MEDICATION ACTION)	1..1

9.9 Detailed Clinical Model Identifier

Identification

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

Definition

Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.102.16210

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Administered Immunisation (MEDICATION ACTION)	1..1

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10 Pathology Test Result Detailed Clinical Model

This chapter describes a reuse of version 3.1 of the *Pathology Test Result* Detailed Clinical Model (DCM).

See *Pathology Test Result Detailed Clinical Model Specification [NEHT2015j]* for more information.

10.1 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.

10.2 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.

The content of instances of this DCM will normally be reported back to the requesting clinician as one component within the context of an overall structured document.

10.3 Misuse

Not to be used for reporting on non-pathology test results, such as 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 is not intended to cover full synoptic reports. For these, additional specialising DCMs are required to represent the data.

10.4 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

Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Test Result Name (Pathology Test Result Name)	1..1
	Diagnostic Service	0..1
	Test Specimen Detail (SPECIMEN)	1..*
	Overall Pathology Test Result Status	1..1
	Clinical Information Provided	0..1
	Result Group (PATHOLOGY TEST RESULT GROUP)	0..*
	Pathological Diagnosis	0..*

Data Type	Name	Occurrences
	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~~
	~~REPORTING PATHOLOGIST~~	~~0..0~~
	~~INFORMATION PROVIDER~~	~~0..0~~
	~~SUBJECT~~	~~0..0~~
	Observation DateTime	1..1
	Pathology Test Result Instance Identifier	0..1
	~~RELATED INFORMATION~~	~~0..0~~
	Detailed Clinical Model Identifier	1..1

10.5 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, for example Glycosylated Haemoglobin (HbA1c), or to a test group such as electrolytes, Full Blood Count (FBC) or coagulation tests. When a *Pathology Test Result* record contains only a single individual test, this name may be the same as the name of the individual test.
Data Type	CodeableText
Value Domain	Pathology Test Result Name Values

Usage

Examples	1) Sputum microscopy and culture 2) FBC 3) Serum bilirubin 4) HbA1c

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	1..1

10.6 Pathology Test Result Name Values

Identification

Label	Pathology Test Result Name Values
Metadata Type	Value Domain
Identifier	VD-11017
OID	1.2.36.1.2001.1001.101.104.11017

Definition

Definition	Set of values for the names of pathology tests requested or performed.
Definition Source	NEHTA
Notes	A pathology test may be performed on a pathology specimen or a person. The codes recommended for pathology terminology by The Royal College of Pathologists of Australasia (RCPA) are included in the Requesting Pathology reference set, which is available at http://www.rcpa.edu.au/Library/Practising-Pathology/PTIS/APUTS-Downloads (accessed 30 October 2014).

Value Domain

Source	RCPA Requesting Pathology reference set

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Test Result Name (Pathology Test Result Name)	1..1

10.7 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	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..1

10.8 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	2.16.840.1.113883.12.74

Definition

Definition	Set of values for the type of diagnostic service.
Definition Source	NEHTA

Value Domain

Source	HL7® Table 0074 (Diagnostic service section ID)

Relationships

Parents

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

10.9 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	Laboratory Specimen Sample Collection
Notes	Do not include specimens described in *PATHOLOGY TEST RESULT GROUP*.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	1..*

Children

Data Type	Name	Occurrences
	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	Occurrences
	IDENTIFIERS	0..1

10.10 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	This is the actual specimen being submitted to the laboratory for analysis.
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) Venous blood 2) Prostate tissue, left base 3) Urine 4) Sputum 5) Scraping 6) Catheter tip 7) Single core (yellow-tan) liver tissue

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Test Specimen Detail (SPECIMEN)	0..1

10.11 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[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) Venepuncture 2) Biopsy 3) Resection

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Test Specimen Detail (SPECIMEN)	0..1

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

10.12 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	

Usage

Conditions of Use	Each instance of this data group **SHALL** contain exactly one SPECIFIC LOCATION or exactly one Anatomical Location Description. This data group **SHALL NOT** contain both an instance of SPECIFIC LOCATION and an instance of Anatomical Location Description.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Test Specimen Detail (SPECIMEN)	0..*

Children

Data Type	Name	Occurrences
	SPECIFIC LOCATION	0..1
	~~RELATIVE LOCATION~~	~~0..0~~
T	Anatomical Location Description	0..1
T	~~Visual Markings/Orientation~~	~~0..0~~

Data Type	Name	Occurrences
	Anatomical Location Image	0..*

10.13 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	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..1

Children

Data Type	Name	Occurrences
001011001	Anatomical Location Name	0..1
001011001	Side	0..1
001011001	~~Numerical Identifier~~	~~0..0~~
001011001	~~Anatomical Plane~~	~~0..0~~

10.14 Anatomical Location Name

Identification

Label	Anatomical Location Name
Metadata Type	Data Element
Identifier	DE-16153
OID	1.2.36.1.2001.1001.101.103.16153

Definition

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

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for CodeableText.

Relationships

Parents

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

10.15 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	Occurrences (child within parent)
	Anatomical Location Name	1..1

10.16 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 the anatomical location.
Definition Source	NEHTA
Synonymous Names	Laterality
Data Type	CodedText
Value Domain	Laterality Reference Set

Usage

Examples	1) Right 2) Left 3) Bilateral

Relationships

Parents

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

10.17 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 the laterality of an anatomical location.
Definition Source	NEHTA

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

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

10.18 Anatomical Location Description

Identification

Label	Anatomical Location Description
Metadata Type	Data Element
Identifier	DE-16319
OID	1.2.36.1.2001.1001.101.103.16319

Definition

Definition	Description of the anatomical location.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..1

10.19 Anatomical Location Image

Identification

Label	Anatomical Location Image
Metadata Type	Data Element
Identifier	DE-16199
OID	1.2.36.1.2001.1001.101.103.16199

Definition

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

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for EncapsulatedData.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..*

10.20 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, lesion or specimen.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Test Specimen Detail (SPECIMEN)	0..*

Children

Data Type	Name	Occurrences
	~~Name (Physical Object Name)~~	~~0..0~~
	Weight	0..1
	DIMENSIONS	0..1
	Description (Object Description)	0..1
	Image	0..1

10.21 Weight

Identification

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

Definition

Definition	Property of a body – commonly, but inadequately, defined as the quantity of matter in it – to which its inertia is ascribed, and expressed as the weight of the body divided by the acceleration due to gravity.
Definition Source	Macquarie Dictionary (2010)
Synonymous Names	
Data Type	Quantity

Usage

Conditions of Use	This data element **SHALL NOT** be included if Volume is included.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Quantity.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..1

10.22 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	Occurrences (child within parent)
	Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..1

Children

Data Type	Name	Occurrences
	~~Diameter~~	~~0..0~~
	~~Circumference~~	~~0..0~~
	~~Length~~	~~0..0~~
	~~Breadth~~	~~0..0~~
	~~Depth~~	~~0..0~~
	~~Area~~	~~0..0~~
	Volume	0..1

10.23 Volume

Identification

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

Definition

Definition	Size, measure or amount of anything in three dimensions; space occupied by a body or substance measured in cubic units.
Definition Source	Macquarie Dictionary (2010)
Synonymous Names	
Data Type	Quantity

Usage

Conditions of Use	This data element **SHALL NOT** not be included if Weight is included.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Quantity.

Relationships

Parents

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

10.24 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 description of the physical characteristics of the object other than weight and volume.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..1

10.25 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 object.
Definition Source	NEHTA
Synonymous Names	
Data Type	EncapsulatedData

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for EncapsulatedData.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..1

10.26 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	Occurrences (child within parent)
	Test Specimen Detail (SPECIMEN)	0..1

Children

Data Type	Name	Occurrences
	~~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~~

10.27 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, or any special instructions on the handling or immediate processing of the sample.
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) centrifuge on receipt 2) fasting 3) full bladder 4) sterile field 5) patient was not fasted

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	COLLECTION AND HANDLING	0..1

10.28 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 or handling.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Test Specimen Detail (SPECIMEN)	1..1

Children

Data Type	Name	Occurrences
	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~~

10.29 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 the 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	Please see DateTime in Appendix C, *Specification Guide for Use* for examples and usage information on specifying a date or time (or both).

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	HANDLING AND PROCESSING	1..1

10.30 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	HANDLING AND PROCESSING	0..1

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	HANDLING AND PROCESSING	0..1

10.32 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	Occurrences (child within parent)
	Test Specimen Detail (SPECIMEN)	0..1

Children

Data Type	Name	Occurrences
	Specimen Identifier	0..1
	Parent Specimen Identifier	0..1
	Container Identifier	0..1
	~~Specimen Collector Identifier~~	~~0..0~~
	~~SPECIMEN COLLECTOR DETAILS~~	~~0..0~~

10.33 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	Each specimen **SHOULD** have an identifier.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.

Relationships

Parents

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

10.34 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.

Relationships

Parents

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

10.35 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.

Relationships

Parents

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

10.36 Overall Pathology Test Result Status

Identification

Label	Overall Pathology 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for CodedText.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	1..1

10.37 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	Set of values for the pathology test result status.
Definition Source	NEHTA
Notes	The *HL7® Table 0085 - Observation result status codes interpretation* is intended to be used at the result or record level, while the *HL7® Table 0123 - Result status* is intended to be used for the overall report status. Having to source values from two HL7® tables and determine which one to apply in a situation is a potential cause of confusion. Consequently NEHTA provides a value set that is applicable across report level and individual result level status values. The single value set has been assessed to be adequate for the PCEHR-based use cases. This approach reduces the chances of confusion and errors in the use of status values.

Value Domain

Source	NCTIS Pathology Test Result Status Values	
Permissible Values	1, Registered	No result yet available.
	2, Interim	This is an initial or interim result: data may be missing or verification has not been performed.
	3, Final	The result is complete and verified by the responsible pathologist.
	4, Amended	The result has been modified subsequent to being Final, and is complete and verified by the responsible pathologist.
	5, Cancelled/Aborted	The result is unavailable because the test was not started or not completed.
	Values sourced by NEHTA from *HL7® Table 0085 - Observation result status codes interpretation*, *HL7® Table 0123 - Result status* and other sources.	

Usage

Conditions of Use	In situations where *NCTIS Pathology Test Result Status Values* is not available, *HL7® v2.x Table 0123 (Result status)* [OID:2.16.840.1.113883.12.123] **MAY** be used.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Overall Pathology Test Result Status	1..1

10.38 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 or summary of relevant, prior clinical information that may help in determining the test(s) to be performed, or interpreting the result when compiling or reading the report.
Definition Source	NEHTA
Synonymous Names	
Notes	This would typically be a summarised restatement of any clinical information provided by the original requester of the test for any of the following reasons: • to justify the request; • to help the pathologist or laboratory scientist to determine whether a better test should be performed; • to help the pathologist or laboratory scientist to determine whether any additional tests are needed; and • to help interpreting the result when reporting or reading the report.
Data Type	Text

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..1

10.39 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 that form all or part of a recognisable pathology test.
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	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..*

Children

Data Type	Name	Occurrences
001011001	Pathology Test Result Group Name	1..1
	Result (INDIVIDUAL PATHOLOGY TEST RESULT)	1..*
	Result Group Specimen Detail (SPECIMEN)	0..1

10.40 Pathology Test Result Group Name

Identification

Label	Pathology Test 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	Pathology Test Result Name Values

Usage

Examples	1) Full blood count 2) Liver function tests

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group (PATHOLOGY TEST RESULT GROUP)	1..1

10.41 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 of a pathology test, including both the value of the result item, and additional information that may be useful for clinical interpretation.
Definition Source	NEHTA
Synonymous Names	
Notes	Many specific data items that pathology labs report as part of a clinical service are treated as results; results are not confined to measurements. Individual results are identified by *Individual Pathology Test Result Name*. If a result is not grouped with others, it is recorded as the only result in a nameless result group.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group (PATHOLOGY TEST RESULT GROUP)	1..*

Children

Data Type	Name	Occurrences
	Individual Pathology Test Result Name	1..1
	Result Value (INDIVIDUAL PATHOLOGY TEST RESULT VALUE)	0..1
	Individual Pathology Test Result Comment	0..*
	Individual Pathology Test Result Reference Range Guidance	0..1
	Individual Pathology Test Result Status	1..1

10.42 Individual Pathology Test Result Name

Identification

Label	Individual Pathology Test 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	Individual Pathology Test Result Name Values

Usage

Examples	1) Serum glucose level 2) Haemoglobin concentration 3) Hepatitis B surface antibody titre 4) Prothrombin Time

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result (INDIVIDUAL PATHOLOGY TEST RESULT)	1..1

10.43 Individual Pathology Test Result Name Values

Identification

Label	Individual Pathology Test Result Name Values
Metadata Type	Value Domain
Identifier	VD-16571
OID	1.2.36.1.2001.1001.101.104.16571

Definition

Definition	Set of values for the names of individual pathology tests performed.
Definition Source	NEHTA
Notes	The codes recommended for pathology terminology by The Royal College of Pathologists of Australasia (RCPA) are included in Requesting Pathology reference set which can be found at http://www.rcpa.edu.au/Library/Practising-Pathology/PTIS/APUTS-Downloads (accessed 24 March 2014). Most codes are LOINC codes.

Value Domain

Source	RCPA Requesting Pathology reference set

Usage

Conditions of Use	Values **SHOULD** be codes recommended for pathology terminology by The Royal College of Pathologists of Australasia.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Individual Pathology Test Result Name	1..1

10.44 INDIVIDUAL PATHOLOGY TEST RESULT VALUE

Identification

Label	Result Value
Metadata Type	Data Group
Identifier	DG-11023
OID	1.2.36.1.2001.1001.101.102.11023

Definition

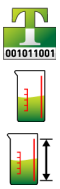
Definition	Value of the result, with reference range information.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result (INDIVIDUAL PATHOLOGY TEST RESULT)	0..1

Children

Data Type	Name	Occurrences
	Individual Pathology Test Result Value	1..1
	Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS)	0..1

10.45 Individual Pathology Test Result Value

Identification

Label	Individual Pathology Test Result Value
Metadata Type	Data Element
Identifier	DE-11023
OID	1.2.36.1.2001.1001.101.103.11023

Definition

Definition	The 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	Result Value Values

Usage

Examples	1) 140 2) ++ 3) Neg

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Value (INDIVIDUAL PATHOLOGY TEST RESULT VALUE)	1..1

10.46 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	Set of values for *Pathology Test Result Value*.
Definition Source	NEHTA
Notes	Which code set is appropriate depends upon the information to be coded.

