nehta

Event Summary

Structured Content Specification

Version 1.1 — 30 Nov 2011

Final

National E-Health Transition Authority Ltd

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

Disclaimer

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

Document Control

This document is maintained in electronic form. The current revision of this document is located on the NEHTA Web site and is uncontrolled in printed form. It is the responsibility of the user to verify that this copy is of the latest revision.

Document Information

Document owner

Document Owner
The National Clinical Terminology and Information Service

Change history

Version	Date	Comments
1.0	31 Oct 2011	Initial draft.
1.1	30 Nov 2011	Final specification for submission to Standards Australia.

Related documents

Name	Version/Release Date
NEHTA Acronyms, Abbreviations & Glossary of Terms	Version 1.2, Issued 25 May 2005
Reason for Encounter Data Specification	Version 2.0
Participation Data Specification	Version 3.2, Issued 20 July 2011
Information Requirements - Event Summary	Version 1.1, Issued 31 October 2011
Imaging Examination Result Detailed Clinical Model Specification	Issued 01 September 2011, Version 2.0
Adverse Reaction Detailed Clinical Model Specification	Issued 01 September 2011, Version 3.0
Medication Instruction And Action Detailed Clinical Model Specification	Issued 01 September 2011, Version 2.0
Problem Diagnosis Detailed Clinical Model Specification	Issued 01 September 2011, Version 3.0
Procedure Detailed Clinical Model Specification	Issued 01 September 2011, Version 3.0
Miscellaneous Detailed Clinical Model Specification	Version 1.1, Issued To Be Published
Pathology Test Result Detailed Clinical Model Specification	Issued 01 September 2011, Version 2.0

Acknowledgements

NEHTA would like to thank the following organisations and individuals for their contribution to these data specifications:

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

Table of Contents

1 Introduction

This document is a Structured Content Specification (SCS) for an Event Summary. It specifies the information structure of NEHTA-compliant Event Summaries in order to support the transfer of health information.

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

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

1.1 Document Purpose

This document describes the Structured Content Specification for an Event Summary from a clinical communication perspective.

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

It is also a key input to the NEHTA Event Summary CDA Implementation Guide [NEHT2011x], 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.

1.4 Known Issues

This is a preliminary draft for trial implementation.

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

2 Event Summary Structured Document

2.1 Purpose

The aim of an Event Summary is to provide information to an individual's Personally Controlled Electronic Health Record (PCEHR) of significant health care events, at the discretion of the clinician, with the consent of the individual.

2.2 Use

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

2.3 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

	EVENT SUMMARY				
CONTEXT					
	SUBJECT OF CARE				1..1
	Encounter Period				1..1
	DOCUMENT AUTHOR				1..1
CONTENT					
	Event Details (EVENT OVERVIEW)				0..1
		Event Details (CLINICAL SYNOPSIS)			1..1
			Clinical Synopsis Description		1..1
			~~DateTime Recorded~~		~~0..0~~
			~~INFORMATION PROVIDER~~		~~0..0~~
			~~SUBJECT~~		~~0..0~~
	Newly Identified Adverse Reactions (ADVERSE REACTIONS)				0..1
		~~EXCLUSION STATEMENT - ADVERSE REACTIONS~~			~~0..0~~

			ADVERSE REACTION			1..*
				Substance/Agent		1..1
				~~Absolute Contraindication~~		~~0..0~~
				~~Comment (Adverse Reaction Comment)~~		~~0..0~~
				REACTION EVENT		0..1
					~~Specific Substance/Agent~~	~~0..0~~
					Manifestation	1..*
					~~Reaction Type~~	~~0..0~~
					~~Certainty (Adverse Reaction Certainty)~~	~~0..0~~
					~~Reaction Description~~	~~0..0~~
					~~Onset of Reaction (Reaction Onset Date)~~	~~0..0~~
					~~Duration of Reaction~~	~~0..0~~
					~~Additional Reaction Detail (ANATOMICAL LOCATION)~~	~~0..0~~
					~~Exposure Description~~	~~0..0~~
					~~Earliest Exposure~~	~~0..0~~
					~~Duration of Exposure~~	~~0..0~~
					~~ADDITIONAL EXPOSURE DETAIL~~	~~0..0~~
					~~Clinical Management Description~~	~~0..0~~
					~~Multimedia~~	~~0..0~~
					~~Reporting Details~~	~~0..0~~
					~~Comment (Adverse Reaction Event Comment)~~	~~0..0~~
			~~Reaction Reported~~			~~0..0~~
			~~Adverse Reaction Report~~			~~0..0~~
			~~Supporting Clinical Record Information~~			~~0..0~~

				~~INFORMATION PROVIDER~~	~~0..0~~
				~~SUBJECT~~	~~0..0~~
		Medications (MEDICATION ORDERS)			0..1
			~~EXCLUSION STATEMENT - MEDICATIONS~~		~~0..0~~
			Medication (MEDICATION INSTRUCTION)		1..*
				Medicine (Therapeutic Good Identification)	1..1
				Directions	1..1
				~~Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)~~	~~0..0~~
				~~Dose Description~~	~~0..0~~
				~~Structured Dose (AMOUNT OF MEDICATION)~~	~~0..0~~
				~~TIMING~~	~~0..0~~
				~~Additional Instruction~~	~~0..0~~
				Clinical Indication	0..1
				~~Administration Details (MEDICATION ADMINISTRATION)~~	~~0..0~~
				Comment (Medication Instruction Comment)	0..1
				~~DISPENSING~~	~~0..0~~
				Change Type	1..1
				Change or Recommendation? (Change Status)	1..1
				Change Description	0..1
				Change Reason (Change or Recommendation Reason)	0..1
				~~Indication for Authorised Use~~	~~0..0~~
				~~Medication Instruction ID~~	~~0..0~~
				~~Concession Benefit~~	~~0..0~~
				~~INFORMATION PROVIDER~~	~~0..0~~

				~~SUBJECT~~	~~0..0~~
				~~Medication Instruction Narrative~~	~~0..0~~
				~~DateTime Medication Instruction Expires~~	~~0..0~~
		Diagnoses/Interventions (MEDICAL HISTORY)			0..1
			PROBLEM/DIAGNOSIS		0..*
				Problem/Diagnosis (Problem/Diagnosis Identification)	1..1
				~~Clinical Description~~	~~0..0~~
				~~Severity~~	~~0..0~~
				Date of Onset	0..1
				~~Age at Onset~~	~~0..0~~
				~~ANATOMICAL LOCATION~~	~~0..0~~
				~~Occurrence Summary (PROBLEM/DIAGNOSIS OCCURRENCE SUMMARY)~~	~~0..0~~
				~~RELATED ITEMS~~	~~0..0~~
				~~Date of Resolution/Remission~~	~~0..0~~
				~~Age at Resolution/Remission~~	~~0..0~~
				~~Diagnostic Criteria~~	~~0..0~~
				~~Clinical Stage/Grade~~	~~0..0~~
				Comment (Problem/Diagnosis Comment)	0..1
				~~Link to Supporting Clinical Evidence~~	~~0..0~~
				~~Status~~	~~0..0~~
				~~INFORMATION PROVIDER~~	~~0..0~~
				~~SUBJECT~~	~~0..0~~
			~~EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES~~		~~0..0~~
			Procedure (PROCEDURE)		0..*

				Procedure Name	1..1
				~~Description (Procedure Description)~~	~~0..0~~
				~~Reason (Procedure Reason)~~	~~0..0~~
				~~ANATOMICAL LOCATION~~	~~0..0~~
				~~Procedure Detail~~	~~0..0~~
				~~Duration (Procedure Duration)~~	~~0..0~~
				~~Multimedia~~	~~0..0~~
				Comment (Procedure Comment)	0..1
				Start Date/Time (DateTime Started)	0..1
				~~DEVICE~~	~~0..0~~
				~~INFORMATION PROVIDER~~	~~0..0~~
				~~SUBJECT~~	~~0..0~~
			~~EXCLUSION STATEMENT - PROCEDURES~~		~~0..0~~
			MEDICAL HISTORY ITEM		0..*
				Medical History Item Description	1..1
				Medical History Item Timeinterval	0..1
				Medical History Item Comment	0..1
				~~INFORMATION PROVIDER~~	~~0..0~~
				~~SUBJECT~~	~~0..0~~
		Administered Immunisations (IMMUNISATIONS)			0..1
			Immunisation (MEDICATION ACTION)		1..*
				Medicine (Therapeutic Good Identification)	1..1
				~~Instructions to Subject of Care or Carer (Medication Action Instructions)~~	~~0..0~~
				~~Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)~~	~~0..0~~

				~~Reason (Reason for Action)~~	~~0..0~~
				~~Quantity of Medication (AMOUNT OF MEDICATION)~~	~~0..0~~
				~~Comment~~	~~0..0~~
				~~Sequence Number~~	~~0..0~~
				~~Administration (MEDICATION ADMINISTRATION)~~	~~0..0~~
				~~Brand Substituted (Brand Substitution Occurred)~~	~~0..0~~
				~~Batchid (Batch Identifier)~~	~~0..0~~
				~~Date of Expiry (Expiry Date)~~	~~0..0~~
				~~DISPENSED TO~~	~~0..0~~
				~~Number of Times Dispensed~~	~~0..0~~
				~~Remaining Repeats~~	~~0..0~~
				~~Claim Category~~	~~0..0~~
				~~Administrative Item Code~~	~~0..0~~
				~~Administrative Manufacturer Code~~	~~0..0~~
				~~INFORMATION PROVIDER~~	~~0..0~~
				~~SUBJECT~~	~~0..0~~
				Medication Action DateTime	1..1
			~~Exclusion Statement - Immunisation (EXCLUSION STATEMENT - MEDICATIONS)~~		~~0..0~~
		DIAGNOSTIC INVESTIGATIONS			0..1
			PATHOLOGY TEST RESULT		0..*
				Test Result Name (Pathology Test Result Name)	1..1
				Diagnostic Service	0..1
				Test Specimen Detail (SPECIMEN)	0..*
				Specimen Tissue Type	0..1