Value Domain

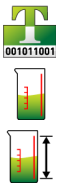
Source	NCTIS Pathology Test Result Value Values

Usage

Conditions of Use	Any code set used **SHALL** be a registered code set, i.e. registered through the HL7® code set registration procedure with an appropriate object identifier (OID), and **SHALL** be publicly available.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	**Occurrences** (child within parent)
	Individual Pathology Test Result Value	1..1

10.47 REFERENCE RANGE DETAILS

Identification

Label	Individual Pathology Test Result Value Reference Ranges
Metadata Type	Data Group
Identifier	DG-16325
OID	1.2.36.1.2001.1001.101.102.16325

Definition

Definition	One or more reference ranges applicable to the *Individual Pathology Test Result Value*.
Definition Source	NEHTA
Synonymous Names	
Notes	A reference range is particular to the patient and context, e.g. sex, age, and any other factor that affects ranges. May be used to represent normal, therapeutic, dangerous, critical and other such clinical ranges.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Value (INDIVIDUAL PATHOLOGY TEST RESULT VALUE)	0..1

Children

Data Type	Name	Occurrences
001011001	Normal Status	0..1
	REFERENCE RANGE	0..*

10.48 Normal Status

Identification

Label	Normal Status
Metadata Type	Data Element
Identifier	DE-11028
OID	1.2.36.1.2001.1001.101.103.11028

Definition

Definition	An indication of the degree of diagnostically significant abnormality of the value, based on available clinical information (including but not limited to the reference range).
Definition Source	NEHTA
Synonymous Names	
Notes	The term “normal” is **not** statistical normality, but rather what would normally be considered healthy for the individual concerned. As such, this data element represents the health risk for the individual, which is indicated by the observation or measurement and the nature and criticality of that health risk.
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	1) Below normal 2) Above normal 3) Critically low 4) Critically high

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS)	0..1

10.49 REFERENCE RANGE

Identification

Label	REFERENCE RANGE
Metadata Type	Data Group
Identifier	DG-11024
OID	1.2.36.1.2001.1001.101.102.11024

Definition

Definition	A named range to be associated with any quantity datum.
Definition Source	NEHTA
Synonymous Names	

Usage

Conditions of Use	If this data group occurs more than once, its contents **SHOULD** include all of the ranges in a single set. All reference ranges **SHALL** come from the one set of reference ranges.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS)	0..*

Children

Data Type	Name	Occurrences
	Reference Range Meaning	1..1
	Reference Range	1..1

10.50 Reference Range Meaning

Identification

Label	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	In the pathology case it is typical to send only one reference range, the applicable Normal reference range. When only one reference range is provided this data element is expected to have an implementation-specific value equivalent to “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[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) Normal 2) Critical 3) Therapeutic

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERENCE RANGE	1..1

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

10.51 Reference Range

Identification

Label	Reference Range
Metadata Type	Data Element
Identifier	DE-11024
OID	1.2.36.1.2001.1001.101.103.11024

Definition

Definition	The data range for the associated *Reference Range Meaning* `data element`.
Definition Source	NEHTA
Synonymous Names	
Data Type	QuantityRange

Usage

Examples	1) 15 - 58 g/L 2) < 15 mmol/L 3) 2.5 - 3.5 kg 4) 23 - 45 cm

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERENCE RANGE	1..1

10.52 Individual Pathology Test Result Comment

Identification

Label	Individual Pathology Test 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result (INDIVIDUAL PATHOLOGY TEST RESULT)	0..*

10.53 Individual Pathology Test Result Reference Range Guidance

Identification

Label	Individual Pathology Test Result 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result (INDIVIDUAL PATHOLOGY TEST RESULT)	0..1

10.54 Individual Pathology Test Result Status

Identification

Label	Individual Pathology Test 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 may be of use to the clinician in deciding how to respond to the report.
Data Type	CodedText
Value Domain	Pathology Test Result Status Values

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for CodedText.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result (INDIVIDUAL PATHOLOGY TEST RESULT)	1..1

10.55 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	Occurrences (child within parent)
	Result Group (PATHOLOGY TEST RESULT GROUP)	0..1

Children

Data Type	Name	Occurrences
	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~~
	IDENTIFIERS	0..1

10.56 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	This is the actual specimen being submitted to the laboratory for analysis.
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) Venous blood 2) Prostate tissue, left base 3) Urine 4) Sputum 5) Scraping 6) Catheter tip 7) Single core (yellow-tan) liver tissue

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group Specimen Detail (SPECIMEN)	0..1

10.57 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[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) Venepuncture 2) Biopsy 3) Resection

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group Specimen Detail (SPECIMEN)	0..1

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

10.58 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	

Usage

Conditions of Use	Each instance of this data group **SHALL** contain exactly one SPECIFIC LOCATION or exactly one Anatomical Location Description. This data group **SHALL NOT** contain both an instance of SPECIFIC LOCATION and an instance of Anatomical Location Description.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group Specimen Detail (SPECIMEN)	0..*

Children

Data Type	Name	Occurrences
	SPECIFIC LOCATION	0..1
	~~RELATIVE LOCATION~~	~~0..0~~
T	Anatomical Location Description	0..1
T	~~Visual Markings/Orientation~~	~~0..0~~

Data Type	Name	Occurrences
	Anatomical Location Image	0..*

10.59 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	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..1

Children

Data Type	Name	Occurrences
	Anatomical Location Name	0..1
	Side	0..1
	~~Numerical Identifier~~	~~0..0~~
	~~Anatomical Plane~~	~~0..0~~

10.60 Anatomical Location Name

Identification

Label	Anatomical Location Name
Metadata Type	Data Element
Identifier	DE-16153
OID	1.2.36.1.2001.1001.101.103.16153

Definition

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

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for CodeableText.

Relationships

Parents

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

10.61 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	Occurrences (child within parent)
	Anatomical Location Name	1..1

10.62 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 the anatomical location.
Definition Source	NEHTA
Synonymous Names	Laterality
Data Type	CodedText
Value Domain	Laterality Reference Set

Usage

Examples	1) Right 2) Left 3) Bilateral

Relationships

Parents

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

10.63 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 the laterality of an anatomical location.
Definition Source	NEHTA

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

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

10.64 Anatomical Location Description

Identification

Label	Anatomical Location Description
Metadata Type	Data Element
Identifier	DE-16319
OID	1.2.36.1.2001.1001.101.103.16319

Definition

Definition	Description of the anatomical location.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..1

10.65 Anatomical Location Image

Identification

Label	Anatomical Location Image
Metadata Type	Data Element
Identifier	DE-16199
OID	1.2.36.1.2001.1001.101.103.16199

Definition

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

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for EncapsulatedData.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..*

10.66 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, lesion or specimen.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group Specimen Detail (SPECIMEN)	0..*

Children

Data Type	Name	Occurrences
	~~Name (Physical Object Name)~~	~~0..0~~
	Weight	0..1
	DIMENSIONS	0..1
	Description (Object Description)	0..1
	Image	0..1

10.67 Weight

Identification

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

Definition

Definition	Property of a body – commonly, but inadequately, defined as the quantity of matter in it – to which its inertia is ascribed, and expressed as the weight of the body divided by the acceleration due to gravity.
Definition Source	Macquarie Dictionary (2010)
Synonymous Names	
Data Type	Quantity

Usage

Conditions of Use	This data element **SHALL NOT** be included if Volume is included.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Quantity.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..1

10.68 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	Occurrences (child within parent)
	Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..1

Children

Data Type	Name	Occurrences
	~~Diameter~~	~~0..0~~
	~~Circumference~~	~~0..0~~
	~~Length~~	~~0..0~~
	~~Breadth~~	~~0..0~~
	~~Depth~~	~~0..0~~
	~~Area~~	~~0..0~~
	Volume	0..1

10.69 Volume

Identification

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

Definition

Definition	Size, measure or amount of anything in three dimensions; space occupied by a body or substance measured in cubic units.
Definition Source	Macquarie Dictionary (2010)
Synonymous Names	
Data Type	Quantity

Usage

Conditions of Use	This data element **SHALL NOT** not be included if Weight is included.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Quantity.

Relationships

Parents

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

10.70 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 description of the physical characteristics of the object other than weight and volume.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..1

10.71 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 object.
Definition Source	NEHTA
Synonymous Names	
Data Type	EncapsulatedData

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for EncapsulatedData.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..1

10.72 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	Occurrences (child within parent)
	Result Group Specimen Detail (SPECIMEN)	0..1

Children

Data Type	Name	Occurrences
	~~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~~

10.73 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, or any special instructions on the handling or immediate processing of the sample.
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	1) centrifuge on receipt 2) fasting 3) full bladder 4) sterile field 5) patient was not fasted

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	COLLECTION AND HANDLING	0..1

10.74 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 or handling.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group Specimen Detail (SPECIMEN)	1..1

Children

Data Type	Name	Occurrences
	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~~

10.75 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 the 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	Please see DateTime in Appendix C, *Specification Guide for Use* for examples and usage information on specifying a date or time (or both).

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	HANDLING AND PROCESSING	1..1

10.76 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	HANDLING AND PROCESSING	0..1

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

Relationships

Parents

Data Type	Name	**Occurrences** (child within parent)
	HANDLING AND PROCESSING	0..1

10.78 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	Occurrences (child within parent)
	Result Group Specimen Detail (SPECIMEN)	0..1

Children

Data Type	Name	Occurrences
	Specimen Identifier	0..1
	Parent Specimen Identifier	0..1
	Container Identifier	0..1
	~~Specimen Collector Identifier~~	~~0..0~~
	~~SPECIMEN COLLECTOR DETAILS~~	~~0..0~~

10.79 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	Each specimen **SHOULD** have an identifier.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.

Relationships

Parents

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

10.80 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.

Relationships

Parents

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

10.81 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.

Relationships

Parents

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

10.82 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[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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for CodeableText.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..*

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

10.83 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..1

10.84 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.
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) is 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 Test Result* `data group` represents the non-numerical pathology results as a single 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

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for EncapsulatedData.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..1

10.85 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 that is not captured in other fields.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..1

10.86 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 requested pathology test.
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	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..*

Children

Data Type	Name	Occurrences
	~~Requester Order Identifier~~	~~0..0~~
	Test Requested Name	0..*
	~~REQUESTER~~	~~0..0~~
	~~Receiver Order Identifier~~	~~0..0~~
	Laboratory Test Result Identifier	0..1

10.87 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 the pathology test which was requested.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	Pathology Test Result Name Values

Usage

Conditions of Use	This `data element` **SHOULD NOT** be used if its value is equal to the value of the Pathology Test Result Name `data element`.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for CodeableText.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	TEST REQUEST DETAILS	0..*

10.88 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	Assigning an identification code to a result allows the result to be linked to a request in the laboratory.
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	TEST REQUEST DETAILS	0..1

10.89 Observation DateTime

Identification

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

Definition

Definition	Date, and optionally time, when an observation is clinically significant to the condition of the subject of the observation.
Definition Source	NEHTA
Synonymous Names	
Assumptions	For an observation based on a specimen the clinically significant time will have the same value as the time of collection of the specimen.
Assumptions Source	NEHTA
Notes	**Clinical Semantics of Event Time.** (Section 8.2.3.3 of *EHR Information Model [OEHR2008a]*) In most cases, the times recorded in [an *Observation DateTime* `data element`] can be thought of as “the times when the observed phenomena were true”. For example, if a pulse of 88bpm is recorded for 12/feb/2005 12:44:00, this is the time at which the heart rate (for which pulse is a surrogate) existed. In such cases, the *sample* time, and the *measuring* time are one and the same. However in cases where the time of sampling is different from that of measurement, the semantics are more subtle. There are two cases. The first is where a sample is taken (e.g. a tissue sample in a needle biopsy), and is tested later on, but from the point of view of the test, the time delay makes no difference. This might be because the sample was immediately preserved (e.g. freezing, placed in a sterile ... transport container), or because even if it decays in some way, it makes no difference to the test (e.g. bacteria may die, but this makes no difference to [an] analysis, as long as the biological matter is not physically destroyed). The second situation is when the sample does decay in some way, and the delay is relevant. Most such cases are in pathology tests, where presence of live biological organisms (e.g. anaerobic bacteria) is being measured. The sample time (or ‘collection’ time) must be recorded. Depending on when the test is done, the results may be interpreted differently. The key question is: what is the meaning of the [`data element`] in these situations? It is tempting to say that [its value is] (as in other cases) just the [time] of the actual act of observation, e.g. microscopy, chromatography etc. However, there are two problems with this. Firstly, and most importantly, all physical samples must be understood as being *indirect surrogates for some aspect of the patient state at the time of sampling*, which cannot be observed by direct, instantaneous means in the way a pulse can be taken. This means that no matter when the laboratory work is done, the time to which the result applies is the *sample* time. It is up to the laboratory to take into account time delays and effects of decay of samples in order to provide a test result which correctly indicates the

	state of the patient at the time of sampling. The common sense of this is clear when one considers the extreme case where the patient is in a coma or dead (possibly for reasons completely unrelated to the problem being tested for) by the time laboratory testing actually occurs; however, the test result indicates the situation at the point in time when the sample was taken, i.e. when the patient was alive. The second reason is that some kinds of testing are themselves lengthy. For example fungal specimens require 4-6 weeks to confirm a negative result; checks will be made on a daily or weekly basis to find positive growth. However, the result data reported by the laboratory (and therefore the structure of the Observation) is not related to the timing of the laboratory testing; it is reported as being the result for the time of collection of the specimen from the patient. The meaning therefore of the [`data element`] is always the time of sampling. Where delays between sample and measurement times exist and are significant, they are [modelled explicitly].
Data Type	DateTime

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	1..1

10.90 Pathology Test Result Instance Identifier

Identification

Label	Pathology Test Result Instance Identifier
Metadata Type	Data Element
Identifier	DE-16714
OID	1.2.36.1.2001.1001.101.103.16714

Definition

Definition	A globally unique identifier for each instance of a *Pathology Test Result* observation.
Definition Source	NEHTA
Synonymous Names	
Notes	This `data element` is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..1

10.91 Detailed Clinical Model Identifier

Identification

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

Definition

Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.102.16144

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	1..1

11 Imaging Examination Result Detailed Clinical Model

This chapter describes a reuse of version 3.1 of the *Imaging Examination Result* Detailed Clinical Model (DCM).

See *Imaging Examination Result Detailed Clinical Model Specification [NEHT2015k]* for more information.

11.1 Purpose

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

11.2 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 echocardiograms or bone density scans) may be represented using templates or specialised archetypes where additional report content is appropriate.

The content of instances of this DCM will normally be reported back to the requesting clinician as one component within the context of an overall report.

11.3 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 shall be recorded using the Procedure archetype for the operative findings. This archetype will only be used to record the findings from the imaging.

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

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

11.4 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

Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Examination Result Name (Imaging Examination Result Name)	1..1
	Imaging Modality	0..1
	Anatomical Site (ANATOMICAL LOCATION)	0..*

Data Type	Name	Occurrences
	~~Anatomical Region~~	~~0..0~~
	Imaging Examination Result Status	1..1
	Clinical Information Provided	0..1
	Findings	0..1
	Result Group (IMAGING EXAMINATION RESULT GROUP)	0..*
	~~Radiological Diagnosis~~	~~0..0~~
	~~Conclusion (Imaging Examination Conclusion)~~	~~0..0~~
	Examination Result Representation	0..1
	~~Examination Comment~~	~~0..0~~
	~~RECEIVING IMAGING SERVICE~~	~~0..0~~
	EXAMINATION REQUEST DETAILS	0..*
	~~Examination Procedure~~	~~0..0~~
	~~COMPARED IMAGE DETAILS~~	~~0..0~~
	~~REPORTING RADIOLOGIST~~	~~0..0~~
	~~INFORMATION PROVIDER~~	~~0..0~~
	~~SUBJECT~~	~~0..0~~
	Observation DateTime	1..1
	Imaging Examination Result Instance Identifier	0..1
	~~RELATED INFORMATION~~	~~0..0~~
	Detailed Clinical Model Identifier	1..1

11.5 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	1) CT chest and abdomen 2) Ultrasound plantar fascia

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	1..1

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

11.6 Imaging Modality

Identification

Label	Imaging 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 or 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 *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	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..1

11.7 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	

Usage

Conditions of Use	Each instance of this data group **SHALL** contain exactly one SPECIFIC LOCATION or exactly one Anatomical Location Description. This data group **SHALL NOT** contain both an instance of SPECIFIC LOCATION and an instance of Anatomical Location Description.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..*

Children

Data Type	Name	Occurrences
	SPECIFIC LOCATION	0..1
	~~RELATIVE LOCATION~~	~~0..0~~
	Anatomical Location Description	0..1
	~~Visual Markings/Orientation~~	~~0..0~~

Data Type	Name	Occurrences
	Anatomical Location Image	0..*

11.8 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	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..1

Children

Data Type	Name	Occurrences
	Anatomical Location Name	0..1
	Side	0..1
	~~Numerical Identifier~~	~~0..0~~
	~~Anatomical Plane~~	~~0..0~~

11.9 Anatomical Location Name

Identification

Label	Anatomical Location Name
Metadata Type	Data Element
Identifier	DE-16153
OID	1.2.36.1.2001.1001.101.103.16153

Definition

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

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for CodeableText.