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

					~~NEEDLE BIOPSY CORE DETAILS~~	~~0..0~~
					COLLECTION AND HANDLING	0..1
					~~Potential Risk / Biohazard~~	~~0..0~~
					Sampling Preconditions	0..1
					~~Number of Containers~~	~~0..0~~
					~~Collection Procedure Details~~	~~0..0~~
					~~Transport Medium~~	~~0..0~~
					~~Testing Method~~	~~0..0~~
					~~DEVICE~~	~~0..0~~
					HANDLING AND PROCESSING	0..1
					Date and Time of Collection (Collection DateTime)	0..1
					Collection Setting	0..1
					Date and Time of Receipt (DateTime Received)	0..1
					~~Date and Time Processed (DateTime Processed)~~	~~0..0~~
					~~SPECIMEN QUALITY~~	~~0..0~~
					IDENTIFIERS	0..1
					Specimen Identifier	0..1
					Parent Specimen Identifier	0..1
					Container Identifier	0..1
					~~Specimen Collector Identifier~~	~~0..0~~
					~~SPECIMEN COLLECTOR DETAILS~~	~~0..0~~
				Overall Test Result Status (Overall Pathology Test Result Status)		1..1
				Clinical Information Provided		0..1
				Result Group (PATHOLOGY TEST RESULT GROUP)		0..*

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

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

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

				~~SUBJECT~~		~~0..0~~
				Pathology Test Result DateTime		1..1
				~~Pathology Test Result Duration~~		~~0..0~~
			IMAGING EXAMINATION RESULT			0..*
				Examination Result Name (Imaging Examination Result Name)		1..1
				Modality (Imaging Modality)		0..1
				Anatomical Site (ANATOMICAL LOCATION)		0..*
					SPECIFIC LOCATION	0..1
					Name of Location (Anatomical Location Name)	0..1
					Side	0..1
					~~Numerical Identifier~~	~~0..0~~
					~~Anatomical Plane~~	~~0..0~~
					~~RELATIVE LOCATION~~	~~0..0~~
					Description (Anatomical Location Description)	0..1
					~~Visual Markings/Orientation~~	~~0..0~~
					Image (Anatomical Location Image)	0..*
				Overall Result Status (Imaging Examination Result Status)		1..1
				Clinical Information Provided		0..1
				Findings		0..1
				Result Group (IMAGING EXAMINATION RESULT GROUP)		0..*
					Result Group Name (Imaging Examination Result Group Name)	1..1
					Result (INDIVIDUAL IMAGING EXAMINATION RESULT)	1..*
					Result Name (Individual Imaging Examination Result Name)	1..1

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

					Examination Requested Name		0..*
					~~REQUESTER~~		~~0..0~~
					~~Receiver Order Identifier~~		~~0..0~~
					DICOM Study Identifier		0..1
					Report Identifier		0..1
					IMAGE DETAILS		0..*
						Image Identifier	0..1
						DICOM Series Identifier	0..1
						View (Image View Name)	0..1
						Position (Subject Position)	0..1
						Image DateTime	0..1
						Image	0..1
				~~Examination Procedure~~			~~0..0~~
				~~COMPARED IMAGE DETAILS~~			~~0..0~~
				~~INFORMATION PROVIDER~~			~~0..0~~
				~~SUBJECT~~			~~0..0~~
				Imaging Examination Result DateTime			1..1
				~~Imaging Examination Result Duration~~			~~0..0~~
			~~Diagnostic Investigation Synopsis (CLINICAL SYNOPSIS)~~				~~0..0~~
			Requested Service (REQUESTED SERVICE)				0..*
				~~Reason for Service~~			~~0..0~~
				Requested Service Description			1..1
				~~Intent of Request~~			~~0..0~~
				~~Request Urgency~~			~~0..0~~

				DateTime Service Scheduled	0..1
				Service Commencement Window	0..1
				Service Booking Status	1..1
				~~Supplementary Information to Follow~~	~~0..0~~
				~~Supplementary Information Expected~~	~~0..0~~
				Subject of Care Instruction Description	0..1
				~~DISTRIBUTION LIST~~	~~0..0~~
				~~SERVICE REQUESTER~~	~~0..0~~
				SERVICE PROVIDER	0..1
				~~Request Validity Period~~	~~0..0~~
				~~INFORMATION PROVIDER~~	~~0..0~~
				~~SUBJECT~~	~~0..0~~
				Requested Service DateTime	1..1

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
External Identifier	AS 5017-2006

Definition

Definition	Identifies the person about whom the healthcare event/encounter/clinical interaction has been captured and/or interchanged, that led to the creation of the document. In other words, the subject of the information.
Definition Source	NEHTA
Synonymous Names	Patient

Usage

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

	• Indigenous Status is **ESSENTIAL**. • Qualifications is **PROHIBITED**. Other additional constraints: • Participation Type **SHALL** have an implementation-specific fixed value equivalent to “Subject of Care”. • Role **SHALL** have an implementation-specific fixed 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.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	EVENT SUMMARY	1..1	

2.5 Encounter Period

Identification

Label	Encounter Period
Metadata Type	Data Element
Identifier	DE-16140
OID	1.2.36.1.2001.1001.101.103.16140

Definition

Definition	The date (and optionally time) of the start and end of the encounter that this event summary refers to.
Definition Source	NEHTA
Synonymous Names	
Notes	Recording the start of the encounter is optional.
Data Type	TimeInterval

Usage

Conditions of Use	The end of the encounter **SHALL** be recorded.
Conditions of Use Source	NEHTA
Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	EVENT SUMMARY	1..1	

2.6 DOCUMENT AUTHOR

Identification

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

Definition

Definition	The healthcare provider who composed the event summary.
Definition Source	NEHTA
Synonymous Names	Author

Usage

Conditions of Use	This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v]. The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B: *Specification Guide for Use*. Additional obligation and occurrence constraints: • LOCATION OF PARTICIPATION is **PROHIBITED**. • Entity Identifier is **ESSENTIAL**. • ADDRESS is **ESSENTIAL**. • EMPLOYMENT DETAIL is **ESSENTIAL**. • EMPLOYER ORGANISATION is **ESSENTIAL**. • Electronic Communication Detail is **ESSENTIAL**. • Relationship to Subject of Care is **PROHIBITED**. • DEMOGRAPHIC DATA is **PROHIBITED**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**. Other additional constraints: • Participation Type **SHALL** have an implementation-specific fixed value equivalent to “Author”.

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

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	EVENT SUMMARY	1..1	

2.7 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	Occur-rences	Condi-tion
	EVENT SUMMARY	0..1	

Children

Data Type	Name	Occur-rences	Condi-tion
	Event Details (CLINICAL SYNOPSIS)	1..1	

2.8 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 of which the author became aware during the health event.
Scope Source	NEHTA

Usage

Conditions of Use	Adverse reactions identified in the event **SHALL** be included. Adverse reactions NOT identified in the event **SHOULD NOT** be included.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	EVENT SUMMARY	0..1	

Children

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

2.9 MEDICATION ORDERS

Identification

Label	Medications
Metadata Type	Section
Identifier	S-16146
OID	1.2.36.1.2001.1001.101.101.16146

Definition

Definition	Therapeutic Goods which are/were prescribed for the patient or the patient has/had been taking.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	EVENT SUMMARY	0..1	

Children

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

2.10 MEDICAL HISTORY

Identification

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

Definition

Definition	The current and past medical history of the subject of care which is relevant to the clinical event, this includes problem/diagnosis and medical or surgical procedures performed.
Definition Source	NEHTA
Synonymous Names	
Notes	This includes diagnoses that were identified at the event which are significant to it, and also any interventions performed during the event or those occurring in the past that are significant to it.

Usage

Conditions of Use	Each instance of this section **SHALL** have at least one instance of 'PROBLEM/DIAGNOSIS' OR 'PROCEDURE' OR 'MEDICAL HISTORY ITEM'.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	EVENT SUMMARY	0..1	

Children

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

Data Type	Name	Occur-rences	Condi-tion
	Procedure (PROCEDURE)	0..*	
	~~EXCLUSION STATEMENT - PROCEDURES~~	~~0..0~~	-
	MEDICAL HISTORY ITEM	0..*	

2.11 IMMUNISATIONS

Identification

Label	Administered Immunisations
Metadata Type	Section
Identifier	S-16638
OID	1.2.36.1.2001.1001.101.101.16638

Definition

Definition	Information about the immunisation history of the subject of care.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	EVENT SUMMARY	0..1	

Children

Data Type	Name	Occur-rences	Condi-tion
	Immunisation (MEDICATION ACTION)	1..*	
	~~Exclusion Statement - Immunisation (EXCLUSION STATEMENT - MEDICATIONS)~~	~~0..0~~	-

2.12 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** have at least one instance of 'PATHOLOGY TEST RESULT' OR 'IMAGING EXAMINATION RESULT' OR 'REQUESTED SERVICE'.
Conditions of Use Source	NEHTA
Misuse	Including diagnostic test results which are NOT considered to be relevant to the subject of care's ongoing care.

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	EVENT SUMMARY	0..1	

Children

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

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

3 Clinical Synopsis Data Group

3.1 Purpose

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

3.2 Use

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

3.3 Misuse

Used in place of other individual data items.