Relationships

Parents

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

11.10 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	Occurrences (child within parent)
	Anatomical Location Name	1..1

11.11 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 the anatomical location.
Definition Source	NEHTA
Synonymous Names	Laterality
Data Type	CodedText
Value Domain	Laterality Reference Set

Usage

Examples	1) Right 2) Left 3) Bilateral

Relationships

Parents

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

11.12 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 the laterality of an anatomical location.
Definition Source	NEHTA

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

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

11.13 Anatomical Location Description

Identification

Label	Anatomical Location Description
Metadata Type	Data Element
Identifier	DE-16319
OID	1.2.36.1.2001.1001.101.103.16319

Definition

Definition	Description of the anatomical location.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..1

11.14 Anatomical Location Image

Identification

Label	Anatomical Location Image
Metadata Type	Data Element
Identifier	DE-16199
OID	1.2.36.1.2001.1001.101.103.16199

Definition

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

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for EncapsulatedData.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..*

11.15 Imaging Examination Result Status

Identification

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

Definition

Definition	The status of the examination result as a whole.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodedText
Value Domain	Imaging Examination Result Status Values

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for CodedText.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	1..1

11.16 Imaging Examination Result Status Values

Identification

Label	Imaging Examination Result Status Values
Metadata Type	Value Domain
Identifier	VD-16501
OID	1.2.36.1.2001.1001.101.104.16501

Definition

Definition	Set of values for the imaging examination result status.
Definition Source	NEHTA
Notes	The *HL7® Table 0085 - Observation result status codes interpretation* is intended to be used at the result or record level, while the *HL7® Table 0123 - Result status* is intended to be used for the overall report status. Having to source values from two HL7® tables and determine which one to apply in a situation is a potential cause of confusion. Consequently NEHTA provides a value set that is applicable across report level and individual result level status values. The single value set has been assessed to be adequate for the PCEHR-based use cases. This approach reduces the chances of confusion and errors in the use of status values.

Value Domain

Source	NCTIS Imaging Examination Result Status Values	
Permissible Values	1, Registered	No result yet available.
	2, Interim	This is an initial or interim result: data may be missing or verification has 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.
	Values sourced by NEHTA from *HL7® Table 0085 - Observation result status codes interpretation*, *HL7® Table 0123 - Result status* and other sources.	

Usage

Conditions of Use	In situations where *NCTIS Imaging Examination Status Values* is not available, *HL7® v2.x Table 0123 (Result status)* [OID:2.16.840.1.113883.12.123] **MAY** be used.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Imaging Examination Result Status	1..1

11.17 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..1

11.18 Findings

Identification

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

Definition

Definition	Clinical assessment and opinion based on one or more observations and examinations.
Definition Source	NEHTA
Synonymous Names	Results Observational Findings Results/Observation
Data Type	Text

Usage

Examples	1) Extensive diverticular disease of the sigmoid colon is demonstrated throughout its length. 2) The gallbladder shows a diffuse thickening with fatty infiltration of the gallbladder wall. 3) The heart size is within normal limits.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..1

11.19 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	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..*

Children

Data Type	Name	Occurrences
	Imaging Examination Result Group Name	1..1
	Result (INDIVIDUAL IMAGING EXAMINATION RESULT)	1..*
	Anatomical Site (ANATOMICAL LOCATION)	0..1

11.20 Imaging Examination Result Group Name

Identification

Label	Imaging Examination 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[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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for CodeableText.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group (IMAGING EXAMINATION RESULT GROUP)	1..1

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

11.21 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 of an imaging examination, 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	Occurrences (child within parent)
	Result Group (IMAGING EXAMINATION RESULT GROUP)	1..*

Children

Data Type	Name	Occurrences
	Individual Imaging Examination Result Name	1..1
	Result Value (IMAGING EXAMINATION RESULT VALUE)	0..1
	Result Comment	0..*

11.22 Individual Imaging Examination Result Name

Identification

Label	Individual Imaging Examination 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[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	1) Cardiac ejection fraction 2) Bone density

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result (INDIVIDUAL IMAGING EXAMINATION RESULT)	1..1

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

11.23 IMAGING EXAMINATION RESULT VALUE

Identification

Label	Result Value
Metadata Type	Data Group
Identifier	DG-11023
OID	1.2.36.1.2001.1001.101.102.11023

Definition

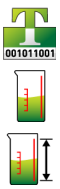
Definition	Value of the result, with reference range information.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result (INDIVIDUAL IMAGING EXAMINATION RESULT)	0..1

Children

Data Type	Name	Occurrences
	Result Value (Imaging Examination Result Value)	1..1
	Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS)	0..1

11.24 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	The 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	Result Value Values

Usage

Examples	1) Within the lumbar spine (L2-L4), the bone mineral density = 1.121g/cm2. This value corresponds to a Z score of 0.5 and a T score of -0.6.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Value (IMAGING EXAMINATION RESULT VALUE)	1..1

11.25 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 *Imaging Examination Result Value*.
Definition Source	NEHTA
Notes	Which code set is appropriate depends upon the information to be coded.

Value Domain

Source	NEHTA

Usage

Conditions of Use	Any code set used **SHALL** be a registered code set, i.e. registered through the HL7® code set registration procedure with an appropriate object identifier (OID), and **SHALL** be publicly available.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Value (Imaging Examination Result Value)	1..1

11.26 REFERENCE RANGE DETAILS

Identification

Label	Imaging Examination Result Value Reference Ranges
Metadata Type	Data Group
Identifier	DG-16325
OID	1.2.36.1.2001.1001.101.102.16325

Definition

Definition	One or more reference ranges applicable to the *Imaging Examination Result Value*.
Definition Source	NEHTA
Synonymous Names	
Notes	A reference range is particular to the patient and context, e.g. sex, age, and any other factor that affects ranges. May be used to represent normal, therapeutic, dangerous, critical and other such clinical ranges.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Value (IMAGING EXAMINATION RESULT VALUE)	0..1

Children

Data Type	Name	Occurrences
	Normal Status	0..1
	REFERENCE RANGE	0..*

11.27 Normal Status

Identification

Label	Normal Status
Metadata Type	Data Element
Identifier	DE-11028
OID	1.2.36.1.2001.1001.101.103.11028

Definition

Definition	An indication of the degree of diagnostically significant abnormality of the value, based on available clinical information (including but not limited to the reference range).
Definition Source	NEHTA
Synonymous Names	
Notes	The term “normal” is **not** statistical normality, but rather what would normally be considered healthy for the individual concerned. As such, this data element represents the health risk for the individual, which is indicated by the observation or measurement and the nature and criticality of that health risk.
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) Normal 2) Abnormal

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS)	0..1

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

11.28 REFERENCE RANGE

Identification

Label	REFERENCE RANGE
Metadata Type	Data Group
Identifier	DG-11024
OID	1.2.36.1.2001.1001.101.102.11024

Definition

Definition	A named range to be associated with any quantity datum.
Definition Source	NEHTA
Synonymous Names	

Usage

Conditions of Use	If this data group occurs more than once, its contents **SHOULD** include all of the ranges in a single set. All reference ranges **SHALL** come from the one set of reference ranges.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS)	0..*

Children

Data Type	Name	Occurrences
	Reference Range Meaning	1..1
	Reference Range	1..1

11.29 Reference Range Meaning

Identification

Label	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	In the imaging examination case it is typical to send only one reference range, the applicable Normal reference range. When only one reference range is provided this data element is expected to have an implementation-specific value equivalent to “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[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) Normal 2) Mildly abnormal 3) Moderately abnormal 4) Severely abnormal

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERENCE RANGE	1..1

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

11.30 Reference Range

Identification

Label	Reference Range
Metadata Type	Data Element
Identifier	DE-11024
OID	1.2.36.1.2001.1001.101.103.11024

Definition

Definition	The data range for the associated *Reference Range Meaning* `data element`.
Definition Source	NEHTA
Synonymous Names	
Data Type	QuantityRange

Usage

Examples	1) 4.2-5.9 2) 6.0-6.3 3) 6.4-6.8 4) >/= 6.9

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERENCE RANGE	1..1

11.31 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result (INDIVIDUAL IMAGING EXAMINATION RESULT)	0..*

11.32 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 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	

Usage

Conditions of Use	Each instance of this data group **SHALL** contain exactly one SPECIFIC LOCATION or exactly one Anatomical Location Description. This data group **SHALL NOT** contain both an instance of SPECIFIC LOCATION and an instance of Anatomical Location Description.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group (IMAGING EXAMINATION RESULT GROUP)	0..1

Children

Data Type	Name	Occurrences
	SPECIFIC LOCATION	0..1
	~~RELATIVE LOCATION~~	~~0..0~~
	Anatomical Location Description	0..1
	~~Visual Markings/Orientation~~	~~0..0~~

Data Type	Name	Occurrences
	Anatomical Location Image	0..*

11.33 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	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..1

Children

Data Type	Name	Occurrences
	Anatomical Location Name	0..1
	Side	0..1
	~~Numerical Identifier~~	~~0..0~~
	~~Anatomical Plane~~	~~0..0~~

11.34 Anatomical Location Name

Identification

Label	Anatomical Location Name
Metadata Type	Data Element
Identifier	DE-16153
OID	1.2.36.1.2001.1001.101.103.16153

Definition

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

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for CodeableText.

Relationships

Parents

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

11.35 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	Occurrences (child within parent)
	Anatomical Location Name	1..1

11.36 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 the anatomical location.
Definition Source	NEHTA
Synonymous Names	Laterality
Data Type	CodedText
Value Domain	Laterality Reference Set

Usage

Examples	1) Right 2) Left 3) Bilateral

Relationships

Parents

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

11.37 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 the laterality of an anatomical location.
Definition Source	NEHTA

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

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

11.38 Anatomical Location Description

Identification

Label	Anatomical Location Description
Metadata Type	Data Element
Identifier	DE-16319
OID	1.2.36.1.2001.1001.101.103.16319

Definition

Definition	Description of the anatomical location.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..1

11.39 Anatomical Location Image

Identification

Label	Anatomical Location Image
Metadata Type	Data Element
Identifier	DE-16199
OID	1.2.36.1.2001.1001.101.103.16199

Definition

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

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for EncapsulatedData.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..*

11.40 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	
Data Type	EncapsulatedData

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for EncapsulatedData.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..1

11.41 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 requested examination.
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	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..*

Children

Data Type	Name	Occurrences
	~~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..*

11.42 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 the imaging examination which was requested.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Conditions of Use	This `data element` **SHOULD NOT** be used if its value is equal to the value of the Imaging Examination Result Name `data element`.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXAMINATION REQUEST DETAILS	0..*

11.43 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXAMINATION REQUEST DETAILS	0..1

11.44 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
Assumptions	The value of *Report Identifier* is intended for machine or computer consumption. It does not need to be used or consumed by the human user, e.g. reporting provider or the recipient of a test report.
Assumptions Source	NEHTA
Notes	This is a unique identifier of a diagnostic imaging procedure (or study) report. A local identifier can be made globally unique by giving it a context. The context may be identified by a globally unique identifier of the system which produces the local identifier.
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXAMINATION REQUEST DETAILS	0..1

11.45 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 referenced or provided to assist clinical understanding of the examination.
Definition Source	NEHTA
Synonymous Names	
Notes	If the attached image is in DICOM (Digital Imaging and Communications in Medicine) format, all fields below the image should be populated so that the values are available to software that does not process DICOM images.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXAMINATION REQUEST DETAILS	0..*

Children

Data Type	Name	Occurrences
	Image Identifier	0..1
	DICOM Series Identifier	0..1
	Image View Name	0..1
	Subject Position	0..1
	Image DateTime	0..1
	Image	0..1

11.46 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.
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.
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.
Assumptions Source	NEHTA
Notes	This is often the DICOM image instance UID. To ensure global uniqueness, the *Image Identifier* value may have to be used or associated with the unique "Organisation identifier" value.
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

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

11.47 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.

Relationships

Parents

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

11.48 Image View Name

Identification

Label	Image View Name
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.
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[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) Lateral 2) Antero-posterior (AP)

Relationships

Parents

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

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

11.49 Subject Position

Identification

Label	Subject 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 imaging examination was performed.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for Text.

Relationships

Parents

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

11.50 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	Date, and optionally time, the imaging examination was performed.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

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

Relationships

Parents

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

11.51 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for EncapsulatedData.

Relationships

Parents

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

11.52 Observation DateTime

Identification

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

Definition

Definition	Date, and optionally time, when an observation is clinically significant to the condition of the subject of the observation.
Definition Source	NEHTA
Synonymous Names	
Assumptions	For an observation based on a specimen the clinically significant time will have the same value as the time of collection of the specimen.
Assumptions Source	NEHTA
Notes	**Clinical Semantics of Event Time.** (Section 8.2.3.3 of *EHR Information Model [OEHR2008a]*) In most cases, the times recorded in [an *Observation DateTime* `data element`] can be thought of as “the times when the observed phenomena were true”. For example, if a pulse of 88bpm is recorded for 12/feb/2005 12:44:00, this is the time at which the heart rate (for which pulse is a surrogate) existed. In such cases, the *sample* time, and the *measuring* time are one and the same. However in cases where the time of sampling is different from that of measurement, the semantics are more subtle. There are two cases. The first is where a sample is taken (e.g. a tissue sample in a needle biopsy), and is tested later on, but from the point of view of the test, the time delay makes no difference. This might be because the sample was immediately preserved (e.g. freezing, placed in a sterile ... transport container), or because even if it decays in some way, it makes no difference to the test (e.g. bacteria may die, but this makes no difference to [an] analysis, as long as the biological matter is not physically destroyed). The second situation is when the sample does decay in some way, and the delay is relevant. Most such cases are in pathology tests, where presence of live biological organisms (e.g. anaerobic bacteria) is being measured. The sample time (or ‘collection’ time) must be recorded. Depending on when the test is done, the results may be interpreted differently. The key question is: what is the meaning of the [`data element`] in these situations? It is tempting to say that [its value is] (as in other cases) just the [time] of the actual act of observation, e.g. microscopy, chromatography etc. However, there are two problems with this. Firstly, and most importantly, all physical samples must be understood as being *indirect surrogates for some aspect of the patient state at the time of sampling*, which cannot be observed by direct, instantaneous means in the way a pulse can be taken. This means that no matter when the laboratory work is done, the time to which the result applies is the *sample* time. It is up to the laboratory to take into account time delays and effects of decay of samples in order to provide a test result which correctly indicates the

	state of the patient at the time of sampling. The common sense of this is clear when one considers the extreme case where the patient is in a coma or dead (possibly for reasons completely unrelated to the problem being tested for) by the time laboratory testing actually occurs; however, the test result indicates the situation at the point in time when the sample was taken, i.e. when the patient was alive. The second reason is that some kinds of testing are themselves lengthy. For example fungal specimens require 4-6 weeks to confirm a negative result; checks will be made on a daily or weekly basis to find positive growth. However, the result data reported by the laboratory (and therefore the structure of the Observation) is not related to the timing of the laboratory testing; it is reported as being the result for the time of collection of the specimen from the patient. The meaning therefore of the [`data element`] is always the time of sampling. Where delays between sample and measurement times exist and are significant, they are [modelled explicitly].
Data Type	DateTime

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	1..1

11.53 Imaging Examination Result Instance Identifier

Identification

Label	Imaging Examination Result Instance Identifier
Metadata Type	Data Element
Identifier	DE-16715
OID	1.2.36.1.2001.1001.101.103.16715

Definition

Definition	A globally unique identifier for each instance of an *Imaging Examination Result* observation.
Definition Source	NEHTA
Synonymous Names	
Notes	This `data element` is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniqueIdentifier

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..1

11.54 Detailed Clinical Model Identifier

Identification

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

Definition

Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.102.16145

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	1..1

12 Requested Service Detailed Clinical Model

This chapter describes a reuse of version 5.0 of the *Requested Service (Action)* Detailed Clinical Model (DCM).