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	A clinical synopsis of the event and its reasons.
Definition Source	NEHTA
Synonymous Names	

Usage

Conditions of Use	This is a reuse of the CLINICAL SYNOPSIS data group, which is described in Miscellaneous Detailed Clinical Model Specification [NEHT2011ag].
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Event Details (EVENT OVERVIEW)	1..1	

Children

Data Type	Name	Occur-rences	Condi-tion
	Clinical Synopsis Description	1..1	
	~~DateTime Recorded~~	~~0..0~~	-
	~~INFORMATION PROVIDER~~	~~0..0~~	-
	~~SUBJECT~~	~~0..0~~	-

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

Usage

Examples	1. William presented to me today after a fall in a local shopping centre. Suffered a deep laceration to his right calf which required cleaning and 4 sutures.

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Event Details (CLINICAL SYNOPSIS)	1..1	

4 Adverse Reaction Data Group

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. Gentamycin), 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:

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

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

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

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

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

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

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

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

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

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/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, including food, plants, animals, venom from animal stings or a medication at therapeutic or sub-therapeutic doses.
Definition Source	NEHTA
Synonymous Names	

Usage

Conditions of Use	This is a reuse of the ADVERSE REACTION data group, which is described in Adverse Reaction Detailed Clinical Model Specification [NEHT2011z].
Conditions of Use Source	NEHTA

Relationships

Parents

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

Children

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

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

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	Occur-rences	Condi-tion
	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/substance causing the adverse reaction experienced by the patient.
Definition Source	NEHTA

Value Domain

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

Relationships

Parents

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

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	Occur-rences	Condi-tion
	ADVERSE REACTION	0..1	

Children

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

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

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

Usage

Examples	1. Itchy eyes. 2. Dysphagia. 3. Tinnitus. 4. Nausea. 5. Rash.

Relationships

Parents

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

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
External Identifier	SNOMED CT-AU Concept ID: 32570071000036102

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

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

5 Medication Instruction Data Group

5.1 Purpose

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

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 and/or administered); or in a summary document such as discharge summary or a referral for care. The instruction may be complex and involve more than one activity, such as in the case of a reducing dose of Predisolone, or multiple medications as components of the same order. This would include a written order by a physician, dentist, nurse practitioner, or other designated health professional for a medication to be dispensed and administered to a patient.

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

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

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

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

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

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

5.3 Misuse

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

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

5.4 MEDICATION INSTRUCTION

Identification

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

Definition

Definition	Information pertaining to one or more therapeutic goods that is represented to achieve, or is likely to achieve, its principal intended action by pharmacological, chemical, immunological or metabolic means in or on the body of a human.
Definition Source	NEHTA
Synonymous Names	Drug Medicine Potion Therapeutic
Scope	For use in the healthcare setting. Captures detailed information on the medication being used by or prescribed for the subject of care for their personal healthcare. This 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

Usage

Conditions of Use	This is a reuse of the MEDICATIONS data group, which is described in Medication Instruction And Action Detailed Clinical Specification [NEHT2011aa].
Conditions of Use Source	NEHTA

Relationships

Parents

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

Children

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

5.5 Therapeutic Good Identification

Identification

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

Definition

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

Usage

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

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

Relationships

Parents

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

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 Editorial Rules [NEHT2009r]. Prescribing and dispensing use different sets of values.

Value Domain

Source	Australian Medicines Terminology
Permissible Values	The permissible values are the members of the following 7 AMT reference sets: • |929360061000036106 *Medicinal product reference set*| • |929360081000036101 *Medicinal product pack reference set*| • |929360071000036103 *Medicinal product unit of use reference set*| • |929360021000036102 *Trade product reference set*| • |929360041000036105 *Trade product pack reference set*| • |929360031000036100 *Trade product unit of use reference set*| • |929360051000036108 *Containered trade product pack reference set*|

Relationships

Parents

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

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	
Data Type	Text

Usage

Conditions of Use	It is essential that when the "Directions" data element is used together with structured information components such as "Ingredient and Form" and "Structured Dose" in clinical records or prescriptions, the contents of "Direction" must not contradict the contents of these structured information components.
Conditions of Use Source	NEHTA
Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	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

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

Relationships

Parents

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

5.9 Medication Instruction Comment

Identification

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

Definition

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

Usage

Examples	1. Patient requires an administration aid. 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	Occur-rences	Condi-tion
	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	Occur-rences	Condi-tion
	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

Definition

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

Value Domain

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

Relationships

Parents

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

5.12 Change Status

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

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

Definition

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

Value Domain

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

Relationships

Parents

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

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	Occur-rences	Condi-tion
	Medication (MEDICATION INSTRUCTION)	0..1	

5.15 Change or Recommendation Reason

Identification

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

Definition

Definition	The justification for the stated change in medication.
Definition Source	NEHTA
Synonymous Names	Reason for Alteration 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	Occur-rences	Condi-tion
	Medication (MEDICATION INSTRUCTION)	0..1	

6 Problem/Diagnosis Data Group

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

6.3 Misuse

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

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

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

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

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

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

Usage

Conditions of Use	This is a reuse of the PROBLEM/DIAGNOSIS data group, which is described in Problem Diagnosis Detailed Clinical Model Specification [NEHT2011ab].
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Diagnoses/Interventions (MEDICAL HISTORY)	0..*	

Children

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

Data Type	Name	Occur-rences	Condi-tion
	~~Severity~~	~~0..0~~	-
	Date of Onset	0..1	
	~~Age at Onset~~	~~0..0~~	-
	~~ANATOMICAL LOCATION~~	~~0..0~~	-
	~~Occurrence Summary (PROBLEM/DIAGNOSIS OCCURRENCE SUMMARY)~~	~~0..0~~	-
	~~RELATED ITEMS~~	~~0..0~~	-
	~~Date of Resolution/Remission~~	~~0..0~~	-
	~~Age at Resolution/Remission~~	~~0..0~~	-
	~~Diagnostic Criteria~~	~~0..0~~	-
	~~Clinical Stage/Grade~~	~~0..0~~	-
	Comment (Problem/Diagnosis Comment)	0..1	
	~~Link to Supporting Clinical Evidence~~	~~0..0~~	-
	~~Status~~	~~0..0~~	-
	~~INFORMATION PROVIDER~~	~~0..0~~	-
	~~SUBJECT~~	~~0..0~~	-

6.5 Problem/Diagnosis Identification

Identification

Label	Problem/Diagnosis
Metadata Type	Data Element
Identifier	DE-15514
OID	1.2.36.1.2001.1001.101.103.15514

Definition

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

Usage

Examples	

Relationships

Parents

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

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Problem/Diagnosis (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/diagnosis began, in the opinion of the clinician.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

Examples	

Relationships

Parents

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

6.8 Problem/Diagnosis Comment

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

7 Procedure (Action) Data Group

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. This is done by the recording of data against specific activities in the care pathway, which covers the entirety of steps required to effect this action, including booking, performing, etc.

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

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

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

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

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

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

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

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

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

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

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 specific DCMs for this purpose.

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

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

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

Usage

Conditions of Use	This is a reuse of the PROCEDURE data group, which is described in Procedure Detailed Clinical Model Specification [NEHT2011ac].
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Diagnoses/Interventions (MEDICAL HISTORY)	0..*	

Children

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

Data Type	Name	Occur-rences	Condi-tion
	~~Procedure Detail~~	~~0..0~~	-
	~~Duration (Procedure Duration)~~	~~0..0~~	-
	~~Multimedia~~	~~0..0~~	-
	Comment (Procedure Comment)	0..1	
	Start Date/Time (DateTime Started)	0..1	
	~~DEVICE~~	~~0..0~~	-
	~~INFORMATION PROVIDER~~	~~0..0~~	-
	~~SUBJECT~~	~~0..0~~	-

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	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Procedure (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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

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

7.7 Procedure Comment

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

7.8 DateTime Started

Identification

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

Definition

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

Usage

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

Relationships

Parents

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

8 Medical History Item Data Group

8.1 Purpose

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

8.2 MEDICAL HISTORY ITEM

Identification

Label	MEDICAL HISTORY ITEM
Metadata Type	Data Group
Identifier	DG-16627
OID	1.2.36.1.2001.1001.101.102.16627

Definition

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

Usage

Conditions of Use	This is a reuse of the MEDICAL HISTORY data group, which is described in Miscellaneous Detailed Clinical Model Specification [NEHT2011ag].
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Diagnoses/Interventions (MEDICAL HISTORY)	0..*	

Children

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

Data Type	Name	Occur-rences	Condi-tion
	~~SUBJECT~~	~~0..0~~	-

8.3 Medical History Item Description

Identification

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

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	MEDICAL HISTORY ITEM	1..1	

8.4 Medical History Item Timeinterval

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	MEDICAL HISTORY ITEM	0..1	

8.5 Medical History Item Comment

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	MEDICAL HISTORY ITEM	0..1	

9 Medication Action Data Group

9.1 Purpose

The recording of activities undertaken with regard to a medicine, vaccine or other therapeutic good and linking to the instruction if appropriate.

9.2 Use

For recording 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 situation). 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

Use when recording an instruction or order (use Medication Instruction DCM).

9.4 MEDICATION ACTION

Identification

Label	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 and/or to counter the effects of an infectious organism or insult.
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

Usage

Conditions of Use	This is a reuse of the MEDICATION ACTION data group, which is described in Medication Instruction And Action Detailed Clinical Specification [NEHT2011aa].
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Administered Immunisations (IMMUNISATIONS)	1..*	

Children

Data Type	Name	Occur-rences	Condi-tion
	Medicine (Therapeutic Good Identification)	1..1	
	~~Instructions to Subject of Care or Carer (Medication Action Instructions)~~	~~0..0~~	-