See *Miscellaneous Detailed Clinical Model Specification [NEHT2015l]* for more information.

12.1 Purpose

Describe 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 or provider (or both) may not be recorded.

12.2 Misuse

Do not use to specify medication prescriptions.

12.3 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 recording the service date and provider is optional.

Usage

Misuse	Recording a requested service that is not a diagnostic service.

Relationships

Parents

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

Children

Data Type	Name	Occurrences
	~~Reason for Service~~	~~0..0~~
	Requested Service Description	1..1
	~~Intent of Request~~	~~0..0~~
	~~Request Urgency~~	~~0..0~~
	DateTime Service Scheduled	0..1

Data Type	Name	Occurrences
	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
	~~SERVICE REQUESTER~~	~~0..0~~
	SERVICE PROVIDER	0..1
	~~Request Validity Period~~	~~0..0~~
	~~Request Identifier (Instruction Identifier)~~	~~0..0~~
	~~INFORMATION PROVIDER~~	~~0..0~~
	~~SUBJECT~~	~~0..0~~
	Requested Service DateTime	1..1
	Requested Service Instance Identifier	0..1
	~~RELATED INFORMATION~~	~~0..0~~
	Detailed Clinical Model Identifier	1..1

12.4 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 a healthcare setting. Used to identify diagnostic procedures requested by the healthcare provider to be undertaken on, or provided to, the subject of care.
Context Source	NEHTA
Data Type	CodeableText

Usage

Examples	1) Dialysis 2) Adjustment of heart failure/hypertensive medications 3) Adjust INR to therapeutic range 4) Elective orthopaedic surgery for TKR 5) Ultrasound pelvis 6) Full blood count

Relationships

Parents

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

12.5 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 date and, optionally, time at which the arranged service is scheduled to be provided to the subject of care.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

Conditions of Use	This data element **SHALL NOT** be included if Service Commencement Window is included.
Conditions of Use Source	NEHTA
Examples	Please see DateTime in Appendix C, *Specification Guide for Use* for examples and usage information on specifying a date or time (or both).

Relationships

Parents

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

12.6 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 or 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

Conditions of Use	This data element **SHALL NOT** be included if DateTime Service Scheduled is included.
Conditions of Use Source	NEHTA
Examples	

Relationships

Parents

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

12.7 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	Please see Appendix C, *Specification Guide for Use* for examples and usage information for CodedText.

Relationships

Parents

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

12.8 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 that indicate the booking status of the arranged service.
Definition Source	NEHTA

Value Domain

Source	HL7® v3 CDA®: Act.moodCode.	
Permissible Values	APT, Appointment	Planned act for specific time and place
	ARQ, Appointment Request	Request for Booking of an Appointment
	EVN, Event	Service actually happens or happened or is ongoing
	INT, Intent	Plan to perform a service
	PRMS, Promise	An intent to perform a service
	PRP, Proposal	Non-mandated intent to perform an act
	RQO, Request	Request or Order for a service

Relationships

Parents

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

12.9 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 or information that has 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	Occurrences (child within parent)
	REQUESTED SERVICE	0..1

12.10 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]*. Further constraints on this data group that apply to this reuse of it are listed below. **Additional obligation and occurrence constraints when the service provider is an individual (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON):** • Entity Identifier is **ESSENTIAL**. • ADDRESS is **ESSENTIAL**. • Relationship to Subject of Care is **PROHIBITED**. • DEMOGRAPHIC DATA is **PROHIBITED**. Other additional constraints: • Participation Type **SHALL** have an implementation-specific value equivalent to “Service Provider”. • Role **SHOULD** have a value chosen from *1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 [ABS2009]*. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7® and is publicly available **MAY** be used. • The value of one Entity Identifier **SHALL** be an Australian HPI-I. • The value of ADDRESS.Address Purpose **SHALL** be “B” (Business). • The value of ELECTRONIC COMMUNICATION DETAIL.Electronic Communication Usage Code **SHALL** be “B” (Business). • 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 an ORGANISATION): • Entity Identifier is **ESSENTIAL**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**. Other additional constraints: • 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 an ORGANISATION. Terms used in obligation and occurrence constraints are explained in Appendix C, *Specification Guide for Use*.
Conditions of Use Source	NEHTA

Relationships

Parents

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

12.11 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	Date, and optionally time, that the *Requested Service* action is completed.
Definition Source	NEHTA
Synonymous Names	
Notes	This is date, and optionally time, the request for a future service was made. For example, where an appointment is made this is the date, and optionally time, the appointment was made rather than the date, and optionally time, of the appointment.
Data Type	DateTime

Usage

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

Relationships

Parents

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

12.12 Requested Service Instance Identifier

Identification

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

Definition

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

Usage

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

Relationships

Parents

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

12.13 Detailed Clinical Model Identifier

Identification

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

Definition

Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item **SHALL** be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, *Specification Guide for Use* for examples and usage information for UniqueIdentifier.
Default Value	1.2.36.1.2001.1001.101.102.20158

Relationships

Parents

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

13 UML Class Diagrams

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

If a data element's label differs from its name, the label is the attribute name and the name is a stereotype of the attribute. If a data group's or section's label differs from its name, the label is the class name and the name is a stereotype of the class.

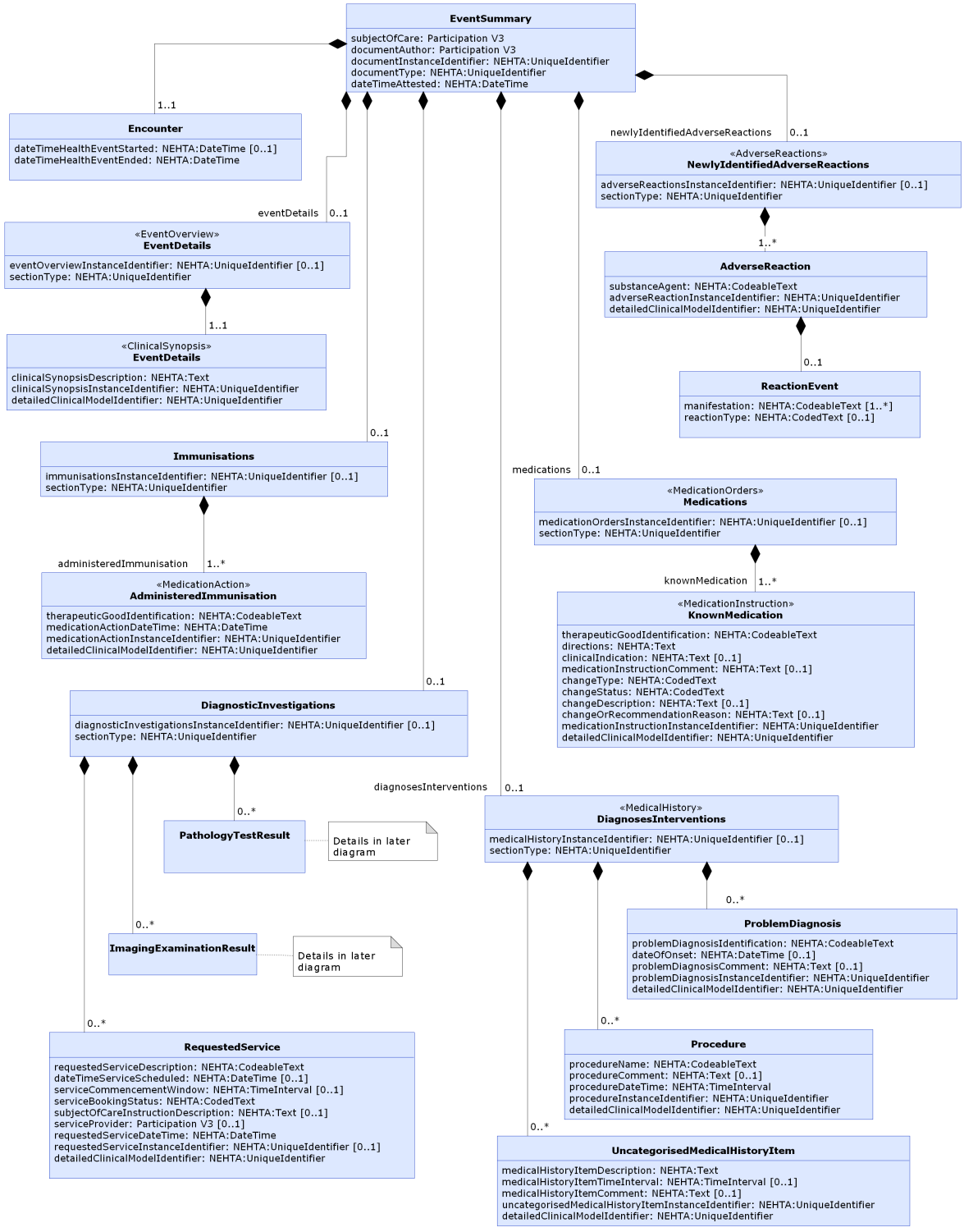


Figure 13.1. Event Summary

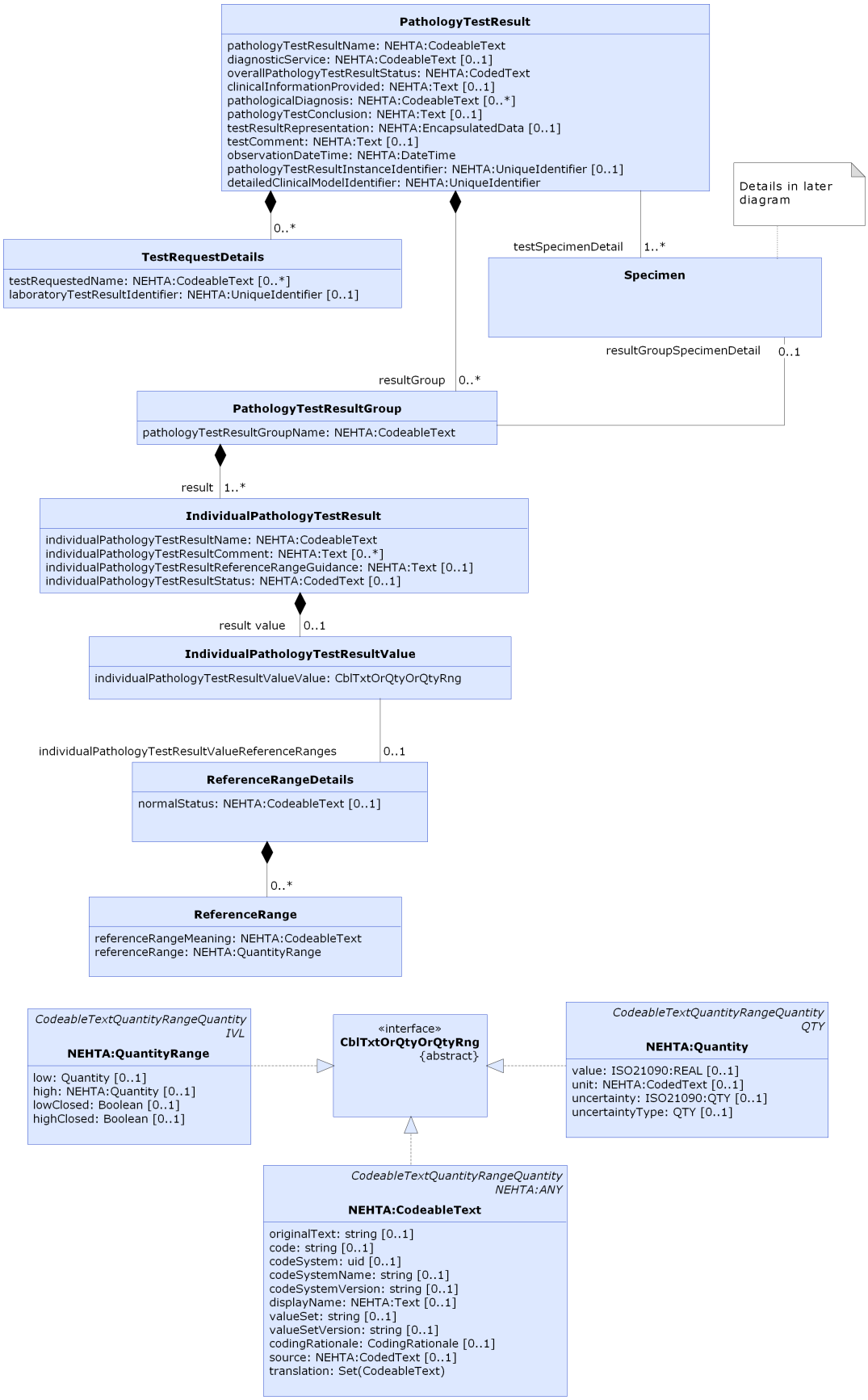


Figure 13.2. Pathology Test Result

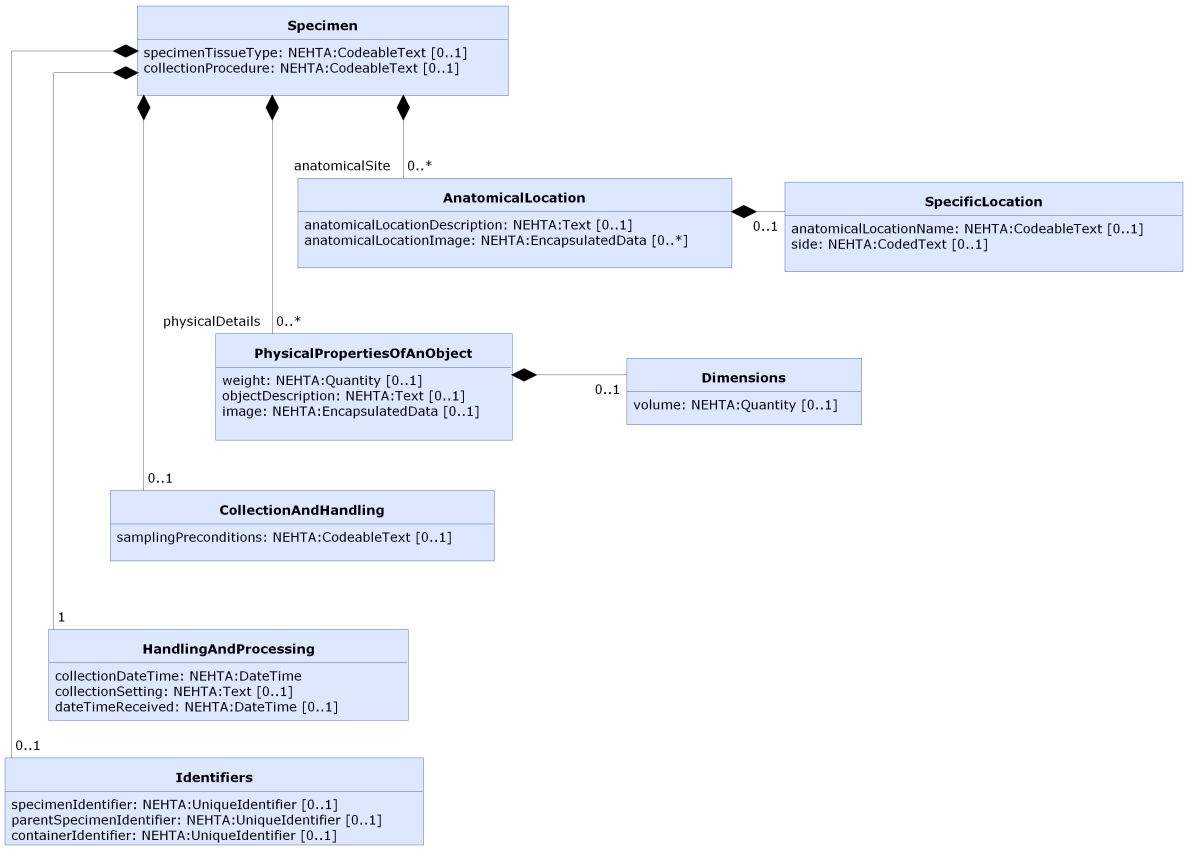


Figure 13.3. Specimen

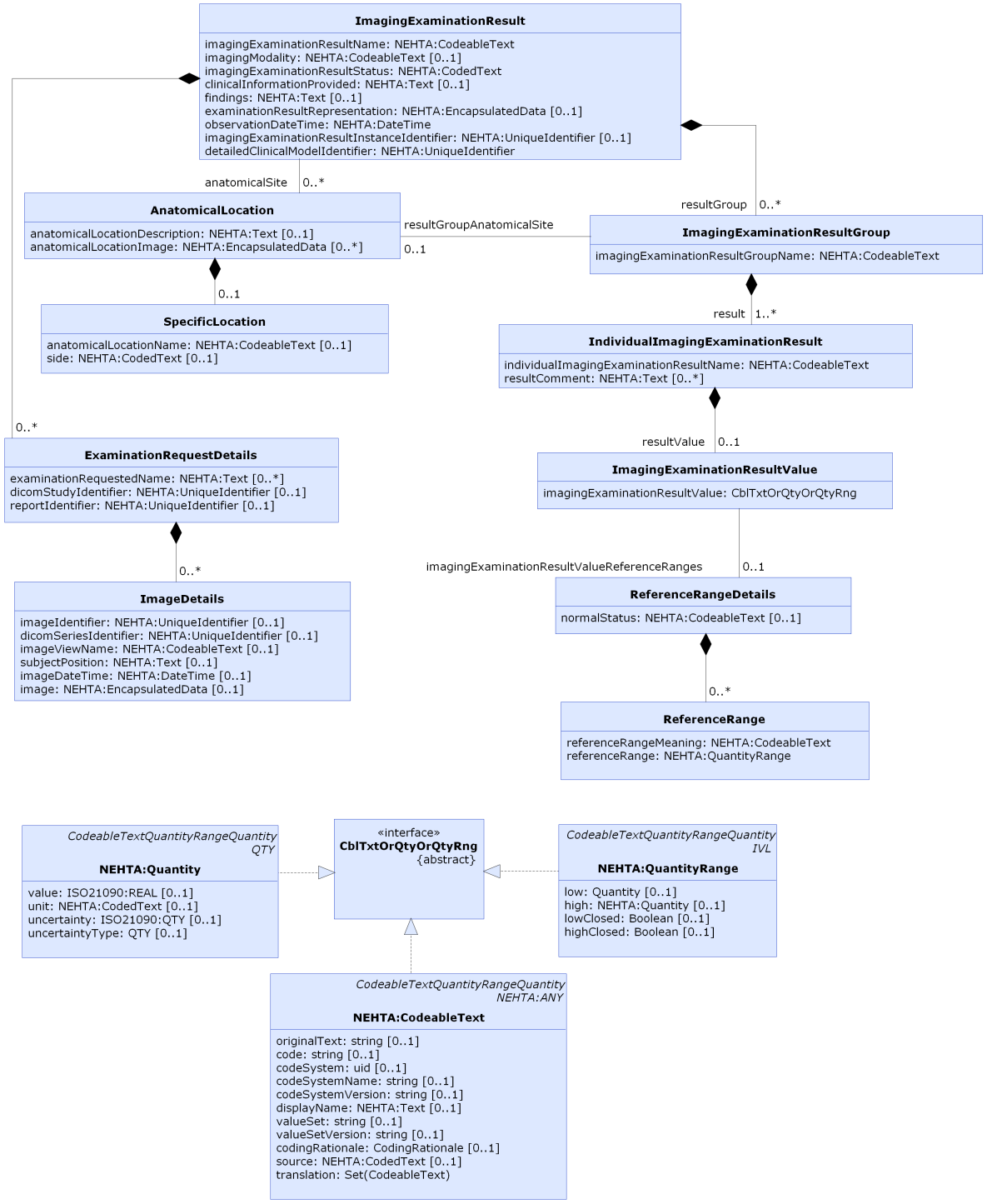


Figure 13.4. Imaging Examination Result

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Appendix A. Mappings from Requirements

This appendix lists data elements from the *NEHTA Event Summary Information Requirements [NEHT2015a]* document and matches them to their associated data elements in this Structured Content Specification (SCS) augmented with *NEHTA Participation Data Specification [NEHT2011v]*.

Data components are identified by their label, e.g. *Known Medication*, rather than by their name, e.g. *Medication Instruction*.

The mappings table below includes links to the SCS data elements that are described in this document.

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	Req No.	SCS Data Element
Individual	N/A	N/A	Subject of Care [SOC] [SOC] > Participant > Person or Organisation or Device > Person [SOC > P > POD > P]
Individual (Core)	N/A	N/A	N/A
	Individual Healthcare Identifier (mandatory)	022082	[SOC] > Participant > Entity Identifier
	Individual's Title (optional)	022081	[SOC > P > POD > P] > Person Name > Name Title
	Individual's Given Name (optional)	023056	[SOC > P > POD > P] > Person Name > Given Name
	Individual's Family Name (mandatory)	023058	[SOC > P > POD > P] > Person Name > Family Name
	Individual's Name Suffix (optional)	023059	[SOC > P > POD > P] > Person Name > Name Suffix
	Individual's Sex (mandatory)	024032	[SOC > P > POD > P] > Demographic Data > Sex
	Individual's Date of Birth (mandatory)	023060	[SOC > P > POD > P] > Demographic Data > Date of Birth Detail > Date of Birth
	Date of Birth accuracy indicator (optional)	024026	[SOC > P > POD > P] > Demographic Data > Date of Birth Detail > Date of Birth Accuracy Indicator
Individual (extension)	N/A	N/A	N/A
	Individual's Address (mandatory)	024041	[SOC] > Participant > Address
	Individual's Electronic Communication Details (optional)	024042	[SOC] > Participant > Electronic Communication Detail

Requirement Section	Data Item	Req No.	SCS Data Element
	Indigenous Status (mandatory)	024033	[SOC > P > POD > P] > Demographic Data > Indigenous Status
Event summary author	N/A	N/A	Document Author [DA] [DA] > Participant > Person or Organisation or Device > Person [DA > P > POD > P]
	Healthcare Provider Professional Role (mandatory)	024040	[DA] > Role
	Healthcare provider organisation name (mandatory)	023070	[DA > P > POD > P] > Employment Detail > Employer Organisation > Person or Organisation or Device > Organisation > Organisation Name
	Healthcare Provider Employer Organisation Address	025064	[DA > P > POD > P] > Employment Detail > Employer Organisation > Address
	Healthcare Provider Employer Organisation Electronic Communication Detail	025063	[DA > P > POD > P] > Employment Detail > Employer Organisation > Electronic Communication Detail
PCEHR participating Healthcare Provider (core)	N/A	N/A	N/A
	Healthcare Provider Identifier-Individual (mandatory)	023066	[DA] > Participant > Entity Identifier
	Healthcare Provider Identifier-Organisation (mandatory)	023071	[DA > P > POD > P] > Employment Detail > Employer Organisation > Entity Identifier
	Healthcare Provider's Title (optional)	023061	[DA > P > POD > P] > Person Name > Name Title
	Healthcare Provider Given Name (optional)	023062	[DA > P > POD > P] > Person Name > Given Name
	Healthcare Provider Family Name (mandatory)	023064	[DA > P > POD > P] > Person Name > Family Name
	Healthcare Provider Name Suffix (optional)	023065	[DA > P > POD > P] > Person Name > Name Suffix

Requirement Section	Data Item	Req No.	SCS Data Element
Healthcare Provider (extension)	N/A	N/A	N/A
	Healthcare Provider Individual's Workplace Address (optional)	024035	[DA] > Participant > Address
	Healthcare Provider Individual's Workplace Electronic Communication Details (optional)	024036	[DA] > Participant > Electronic Communication Detail
Event details	N/A	N/A	Event Details [ED]
	Component	025005	[ED]
	Reason for Visit	025006	[ED] > Event Details > Clinical Synopsis Description
	Event Date	025007	ENCOUNTER > DateTime Health Event Started ENCOUNTER > DateTime Health Event Ended
Newly identified allergies and adverse reactions	N/A	N/A	Newly Identified Adverse Reaction [NIAR]
	Component	025008	[NIAR]
		025009	
	Agent Description	025010	[NIAR] > Adverse Reaction > Substance/Agent
		025011	
	Reaction Type	024963	[NIAR] > Adverse Reaction > Reaction Event > Reaction Type
		024964	
	Reaction Description	025012	[NIAR] > Adverse Reaction > Reaction Event > Manifestation
		025013	
		025014	
		025015	
Medicines	N/A	N/A	Medications [M]
	Component	025016	[M]
		025017	
	Item Description	025018	[M] > Known Medication > Therapeutic Good Identification
		025019	
		025020	
	Status	025021	[M] > Known Medication > Change Type
		025022	
	Dose Instructions	025023	[M] > Known Medication > Directions

Requirement Section	Data Item	Req No.	SCS Data Element
	Reason for Medicine	025024	[M] > Known Medication > Clinical Indication
		025025	
	Additional Comments	025026	[M] > Known Medication > Medication Instruction Comment
		025027	
	Reason for Change	025028	[M] > Known Medication > Change or Recommendation Reason
		025029	
Diagnoses / interventions	N/A	N/A	Diagnoses/Interventions [DI] [DI] > PROBLEM/DIAGNOSIS [DI > PD] [DI] > PROCEDURE [DI > P] [DI] > UNCATEGORISED MEDICAL HISTORY ITEM [DI > UMHI]
	Component	025030	N/A
		025031	
	Diagnosis and Intervention Description	025032	[DI > PD] > Problem/Diagnosis Identification [DI > P] > Procedure Name [DI > UMHI] > Medical History Item Description
		025033	
	Diagnosis and Intervention comments	025035	[DI > PD] > Problem/Diagnosis Comment [DI > P] > Procedure Comment [DI > UMHI] > Medical History Item Comment
Immunisations	N/A	N/A	Immunisations [I]
	Component	025036	[I]
		025037	
	Vaccine Name	025038	[I] > Administered Immunisation > Therapeutic Good Identification
		025039	
		025040	
Diagnostic investigations	N/A	N/A	DIAGNOSTIC INVESTIGATIONS [DI] [DI] > PATHOLOGY TEST RESULT [DI > PTR] [DI] > IMAGING EXAMINATION RESULT [DI > IER] [DI] > REQUESTED SERVICE [DI > RS]
	Component	025041	N/A
		025042	
	Investigation Type	025043	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

Requirement Section	Data Item	Req No.	SCS Data Element
	Investigation Name	025044	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
	Result Status	025045	[DI > PTR] > Overall Pathology Test Result Status [DI > IER] > Imaging Examination Result Status [DI > RS] > Service Booking Status
	Result content	025046	[DI > PTR] > Test Result Representation
Document control	N/A	N/A	*This is described in the CDA® Implementation Guide*
	Component	025047	
		025048	
	Document Status	025049	
		025050	
	DateTime Attested	025051	DateTime Attested

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Appendix B. Known Issues

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

Reference	Description
Links to external resources	If a link (usually in references section) spans several lines, certain PDF readers have problems opening it.
Medicines Terminology	The described use of TPUU for administration of therapeutic goods does not work for vaccines where two or more components need to be combined prior to administration.
PROBLEM/DIAGNOSIS	The requirements for the Problem/Diagnosis data group do not distinguish between a clinical description of the problem/diagnosis and a comment on the problem/diagnosis. An issue has been raised as to whether this SCS should include *Problem/Diagnosis.Clinical Description* as well as or instead of the *Problem/Diagnosis.Problem/Diagnosis Comment* data element.
Procedure DateTime	In the previous version of the SCS the data element Start Date/Time (DateTime Started) was used to capture the date and time the procedure ended. The new data element is suitable for that. There is no change to the implementation in HL7® CDA®.
ADVERSE REACTIONS	There is no provision in *Newly Identified Adverse Reactions (ADVERSE REACTION)* section to record a patient's repudiation of a previously recorded adverse reaction statement.
10.9 SPECIMEN 10.55 SPECIMEN	The *Test Specimen Detail* and *Result Group Specimen Detail* data groups contain a large number of data components which are unlikely to be used in an Event Summary. The scope should be clarified.
10.22 DIMENSIONS 10.68 DIMENSIONS	There is no provision to include measurements other than volume, in particular for tissue specimens where at least length, width/breath and depth are required.
Test Result Representation	There is no provision to include multiple formats for diagnostic service reports ((i.e. pdf, rtf, xhtml etc) where each report contains the same content but the renderer can choose the format that they are best able to support when showing the content (depending on platform and tools available).
Examination Result Representation	There is no provision to include multiple formats for diagnostic service reports ((i.e. pdf, rtf, xhtml etc) where each report contains the same content but the renderer can choose the format that they are best able to support when showing the content (depending on platform and tools available).
SERVICE PROVIDER	There is no provision to include unstructured names for *Service Provider* instantiated as a person.
10.29 Collection DateTime 10.75 Collection DateTime	*Collection DateTime* data element and it's parent data group *HANDLING AND PROCESSING* should be optional as, for observations based on a specimen, the clinically significant time is held in the *Observation DateTime* data element.

Reference	Description
Undefined Value Domains	The following `data elements` lack a defined value domain: *Specimen Tissue Type*, *Collection Procedure*, *Sampling Preconditions*, *Normal Status*, *Reference Range Meaning*, *Pathological Diagnosis*, *Imaging Examination Result Name*, *Imaging Modality*, *Imaging Examination Result Group Name*, *Individual Imaging Examination Result Name*, *Normal Status*, *Image View Name* and *Requested Service Description*. NEHTA is in the process of developing national code sets for these items. In the meantime, you are free to use your own code set(s), providing any code set used **SHALL** be registered, i.e. registered through the HL7® code set registration procedure with an appropriate object identifier (OID), and **SHALL** be publicly available. Note that when national standard code set(s) do become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.
UML Class Diagram	The representation of data component names and labels with stereotypes and names is not good UML practice. It will be changed when a diagramming tool that supports an appropriate representation is adopted by NEHTA.
DateTime Attested	Many other documents do not have this data element, they record the date and time authored. The definition and exact intent of this data element need clarification.

Appendix C. Specification Guide for Use

C.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 the 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 that have been constrained to eliminate data components not relevant to the particular context. For example, *Procedure* in a discharge summary uses only some of the data components required by *Procedure* in a specialist report.

C.2 The Structured Content Specification Metamodel

The NEHTA Structured Content Specification Metamodel (see Figure 1) is used to specify the overall structure of a Structured Content Specification.

A DCM can be regarded as a data group with no parent.