Data Type	Name	Occur-rences	Condi-tion
	~~Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)~~	~~0..0~~	-
	~~Reason (Reason for Action)~~	~~0..0~~	-
	~~Quantity of Medication (AMOUNT OF MEDICATION)~~	~~0..0~~	-
	~~Comment~~	~~0..0~~	-
	~~Sequence Number~~	~~0..0~~	-
	~~Administration (MEDICATION ADMINISTRATION)~~	~~0..0~~	-
	~~Brand Substituted (Brand Substitution Occurred)~~	~~0..0~~	-
	~~Batchid (Batch Identifier)~~	~~0..0~~	-
	~~Date of Expiry (Expiry Date)~~	~~0..0~~	-
	~~DISPENSED TO~~	~~0..0~~	-
	~~Number of Times Dispensed~~	~~0..0~~	-
	~~Remaining Repeats~~	~~0..0~~	-
	~~Claim Category~~	~~0..0~~	-
	~~Administrative Item Code~~	~~0..0~~	-
	~~Administrative Manufacturer Code~~	~~0..0~~	-
	~~INFORMATION PROVIDER~~	~~0..0~~	-
	~~SUBJECT~~	~~0..0~~	-
	Medication Action DateTime	1..1	

9.5 Therapeutic Good Identification

Identification

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

Definition

Definition	The medicine, vaccine or other therapeutic good which was the focus of the action.
Definition Source	Therapeutic Goods Administration
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; • influencing, inhibiting or modifying a physiological process; • testing the susceptibility of persons to a disease or ailment; • influencing, controlling or preventing conception; • testing for pregnancy; or • replacement or modification of parts of the anatomy. From [TGA1989a]. The formal definition of a therapeutic good (from the Therapeutic Goods Act 1989) can be found at: [TGA1989a].
Data Type	CodeableText
Value Domain	Medicines Terminology

Usage

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

	For items without an AMT code (including some extemporaneous preparations), a text description is suitable. For a medication this **SHALL** include the name of the medication (brand name or generic name equivalent), strength and dose form, where appropriate. This **SHALL** be a vaccine.
Conditions of Use Source	NEHTA
Examples	An example of an AMT ConceptID and its AMT Preferred Term is: 1. 73875011000036101, Je-Vax (Japanese encephalitis virus inactivated vaccine) injection: powder for, vial

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	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 Editorial Rules [NEHT2009r]. Prescribing and dispensing use different sets of values.

Value Domain

Source	Australian Medicines Terminology
Permissible Values	The permissible values are the members of the following AMT reference set: • |929360031000036100 *Trade product unit of use reference set*|

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Medicine (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	The point in time at which the Medication Action is completed.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Immunisation (MEDICATION ACTION)	1..1	

10 Pathology Test Result Data Group

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.

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

10.3 Misuse

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

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

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

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

Usage

Conditions of Use	This is a reuse of the PATHOLOGY TEST RESULT data group, which is described in Pathology Test Result Detailed Clinical Model Specification [NEHT2011ae].
Conditions of Use Source	NEHTA

Relationships

Parents

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

Children

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

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

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 (e.g. HbA1c) or to a test group such as electrolytes, FBC or coagulation tests.
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[1] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

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

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

10.6 Diagnostic Service

Identification

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

Definition

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

Usage

Examples	1. Microbiology. 2. Haematology.

Relationships

Parents

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

10.7 Diagnostic Service Values

Identification

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

Definition

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

Value Domain

Source	HL7

Relationships

Parents

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

10.8 SPECIMEN

Identification

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

Definition

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

Relationships

Parents

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

Children

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

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

10.9 Specimen Tissue Type

Identification

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

Definition

Definition	The type of specimen to be collected.
Definition Source	NEHTA
Synonymous Names	
Notes	The categorisation of the sample taken from an individual and submitted for pathology investigation.
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[2] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

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

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

Relationships

Parents

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

10.10 Collection Procedure

Identification

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

Definition

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

Usage

Examples	1. Venepuncture 2. Biopsy 3. Resection

Relationships

Parents

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

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

10.11 ANATOMICAL LOCATION

Identification

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

Definition

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

Relationships

Parents

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

Children

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

10.12 SPECIFIC LOCATION

Identification

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

Definition

Definition	Specific and identified anatomical location.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

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

Children

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

10.13 Anatomical Location Name

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.14 Body Structure Foundation Reference Set

Identification

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

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

10.15 Side

Identification

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

Definition

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

Usage

Examples	1. Right. 2. Left. 3. Bilalteral.

Relationships

Parents

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

10.16 Laterality Reference Set

Identification

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

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

10.17 Anatomical Location Description

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.18 Anatomical Location Image

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.19 PHYSICAL PROPERTIES OF AN OBJECT

Identification

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

Definition

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

Relationships

Parents

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

Children

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

10.20 Weight

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.21 DIMENSIONS

Identification

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

Definition

Definition	The dimensions of the object.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

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

Children

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

10.22 Volume

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.23 Object Description

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.24 Image

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.25 COLLECTION AND HANDLING

Identification

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

Definition

Definition	Collection and handling requirements.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

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

Children

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

10.26 Sampling Preconditions

Identification

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

Definition

Definition	Any conditions to be met before the sample should be taken.
Definition Source	NEHTA
Synonymous Names	
Notes	Can also be used to document any known deviations from collection or handling instructions, e.g. patient was not fasted. Examples include fasting, 'full bladder', 'sterile field' or any special instructions on the handling or immediate processing of the sample e.g. centrifuge on receipt.
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[4] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