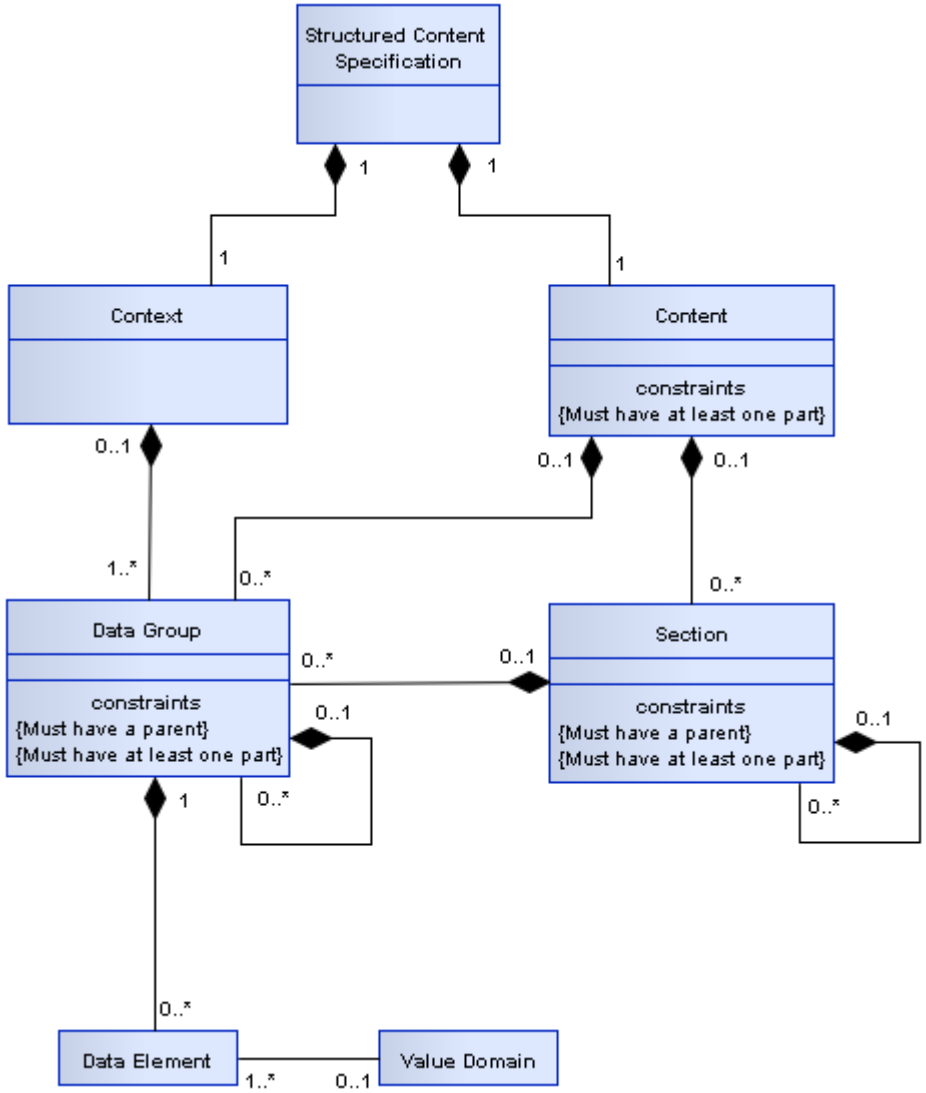

Figure 1: SCS Metamodel

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

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

Content: This contains information that changes between different SCSs, but is always structured as shown, 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

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

Section

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

Data Group

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

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

Participation

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

A Participant has been defined to align with the concepts of the NEHTA interoperability framework [NEHT2007b]. It equates to an *Entity* that is related to the action described in an SCS as an *Actor*. A Participant can be a human, an organisation or an IT system.

[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 is chosen for each instance of the choice.

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

Data Element

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

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

Value Domain

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

Value domains are reusable 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 is noted that many of these reference sets have been developed specifically for the context in which they appear. It is recommended that an assessment of fitness for purpose be undertaken before using any of the reference sets in another context.

Value domains constrain by either specifying a lower or upper bound (or both) 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 1: Value Domain Examples

<table>
<tr><th>Data Element</th><th>Data Type</th><th>Example of Value Domain</th></tr>
<tr><td>Sex</td><td>CodedText</td><td>[SA2006a] and [SA2006b] derive their values from METeOR 287316 which includes values such as:

<table><tr><th>Value</th><th>Meaning</th></tr><tr><td>1</td><td>Male</td></tr><tr><td>2</td><td>Female</td></tr><tr><td>3</td><td>Intersex or Indeterminate</td></tr><tr><td>9</td><td>Not Stated/Inadequately Described</td></tr></table></td></tr>
<tr><td>Diagnosis</td><td>CodeableText</td><td>A SNOMED CT-AU reference set 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>Individual Pathology Test Result Name</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>

C.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.

Table 2: Metadata Types Legend

Icon	Metadata Types
	Structured Document

	Section
	Data Group
	Participation
	Choice

Data Types Legend

The following table explains each of the icons used to represent the data types bound to each data element in the SCSs. These data types are a profile of the **ISO 21090-2011** data types as specified in [NEHT2010c].

Table 3: Data Types Legend

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; a 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. While it is recommended that the values in this data type come from the bound value domain, it allows other value domains to also be used (with or without translations to the bound value domain) or free text alternatives. This is in 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 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 or time (or both). Has the ability to indicate a level of precision, but not whether the date or time is estimated. String representations of known dates **SHALL** conform to the nonextended format within the **ISO 21090-2011** standard, i.e. YYYY[MM[DD[HH[MM[SS[.U[U[U[U]]]]]]]]][+|-ZZzz].

Usage/Examples

- Partial dates: 2008, 20081001.
- To indicate 1:20 pm on May the 31st, 1999 for a time zone 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 on 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 or directory structure – e.g. in the Windows® operating system, the “link” or absolute path to a particular letter could be *C:\Documents and Settings\GuestUser\MyDocuments\letter.doc*
 Quantity (ISO 21090: PQ)	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

 Real (ISO 21090: REAL)	A computational approximation to the standard mathematical concept of real numbers. These are often called floating-point numbers. **Usage/Examples** • 1.075 • -325.1 • 3.14157
 Text (ISO 21090: ST)	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. This is 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 for that purpose. • *identifierScope*: the geographic span or coverage that applies to or constrains the identifier. It is directly equivalent to the geographic area element. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used as such. Also, the following constraints apply on the UniqueIdentifier data type: 1) The *root* attribute **SHALL** be used. 2) For an entity identifier, the *root* attribute **SHALL** be an OID that consists of a node in a hierarchically-assigned namespace, formally defined using the ITU-T's ASN.1 standard. 3) For an entity identifier, the *root* attribute **SHALL NOT** be a UUID. 4) The *extension* attribute **SHALL** be used. **Usage/Examples** IHIs, HPI-Is, HPI-Os and patient hospital medical record numbers are examples of identifiers that **MAY** be carried by this data type.

Keywords Legend

Where used in this document and in DCMs and SCSs, the keywords **SHALL, SHOULD, MAY, SHALL NOT** and **SHOULD NOT** are to be interpreted as described in [RFC2119].

The following table defines these keywords.

Table 4: Keywords Legend

Keyword	Interpretation
SHALL	This word, or the term “required”, means that the statement 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 that does not include a particular option **SHALL** be prepared to interoperate with another implementation that does include the option, perhaps with reduced functionality. In the same vein, an implementation that does include a particular option **SHALL** be prepared to interoperate with another implementation that does not include the option (except of course, for the feature the option provides).
SHALL NOT	This phrase means that the statement is an absolute prohibition of the specification.
SHOULD NOT	This phrase, 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.

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.

Table 5: Obligations Legend

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.

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.

C.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 at least three occupied cells. The left-most cell contains an icon to indicate the entry's data type. The next cell to the right contains the label and description of the component (if the label is different from the name, the name is displayed in brackets after the label). The next cell to the right contains the multiplicity range for the data component.

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

In an 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.

Table 6: Identification Section Legend

Label	A suggested display name for the component. (Source NEHTA.)
Metadata Type	The 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 that is assigned by an organisation other than NEHTA. (Source NEHTA.)

Definition Section Legend

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

Table 7: Definition Section Legend

Definition	The meaning, description 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 is 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.

Value Domain Section Legend

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

Table 8: Value Domain Section Legend

Source	The name of the terminology or vocabulary from which the value domain's permissible values are sourced, e.g. SNOMED CT-AU, LOINC.
Version Number	Version number of the value domain source.
Permissible Values	List of permissible values in the value domain.

Usage Section Legend

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

Table 9: Usage Section Legend

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 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 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 or applicable, typically assigned at the creation of an instance of the component. (Source NEHTA.)

Relationships Section Legend

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

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

Table 10: Parent Legend

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

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

Table 11: Children Legend

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

Appendix D. Change History

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

D.1 Changes Since Version 1.1 - 30 November 2011

Significant changes

Significant changes are listed here as well as in the next section. Significant changes are additions, deletions and substitutions of clinical data elements and changes of cardinality range, data type or conditions of use of clinical data elements. Significant changes do not include rewording of definitions, notes or conditions of use where the intended meaning has not changed. Reworded definitions, notes and conditions of use should be reviewed, as the previous wording may have been misunderstood.

Data Hierarchy changes

The following data components were added, deleted or substituted:

- data group *ENCOUNTER* has been added;
- data element *Encounter Period* has been replaced with *Encounter* > *DateTime Health Event Started* and *Encounter* > *DateTime Health Event Ended* data elements;
- data element *DateTime Attested* has been added;
- data group *ADVERSE REACTIONS* > *ADVERSE REACTION*, the data element *Reaction Type* has been added;
- data group *Diagnoses/Interventions* > *PROCEDURE*, the data element *Start Date/Time (DateTime Started)* has been replaced with the new data element *Procedure DateTime*;
- section *Diagnoses/Interventions*, the data group *MEDICAL HISTORY ITEM* has been renamed to *UNCATEGORISED MEDICAL HISTORY ITEM*;
- data group *DIAGNOSTIC INVESTIGATIONS* > *PATHOLOGY TEST RESULT* > *Result Group* > *Result* > the data group *Result Value Reference Range Details* and its child data have been replaced with a new data group *REFERENCE RANGE DETAILS* and its child data components;
- data group *DIAGNOSTIC INVESTIGATIONS* > *PATHOLOGY TEST RESULT*, the data element *Pathology Test Result DateTime* has been replaced with the new data element *Observation DateTime*;
- data group *DIAGNOSTIC INVESTIGATIONS* > *IMAGING EXAMINATION RESULT* > *Result Group* > *Result*, the data group *Result Value Reference Range Details* and its child data have been replaced with a new data group *REFERENCE RANGE DETAILS* and its child data components; and
- data group *DIAGNOSTIC INVESTIGATIONS* > *IMAGING EXAMINATION RESULT*, the data element *Imaging Examination Result DateTime* has been replaced with the new data element *Observation DateTime*.

The following data elements have had their cardinality changed:

- *DIAGNOSTIC INVESTIGATIONS* > *PATHOLOGY TEST RESULT* > *Test Specimen Detail*;
- *DIAGNOSTIC INVESTIGATIONS* > *PATHOLOGY TEST RESULT* > *Test Specimen Detail* > *HANDLING AND PROCESSING*;

- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Test Specimen Detail > HANDLING AND PROCESSING > Date and Time of Collection*;
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Result Group Specimen Detail > HANDLING AND PROCESSING*; and
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Result Group Specimen Detail > HANDLING AND PROCESSING > Date and Time of Collection*.

Chapter 2 Event Summary Structured Document

In 2.4 SUBJECT OF CARE, the following Conditions of Use have been changed:

- “Source of Death Notification is PROHIBITED” has been deleted; and
- “Mothers Original Family Name is PROHIBITED” has been deleted.

In 2.5 DOCUMENT AUTHOR, the following Conditions of Use have been changed:

- “Participation Period is ESSENTIAL” has been added;
- “ADDRESS is ESSENTIAL” has been deleted;
- “ELECTRONIC COMMUNICATION DETAIL is ESSENTIAL” has been deleted;
- “EMPLOYER ORGANISATION.Entity Identifier is ESSENTIAL” has been added;
- “EMPLOYER ORGANISATION.ADDRESS is ESSENTIAL” has been added;
- “ENTITLEMENT is PROHIBITED” has been deleted;
- “Qualifications is PROHIBITED” has been deleted;
- “The value of ADDRESS.Address Purpose SHALL be ‘B’ (Business)” has been added;
- “The value of ELECTRONIC COMMUNICATION DETAIL.Electronic Communication Usage Code SHALL be ‘B’ (Business)” has been added; and
- “The value of one EMPLOYER ORGANISATION.Entity Identifier SHALL be an Australian HPI-O” has been added.

In 2.21 MEDICAL HISTORY, Conditions of Use have changed.

Chapter 3 Event Details Detailed Clinical Model

No significant changes.

Chapter 4 Adverse Reaction Detailed Clinical Model

In 4.6 Substance/Agent Values Permissible Values, the set of values has been widened.

In 4.9 Clinical Manifestation Values Permissible Values, the set of values has been widened.

Chapter 5 Known Medication Detailed Clinical Model

In 5.11 Change Type Values, the set of values has been changed.

In 5.13 Change Status Values, the set of values has been changed.

Chapter 6 Problem/Diagnosis Detailed Clinical Model

In 6.7 Date of Onset Conditions of Use, a condition prohibiting time has been added.

Chapter 7 Procedure Detailed Clinical Model

No significant changes additional to those listed in the Data Hierarchy changes.

Chapter 8 Uncategorised Medical History Item Detailed Clinical Model

8.4 UNCATEGORISED MEDICAL HISTORY ITEM has a new Name, Label, Definition and Usage. The Identifier is the same as the meaning has not changed.

Chapter 9 Administered Immunisation Detailed Clinical Model

In 9.6 Medicines Terminology Conditions of Use, the set of values has been widened.

Chapter 10 Pathology Test Result Detailed Clinical Model

In 10.5 Pathology Test Result Name, Value Domain has been added.

In 10.12 ANATOMICAL LOCATION, Conditions of Use has been added.

In 10.21 Weight, Conditions of Use has been added.

In 10.23 Volume, Conditions of Use has been added.

In 10.40 Pathology Test Result Group Name, Value Domain has been added.

In 10.42 Individual Pathology Test Result Name, Value Domain has been added.

In 10.58 ANATOMICAL LOCATION, Conditions of Use has been added.

In 10.67 Weight, Conditions of Use has been added.

In 10.69 Volume, Conditions of Use has been added.

In 10.87 Test Requested Name, Value Domain and Conditions of Use have been added.

Chapter 11 Imaging Examination Result Detailed Clinical Model

In 11.7 ANATOMICAL LOCATION, Conditions of Use has been added.

In 11.15 Imaging Examination Result Status, Value Domain has been added.

In 11.24 Imaging Examination Result Value, Value Domain has been added.

In 11.32 ANATOMICAL LOCATION, Conditions of Use has been added.

In 11.42 Examination Requested Name, Conditions of Use has been added.

Chapter 12 Requested Service Detailed Clinical Model

In 12.5 DateTime Service Scheduled, Conditions of Use has been added.

In 12.6 Service Commencement Window, Conditions of Use has been added.

In 12.10 SERVICE PROVIDER, the following Conditions of Use have been changed:

- when the service provider is an individual (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON):
  - “ENTITLEMENT is PROHIBITED” has been deleted;
  - “Qualifications is PROHIBITED” has been deleted;
  - Role statement has been updated to add “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” has been updated to add “one”;
  - “The value of ADDRESS.Address Purpose SHALL be “B” (Business)” has been added; and
  - “The value of ELECTRONIC COMMUNICATION DETAIL.Electronic Communication Usage Code SHALL be “B” (Business)” has been added.
- when the service provider is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an ORGANISATION):
  - “The value of one Entity Identifier SHALL be an Australian HPI-O” has been updated to add “one”.

Changes

This includes those changes listed in the previous section.

The presentation format has changed between version 1.1 and version 1.2. Changes that result from the change in presentation format are not listed below.

Changes to prohibited data components are not described.

Changes to the appendices are not described.

Data Hierarchy changes

The following data components were added, deleted or substituted:

- data group *ENCOUNTER* has been added;
- data element *Encounter Period* has been replaced with *ENCOUNTER > DateTime Health Event Started* and *ENCOUNTER > DateTime Health Event Ended* data elements;
- data element *DateTime Attested* has been added;
- data group *ADVERSE REACTIONS > ADVERSE REACTION*, the data element *Reaction Type* has been added;
- data group *Diagnoses/Interventions > PROCEDURE*, the data element *Start Date/Time (DateTime Started)* has been replaced with the new data element *Procedure DateTime*;
- section *Diagnoses/Interventions*, the data group *Other Medical History Item (Medical History Item)* has been renamed to *UNCATEGORISED MEDICAL HISTORY ITEM*;
- data group *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Result Group > Result*, the data group *Result Value* has been added;
- data group *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Result Group > Result > Result Value*, the data group *Individual Pathology Test Result Value Reference Ranges* has been added;

- data group *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Result Group > Result*, the data element *Result Value Normal Status (Individual Pathology Test Result Value Normal Status)* has been removed;
- data group *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Result Group > Result > Result Value > Individual Pathology Test Result Value Reference Ranges*, the data element *Normal Status* has been added;
- data group *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Result Group >*; *Result > Result Value > Individual Pathology Test Result Value Reference Ranges*, the data group *Reference Range* has been added;
- data group *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Result Group > Result > Result Value > Individual Pathology Test Result Value Reference Ranges > Reference Range*, the data element *Individual Pathology Test Result Value Reference Range* has been replaced with *Reference Range*;
- data group *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT*, the data element *Pathology Test Result DateTime* has been replaced with the new data element *Observation DateTime*;
- data group *DIAGNOSTIC INVESTIGATIONS > Imaging Examination Result > Result Group > Result*, the data group *Imaging Examination Result Value* has been added;
- data group *DIAGNOSTIC INVESTIGATIONS > Imaging Examination Result > Result Group > Result > Imaging Examination Result Value*, the data group *Imaging Examination Result Value Reference Ranges* has been added;
- data group *DIAGNOSTIC INVESTIGATIONS > Imaging Examination Result > Result Group > Result > Imaging Examination Result Value > Imaging Examination Result Value Reference Ranges*, the data element *Imaging Examination Result Value Normal Status* has been replaced with *Normal Status*;
- data group *DIAGNOSTIC INVESTIGATIONS > Imaging Examination Result > Result Group > Result > Imaging Examination Result Value > Imaging Examination Result Value Reference Ranges*, the data group *Reference Range* has been added;
- data group *DIAGNOSTIC INVESTIGATIONS > Imaging Examination Result > Result Group > Result > Imaging Examination Result Value > Imaging Examination Result Value Reference Ranges > Reference Range*, the data element *Imaging Examination Result Value Reference Range* has been replaced with *Reference Range*; and
- data group *DIAGNOSTIC INVESTIGATIONS > Imaging Examination Result*, the data element *Imaging Examination Result DateTime* has been replaced with the new data element *Observation DateTime*.

The following data elements have had their cardinality changed:

- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Test Specimen Detail*;
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Test Specimen Detail > HANDLING AND PROCESSING*;
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Test Specimen Detail > HANDLING AND PROCESSING > Date and Time of Collection*;
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Result Group Specimen Detail > HANDLING AND PROCESSING*; and
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Result Group Specimen Detail > HANDLING AND PROCESSING > Date and Time of Collection*.

The following technical identifiers have been added:

- *Document Instance Identifier*;
- *Document Type*;

- *Event Details > Event Details > Clinical Synopsis Instance Identifier*;
- *Event Details > Event Details > Detailed Clinical Model Identifier*;
- *Event Details > Event Overview Instance Identifier*;
- *Event Details > Section Type*;
- *Newly Identified Adverse Reactions > ADVERSE REACTION > Adverse Reaction Instance Identifier*;
- *Newly Identified Adverse Reactions > ADVERSE REACTION > Detailed Clinical Model Identifier*
- *Newly Identified Adverse Reactions > Adverse Reactions Instance Identifier*;
- *Newly Identified Adverse Reactions > Section Type*;
- *Medications > Known Medication > Medication Instruction Instance Identifier*;
- *Medications > Known Medication > Detailed Clinical Model Identifier*;
- *Medications > Medication Orders Instance Identifier*;
- *Medications > Section Type*;
- *Diagnoses/Interventions > PROBLEM/DIAGNOSIS > Problem/Diagnosis Instance Identifier*;
- *Diagnoses/Interventions > PROBLEM/DIAGNOSIS > Detailed Clinical Model Identifier*;
- *Diagnoses/Interventions > PROCEDURE > Procedure Instance Identifier*;
- *Diagnoses/Interventions > PROCEDURE > Detailed Clinical Model Identifier*;
- *Diagnoses/Interventions > UNCATEGORISED MEDICAL HISTORY ITEM > Uncategorised Medical History Item Instance Identifier*;
- *Diagnoses/Interventions > UNCATEGORISED MEDICAL HISTORY ITEM > Detailed Clinical Model Identifier*;
- *Diagnoses/Interventions > Medical History Instance Identifier*;
- *Diagnoses/Interventions > Section Type*;
- *Immunisations > Administered Immunisation > Medication Action Instance Identifier*;
- *Immunisations > Administered Immunisation > Detailed Clinical Model Identifier*;
- *Immunisations > Immunisations Instance Identifier*;
- *Immunisations > Section Type*;
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Pathology Test Result Instance Identifier*;
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Detailed Clinical Model Identifier*;
- *DIAGNOSTIC INVESTIGATIONS > IMAGING EXAMINATION RESULT > Imaging Examination Result Instance Identifier*;
- *DIAGNOSTIC INVESTIGATIONS > IMAGING EXAMINATION RESULT > Detailed Clinical Model Identifier*;
- *DIAGNOSTIC INVESTIGATIONS > REQUESTED SERVICE > Requested Service Instance Identifier*;
- *DIAGNOSTIC INVESTIGATIONS > REQUESTED SERVICE > Detailed Clinical Model Identifier*;
- *DIAGNOSTIC INVESTIGATIONS > Diagnostic Investigations Instance Identifier*; and

- *DIAGNOSTIC INVESTIGATIONS > Section Type*;

The following data elements have had their labels changed to match their names:

- *Medications > Known Medication > Therapeutic Good Identification*;
- *Medications > Known Medication > Medication Instruction Comment*;
- *Medications > Known Medication > Change Status*;
- *Medications > Known Medication > Change or Recommendation Reason*;
- *Diagnoses/Interventions > PROBLEM/DIAGNOSIS > Problem/Diagnosis Identification*;
- *Diagnoses/Interventions > PROBLEM/DIAGNOSIS > Problem/Diagnosis Comment*;
- *Diagnoses/Interventions > PROCEDURE > Procedure Comment*;
- *Immunisations > Administered Immunisation > Therapeutic Good Identification*;
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Anatomical Site > Specific Location > Anatomical Location Name*;
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Anatomical Site > Anatomical Location Description*;
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Anatomical Site > Anatomical Location Image*;
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Overall Pathology Test Result Status*;
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Result Group > Pathology Test Result Group Name*;
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Result Group > Result > Individual Pathology Test Result Name*;
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Result Group > Result > Individual Pathology Test Result Comment*;
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Result Group Specimen Detail > Anatomical Site > Specific Location > Anatomical Location Name*;
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Result Group Specimen Detail > Anatomical Site > Anatomical Location Description*;
- *DIAGNOSTIC INVESTIGATIONS > PATHOLOGY TEST RESULT > Result Group Specimen Detail > Anatomical Site > Anatomical Location Image*;
- *DIAGNOSTIC INVESTIGATIONS > IMAGING EXAMINATION RESULT > Imaging Modality*;
- *DIAGNOSTIC INVESTIGATIONS > IMAGING EXAMINATION RESULT > Anatomical Site > Specific Location > Anatomical Location Name*;
- *DIAGNOSTIC INVESTIGATIONS > IMAGING EXAMINATION RESULT > Anatomical Site > Anatomical Location Description*;
- *DIAGNOSTIC INVESTIGATIONS > IMAGING EXAMINATION RESULT > Anatomical Site > Anatomical Location Image*;
- *DIAGNOSTIC INVESTIGATIONS > IMAGING EXAMINATION RESULT > Imaging Examination Result Group Name*;

- *DIAGNOSTIC INVESTIGATIONS > IMAGING EXAMINATION RESULT > Result > Individual Imaging Examination Result Name*;
- *DIAGNOSTIC INVESTIGATIONS > IMAGING EXAMINATION RESULT > Result Group > Result > Result Group Anatomical Site > Anatomical Site > Specific Location > Anatomical Location Name*;
- *DIAGNOSTIC INVESTIGATIONS > IMAGING EXAMINATION RESULT > Result Group > Result > Result Group Anatomical Site > Anatomical Site > Anatomical Location Description*;
- *DIAGNOSTIC INVESTIGATIONS > IMAGING EXAMINATION RESULT > Result Group > Result > Result Group Anatomical Site > Anatomical Site > Anatomical Location Image*;
- *DIAGNOSTIC INVESTIGATIONS > IMAGING EXAMINATION RESULT > EXAMINATION REQUEST DETAILS > Image Details > Image View Name*; and
- *DIAGNOSTIC INVESTIGATIONS > IMAGING EXAMINATION RESULT > EXAMINATION REQUEST DETAILS > Image Details > Subject Position*.

Chapter 2 Event Summary Structured Document

In 2.4 SUBJECT OF CARE the following changes have been made:

- External Identifier has been deleted;
- in Definition, Synonymous Names and Scope, the text has changed; and
- in Conditions of Use, the condition:
  - “Source of Death Notification is PROHIBITED” has been deleted;
  - “Mothers Original Family Name is PROHIBITED” has been deleted;
  - “Participation Type SHALL have an implementation-specific fixed value equivalent to ‘Subject of Care’ ” has been reworded, the word “fixed” has been deleted;
  - “Role SHALL have a fixed value of ‘Patient’ ” has been reworded; and
  - “The value of Entity Identifier SHALL be an Australian IHI” has been reworded.

In 2.5 DOCUMENT AUTHOR the following changes have been made:

- in Definition and Scope, the text has changed;
- in Notes, the note has been replaced; and
- in Conditions of Use, the condition :
  - “Participation Period is ESSENTIAL” has been added;
  - “ADDRESS is ESSENTIAL” has been deleted;
  - “ELECTRONIC COMMUNICATION DETAIL is ESSENTIAL” has been deleted;
  - “ENTITLEMENT is PROHIBITED” has been deleted;
  - “Qualifications is PROHIBITED” has been deleted;
  - “EMPLOYER ORGANISATION.Entity Identifier is ESSENTIAL” has been added;
  - “EMPLOYER ORGANISATION.ADDRESS is ESSENTIAL” has been added;
  - “EMPLOYER ORGANISATION.ELECTRONIC COMMUNICATION DETAIL is ESSENTIAL” has been added;

- “Participation Type SHALL have an implementation-specific fixed value equivalent to ‘Document Author’ ” has been reworded, the word “fixed” has been deleted;
- “The value of ADDRESS.Address Purpose SHALL be ‘B’ (Business)” has been added;
- “The value of ELECTRONIC COMMUNICATION DETAILS.Electronic Communication Usage Code SHALL be ‘B’ (Business)” has been added; and
- “The value of one EMPLOYER ORGANISATION.Entity Identifier SHALL be an Australian HPI-O” has been added.

2.6 ENCOUNTER has been added.

2.7 DateTime Health Event Started has been added.

2.8 DateTime Health Event Ended has been added.

2.9 Document Instance Identifier has been added.

2.10 Document Type has been added.

2.11 DateTime Attested has been added.

2.13 Event Overview Instance Identifier has been added.

2.14 Section Type has been added.

In 2.15 ADVERSE REACTIONS:

- Scope and Misuse have been reworded; and
- Conditions of Use has been deleted.

2.16 Adverse Reactions Instance Identifier has been added.

2.17 Section Type has been added.

In 2.18 MEDICATION ORDERS:

- Definition has been reworded; and
- Scope and Notes have been reworded.

2.19 Medication Orders Instance Identifier has been added.

2.20 Section Type has been added.

In 2.21 MEDICAL HISTORY:

- Definition and Notes have been reworded; and
- Assumptions, Assumptions Source and Misuse have been added.

In 2.13 Medical History, Conditions of Use have changed.

2.22 Medical History Instance Identifier has been added.

2.23 Section Type has been added.

In 2.24 IMMUNISATIONS:

- the label has changed from *Administered Immunisations* to match the name;
- Definition has been reworded; and

- Scope, Scope Source and Misuse have been added.

2.25 Immunisations Instance Identifier has been added.

2.26 Section Type has been added.

In 2.27 DIAGNOSTIC INVESTIGATIONS, Conditions of Use and Misuse have been reworded.

2.28 Diagnostic Investigations Instance Identifier has been added.

2.29 Section Type has been added.

Chapter 3 Event Details Detailed Clinical Model

The version of the DCM used has changed from 4.1 to 4.3.

In 3.4 CLINICAL SYNOPSIS:

- Definition has been reworded;
- Synonymous Names, Scope and Notes have been added; and
- Conditions of Use has been removed.

In 3.5 Clinical Synopsis Description:

- Definition, Notes and Examples have been reworded; and
- Context and Context Source has been added.

3.6 Clinical Synopsis Instance Identifier has been added.

3.7 Detailed Clinical Model Identifier has been added.

Chapter 4 Adverse Reaction Detailed Clinical Model

The version of the DCM used has changed from 5.1 to 5.2.

In 4.4 ADVERSE REACTION:

- Definition has been reworded;
- Scope and Scope Source have been added; and
- Conditions of Use and Conditions of Use Source have been removed.

In 4.6 Substance/Agent Values:

- Definition has been reworded; and
- in Permissible Values, the set of values has been widened.

In 4.8 Manifestation, Definition and Notes have been reworded.

In 4.9 Clinical Manifestation Values:

- External Identifier has been deleted;
- Definition has been reworded; and
- in Value Domain, Permissible Values have been added.

4.10 Reaction Type has been added.

4.11 Adverse Reaction Type Values has been added.

4.12 Adverse Reaction Instance Identifier has been added.

4.13 Detailed Clinical Model Identifier has been added.

Chapter 5 Known Medication Detailed Clinical Model

The version of the DCM used has changed from 3.2 to 3.3.

In 5.4 MEDICATION INSTRUCTION:

- Synonymous Names has been updated; and
- Conditions of Use has been removed.

In 5.5 Therapeutic Good Identification:

- the label has changed from *Medicine* to match the name; and
- Definition, Context, Notes, Conditions of Use and Examples have been reworded.

In 5.6 Medicines Terminology, Notes and Permissible Values have been reworded.

In 5.7 Directions, Conditions of Use has been moved to Notes.

In 5.8 Clinical Indication, Conditions of Use has been removed.

In 5.9 Medication Instruction Comment, the label has changed from *Comment* to match the name.

In 5.11 Change Type Values:

- External Identifier has been added.
- Definition has been reworded;
- Source has been updated to “SNOMED CT-AU”; and
- Permissible Values has been removed.

In 5.12 Change Status:

- the label has changed from *Change or Recommendation?* to match the name; and
- Definition has been reworded.

In 5.13 Change Status Values:

- External Identifier has been added.
- Definition has been reworded;
- Source has been updated to “SNOMED CT-AU”; and
- Permissible Values has been removed.

In 5.9 Change or Recommendation Reason, the label has changed from *Change Reason* to match the name.

5.16 Medication Instruction Instance Identifier has been added.

5.17 Detailed Clinical Model Identifier has been added.

Chapter 6 Problem/Diagnosis Detailed Clinical Model

The version of the DCM used has changed from 5.1 to 5.2.

In 6.4 PROBLEM/DIAGNOSIS:

- Definition and Notes have been reworded;
- Scope has been added; and
- Conditions of Use has been removed.

In 6.5 Problem/Diagnosis Identification, the label has changed from *Problem/Diagnosis* to match the name.

In 6.6 Problem/Diagnosis Reference Set, External Identifier and Definition have been reworded.

In 6.7 Date of Onset:

- Definition has been reworded; and
- in Conditions of Use, a condition prohibiting time has been added.

In 6.8 Problem/Diagnosis Comment, the label has changed from *Comment* to match the name.

6.9 Problem/Diagnosis Instance Identifier has been added.

6.10 Detailed Clinical Model Identifier has been added.

Chapter 7 Procedure Detailed Clinical Model

The version of the DCM used has changed from 4.1 to 4.2.

In 7.4 PROCEDURE:

- Scope, Scope Source and Misuse have been added; and
- Conditions of Use has been removed.

In 7.6 Procedure Foundation Reference Set, External Identifier has been updated with the name of reference set.

In 7.7 Procedure Comment, the label has changed from *Comment* to match the name.

7.8 DateTime Started has been deleted.

7.8 Procedure DateTime has been added.

7.9 Procedure Instance Identifier has been added.

7.10 Detailed Clinical Model Identifier has been added.

Chapter 8 Uncategorised Medical History Item Detailed Clinical Model

The version of the DCM used has changed from 1.1 to 2.0.

8.4 UNCATEGORISED MEDICAL HISTORY ITEM has a new Name, Label, Definition and Usage. The Identifier is the same as the meaning has not changed.

8.5 Medical History Item Description, Definition has been reworded.

8.6 Medical History Timeinterval has been renamed to *Medical History TimeInterval*.

8.6 Medical History TimeInterval, Definition has been reworded.

8.7 Medical History Comment, Definition has been reworded.

8.8 Uncategorised Medical History Item Instance Identifier has been added.

8.9 Detailed Clinical Model Identifier has been added.

Chapter 9 Administered Immunisation Detailed Clinical Model

The version of the DCM used has changed from 4.0 to 4.1.

In 9.4 MEDICATION ACTION:

- the label has changed from *Immunisation* to *Administered Immunisation*;
- Definition has been reworded; and
- Conditions of Use has been deleted.

In 9.5 Therapeutic Good Identification:

- the label has changed from *Medicine* to match the name; and
- Definition, Notes, Conditions of Use and Examples have been reworded.

In 9.6 Medicines Terminology Conditions of Use, the set of values has been widened.

In 9.7 Medication Action DateTime, Definition has been reworded.

9.8 Medication Action Instance Identifier has been added.

9.9 Detailed Clinical Model Identifier has been added.

Chapter 10 Pathology Test Result Detailed Clinical Model

The version of the DCM used has changed from 2.1 to 3.1.

In 10.4 PATHOLOGY TEST RESULT, Conditions of Use has been deleted.

In 10.5 Pathology Test Result Name:

- Notes has been reworded; and
- Value Domain and Examples has been added.

10.6 Pathology Test Result Name Values has been added.

In 10.8 Diagnostic Service Values, External Identifier, Definition and Source have been updated.

In 10.9 SPECIMEN:

- Definition has been reworded;
- cardinality has been changed from [0..*] to [1..*]; and
- Synonymous Names and Notes have been added.

In 10.10 Specimen Tissue Type:

- Notes has been reworded; and
- Conditions of Use has been deleted.

In 10.12 ANATOMICAL LOCATION, Conditions of Use has been added.

In 10.14 Anatomical Location Name:

- the label has changed from *Name of Location* to match the name; and
- Definition has been reworded.

In 10.16 Side, Definition has been reworded.

In 10.17 Laterality Reference Set, Definition has been reworded.

In 10.18 Anatomical Location Description:

- the label changed from *Description* to match the name; and
- Definition has been reworded.

In 10.19 Image:

- the label changed from *Image* to match the name; and
- Definition has been reworded.

In 10.20 Physical Properties of an Object, Definition has been reworded.

In 10.21 Weight:

- Definition and Definition Source have been updated; and
- Conditions of Use has been added.

In 10.23 Volume:

- Definition and Definition Source have been updated; and
- Conditions of Use has been added.

In 10.24 Object Description, Definition has been reworded.

In 10.25 Image, Definition has been reworded.

In 10.27 Sampling Preconditions:

- Notes has been reworded; and
- Examples has been added.

In 10.28 HANDLING AND PROCESSING:

- Definition has been reworded; and
- cardinality has been changed from [0..1] to [1..1].

In 10.29 Collection DateTime:

- Definition has been reworded; and
- cardinality has been changed from [0..1] to [1..1].

In 10.33 Specimen Identifier, Notes and Conditions of Use have been reworded.

In 10.34 Parent Specimen Identifier, Definition has been reworded.

In 10.36 Overall Pathology Test Result Status:

- the label changed from *Overall Test Result Status* to match the name; and
- Examples has been deleted.

In 10.37 Pathology Test Result Status Values, has new Definition, Notes, Source, Permissible Values and Conditions of Use.

In 10.38 Clinical Information Provided:

- Definition has been reworded; and
- Notes has been added.

In 10.39 PATHOLOGY TEST RESULT GROUP, Definition has been reworded.

In 10.40 Pathology Test Result Group Name:

- the label changed from *Result Group Name* to match the name; and
- Examples and Value Domain *Pathology Test Result Name Values* have been added.

In 10.41 INDIVIDUAL PATHOLOGY TEST RESULT, Definition and Notes have been reworded.

In 10.42 Individual Pathology Test Result Name:

- the label changed from *Result Name* to match the name; and
- the data type has been changed.

In 10.42 Individual Pathology Test Result Name, Value Domain *Individual Pathology Test Result Name Values* has been added.

10.43 Individual Pathology Test Result Name Values has been added.

10.44 Individual Pathology Test Result Value has been added.

In 10.46 Result Value Values:

- Definition has been reworded;
- Notes and Conditions of Use have been added; and
- Source has been updated.

10.47 REFERENCE RANGE DETAILS:

- the label *Result Value Reference Range Details* has been changed to *Individual Pathology Test Result Value Reference Ranges*;
- the name *Individual Pathology Test Result Value Reference Ranges* has been changed to *Reference Range Details*;
- Definition and Notes have been reworded; and
- Conditions of Use have been deleted.

10.44 Individual Pathology Test Result Value Normal Status has been removed.

10.48 Normal Status has been added.

10.49 REFERENCE RANGE has been added.

In 10.50 Reference Range Meaning:

- the label *Result Value Reference Range Meaning* and the name *Individual Pathology Test Result Value Reference Range Meaning* have been updated to match the name; and
- Notes has been updated.

10.48 Individual Pathology Test Result Value Reference Range has been removed.

10.51 Reference Range has been added.

In 10.52 Individual Pathology Test Result Comment, the label has changed from *Result Comment* to match the name.

In 10.53 Individual Pathology Test Result Reference Range Guidance, the label has been changed from *Reference Range Guidance* to match the name.

In 10.54 Individual Pathology Test Result Status:

- the label has been changed from *Result Status* to match the name; and
- Notes has been reworded.

In 10.54 Individual Pathology Test Result Status, Examples has been deleted.

In 10.55 SPECIMEN, Definition has been reworded.

In 10.56 Specimen Tissue Type:

- Notes has been reworded; and
- Conditions of Use has been deleted.

In 10.58 ANATOMICAL LOCATION:

- Definition has been reworded; and
- Conditions of Use has been added.

In 10.60 Anatomical Location Name:

- the label has been changed from *Name of Location* to match the name; and
- Definition has been reworded.

In 10.62 Side, Definition has been reworded.

In 10.64 Anatomical Location Description:

- the label has been changed from *Description* to match the name; and
- Definition has been reworded.

In 10.65 Anatomical Location Image:

- the label has been changed from *Image* to match the name; and
- Definition has been reworded.

In 10.66 PHYSICAL PROPERTIES OF AN OBJECT, Definition has been reworded.

In 10.67 Weight:

- Definition has been reworded; and
- Conditions of Use has been added.

In 10.69 Volume:

- Definition has been reworded; and
- Conditions of Use has been added.

In 10.70 Object Description, Definition has been reworded.

In 10.71 Image, Definition has been reworded.

In 10.73 Sampling Preconditions:

- Notes has been reworded; and
- Examples has been added.

In 10.74 HANDLING AND PROCESSING:

- Definition has been reworded; and
- cardinality has been changed from [0..1] to [1..1].

In 10.75 Collection DateTime:

- Definition has been reworded; and
- cardinality has been changed from [0..1] to [1..1].

In 10.79 Specimen Identifier, Notes and Conditions of Use have been reworded.

In 10.80 Parent Specimen Identifier, Definition has been reworded.

In 10.84 Test Result Representation:

- Definition and Notes have been reworded; and
- Conditions of Use have been deleted.

In 10.85 Test Comment, Definition has been reworded.

In 10.86 TEST REQUEST DETAILS, Definition and Notes have been reworded.

In 10.87 Test Requested Name:

- Definition has been reworded; and
- Value Domain and Conditions of Use have been added.

In 10.88 Laboratory Test Result Identifier, Notes has been reworded.

10.86 Pathology Test Result DateTime has been deleted.

10.89 Observation DateTime has been added.

10.90 Pathology Test Result Instance Identifier has been added.

10.91 Detailed Clinical Model Identifier has been added.

Chapter 11 Imaging Examination Result Detailed Clinical Model

The version of the DCM used has changed from 2.1 to 3.1.

In 11.4 IMAGING EXAMINATION RESULT, Conditions of Use has been deleted.

In 11.5 Imaging Examination Result Name, Examples have been added.

In 11.6 Imaging Modality:

- the label has been changed from *Modality* to match the name; and
- Context and Notes have been reworded.

In 11.7 ANATOMICAL LOCATION:

- Definition has been reworded; and
- Conditions of Use has been added.

In 11.9 Anatomical Location Name:

- the label has been changed from *Name of Location* to match the name; and
- Definition has been reworded.

11.11 Side, Definition has been reworded.

11.12 Laterality Reference Set, Definition has been reworded.

In 11.13 Anatomical Location Description:

- the label has been changed from *Description* to match the name; and
- Definition has been reworded.

In 11.14 Anatomical Location Image:

- the label has been changed from *Image* to match the name; and
- Definition has been reworded.

In 11.15 Imaging Examination Result Status:

- the label has been changed from *Overall Result Status* to match the name;
- Value Domain has been added; and
- Examples have been deleted.

11.16 Imaging Examination Result Status Values has been added.

In 11.18 Findings:

- Definition has been reworded; and
- Synonymous Names and Examples have been added.

In 11.20 Imaging Examination Result Group Name:

- the label has been changed from *Result Group Name* to match the name; and
- the data type has been changed.

In 11.21 INDIVIDUAL IMAGING EXAMINATION RESULT, Definition and Notes have been reworded.

In 11.22 Individual Imaging Examination Result Name:

- the label has been changed from *Result Name* to match the name; and
- the data type has been changed.

11.23 Imaging Examination Result Value has been added.

In 11.24 Imaging Examination Result Value:

- Definition and Examples have been reworded; and
- Value Domain has been added.

11.25 Result Value Values has been added.

11.26 REFERENCE RANGE DETAILS has been added.

11.23 Imaging Examination Result Value Normal Status has been removed.

11.24 Imaging Examination Result Value Normal Status Values has been removed.

11.27 Normal Status has been added.

11.28 REFERENCE RANGE has been added.

In 11.29 Reference Range Meaning:

- the label has been changed from *Result Value Reference Range Meaning* and name from *Imaging Examination Result Value Reference Range Meaning*; and
- Notes has been reworded.

11.27 Imaging Examination Result Value Reference Range has been removed.

11.30 Reference Range has been added.

In 11.32 ANATOMICAL LOCATION:

- label has been changed;
- Definition has been reworded; and
- Conditions of Use has been added.

In 11.34 Anatomical Location Name:

- the label has been changed from *Name of Location* to match the name; and
- Definition has been reworded.

In 11.36 Side, Definition has been reworded.

In 11.37 Laterality Reference Set, Definition has been reworded.

In 11.38 Anatomical Location Description:

- the label has been changed from *Description* to match the name; and
- Definition has been reworded.

In 11.39 Anatomical Location Image:

- the label has been changed from *Image* to match the name; and
- Definition has been reworded.

In 11.40 Examination Result Representation, Notes has been removed.

In 11.41 EXAMINATION REQUEST DETAILS, Definition and Notes have been reworded.

In 11.42 Examination Requested Name:

- Definition has been reworded; and
- Conditions of Use has been added.

In 11.44 Report Identifier:

- Synonymous Names and Assumptions have been reworded;
- Context has been reworded and moved to Notes; and
- Definition and Notes have been reworded.

In 11.46 Image Identifier:

- Definition, Context and Assumptions have been reworded; and
- Notes has been added.

In 11.48 Image View Name:

- the label has been changed from *View* to match the name;
- Definition has been reworded; and
- Examples has been added.

In 11.49 Subject Position:

- the label has been changed from *Position* to match the name; and
- Definition has been reworded.

In 11.50 Image DateTime, Definition has been reworded.

11.49 Imaging Examination Result DateTime has been removed.

11.52 Observation DateTime has been added.

11.53 Imaging Examination Result Instance Identifier has been added.

11.54 Detailed Clinical Model Identifier has been added.

Chapter 12 Requested Service Detailed Clinical Model

The version of the DCM used has changed from 4.0 to 5.0.

In 12.3 REQUESTED SERVICE:

- Notes and Misuse have been reworded; and
- Conditions of Use has been removed.

In 12.4 Requested Service Description, Context and Examples have been reworded.

In 12.5 DateTime Service Scheduled:

- Definition has been reworded; and
- Conditions of Use and Conditions of Use Source have been added.

In 12.6 Service Commencement Window:

- Definition has been reworded; and

- Conditions of Use and Conditions of Use Source have been added.

In 12.7 Service Booking Status Values:

- Definition has been reworded; and
- Permissible Values has been updated.

In 12.9 Subject of Care Instruction Description, Definition has been reworded.

In 12.10 SERVICE PROVIDER:

- Definition and Notes have been reworded;
- when the service provider is an individual (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON), the following Conditions of Use have been changed:
  - “ENTITLEMENT is PROHIBITED” has been deleted;
  - “Qualifications is PROHIBITED” has been deleted;
  - Role statement has been updated to add “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” has been updated to add “one”;
  - “The value of ADDRESS.Address Purpose SHALL be “B” (Business)” has been added; and
  - “The value of ELECTRONIC COMMUNICATION DETAIL.Electronic Communication Usage Code SHALL be “B” (Business)” has been added.
- when the service provider is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an ORGANISATION), the following Conditions of Use have been changed:
  - “The value of one Entity Identifier SHALL be an Australian HPI-O” has been updated to add “one”;

12.12 Requested Service Instance Identifier has been added.

12.13 Detailed Clinical Model Identifier has been added.

Chapter 14 UML Class Diagrams

The diagram has been updated to include all changes to the data hierarchy and use current NEHTA data component modelling conventions.

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