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

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

10.27 HANDLING AND PROCESSING

Identification

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

Definition

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

Relationships

Parents

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

Children

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

10.28 Collection DateTime

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.29 Collection Setting

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.30 DateTime Received

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.31 IDENTIFIERS

Identification

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

Definition

Definition	Sample identifications.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

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

Children

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

10.32 Specimen Identifier

Identification

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

Definition

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

Usage

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

Relationships

Parents

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

10.33 Parent Specimen Identifier

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.34 Container Identifier

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.35 Overall Pathology Test Result Status

Identification

Label	Overall Test Result Status
Metadata Type	Data Element
Identifier	DE-16155
OID	1.2.36.1.2001.1001.101.103.16155

Definition

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

Usage

Examples	1. Interim 2. Final

Relationships

Parents

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

10.36 Pathology Test Result Status Values

Identification

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

Definition

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

Value Domain

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

Relationships

Parents

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

10.37 Clinical Information Provided

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.38 PATHOLOGY TEST RESULT GROUP

Identification

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

Definition

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

Relationships

Parents

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

Children

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

10.39 Pathology Test Result Group Name

Identification

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

Definition

Definition	The name of a group of pathology test results.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodedText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[5] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

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

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

10.40 INDIVIDUAL PATHOLOGY TEST RESULT

Identification

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

Definition

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

Relationships

Parents

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

Children

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

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

10.41 Individual Pathology Test Result Name

Identification

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

Definition

Definition	The name of an individual pathology test result.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodedText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[6] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

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

Relationships

Parents

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

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

10.42 Individual Pathology Test Result Value

Identification

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

Definition

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

Usage

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

Relationships

Parents

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

10.43 Result Value Values

Identification

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

Definition

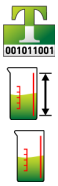
Definition	The set of values for the measured level/magnitude of the test result component.
Definition Source	NEHTA

Value Domain

Source	NEHTA

Relationships

Parents

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

10.44 Individual Pathology Test Result Value Normal Status

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.45 Individual Pathology Test Result Value Normal Status Values

Identification

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

Definition

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

Value Domain

Source	HL7 V3: ObservationInterpretationNormality code set

Relationships

Parents

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

10.46 INDIVIDUAL PATHOLOGY TEST RESULT VALUE REFERENCE RANGE DETAILS

Identification

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

Definition

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

Usage

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

Relationships

Parents

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

Children

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

10.47 Individual Pathology Test Result Value Reference Range Meaning

Identification

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

Definition

Definition	Term whose value indicates the meaning of this range.
Definition Source	NEHTA
Synonymous Names	
Notes	Default value is "normal".
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[7] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. "Normal". 2. "Critical". 3. "Therapeutic".

Relationships

Parents

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

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

10.48 Individual Pathology Test Result Value Reference Range

Identification

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

Definition

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

Usage

Examples	1. 60-400 U/L (male) 2. 40-150 U/L (female)

Relationships

Parents

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

10.49 Individual Pathology Test Result Comment

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.50 Individual Pathology Test Result Reference Range Guidance

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.51 Individual Pathology Test Result Status

Identification

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

Definition

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

Usage

Examples	1. Corrected/Amended 2. Final 3. Interim 4. Preliminary 5. Supplementary

Relationships

Parents

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

10.52 SPECIMEN

Identification

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

Definition

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

Relationships

Parents

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

Children

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

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

10.53 Specimen Tissue Type

Identification

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

Definition

Definition	The type of specimen to be collected.
Definition Source	NEHTA
Synonymous Names	
Notes	The categorisation of the sample taken from an individual and submitted for pathology investigation.
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[8] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

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

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

Relationships

Parents

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

10.54 Collection Procedure

Identification

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

Definition

Definition	The method of collection to be used.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[9] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Venepuncture 2. Biopsy 3. Resection

Relationships

Parents

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

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

10.55 ANATOMICAL LOCATION

Identification

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

Definition

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

Relationships

Parents

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

Children

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

10.56 SPECIFIC LOCATION

Identification

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

Definition

Definition	Specific and identified anatomical location.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

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

Children

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

10.57 Anatomical Location Name

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.58 Body Structure Foundation Reference Set

Identification

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

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

10.59 Side

Identification

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

Definition

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

Usage

Examples	1. Right. 2. Left. 3. Bilalteral.

Relationships

Parents

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

10.60 Laterality Reference Set

Identification

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

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

10.61 Anatomical Location Description

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.62 Anatomical Location Image

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.63 PHYSICAL PROPERTIES OF AN OBJECT

Identification

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

Definition

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

Relationships

Parents

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

Children

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

10.64 Weight

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.65 DIMENSIONS

Identification

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

Definition

Definition	The dimensions of the object.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

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

Children

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

10.66 Volume

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.67 Object Description

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.68 Image

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.69 COLLECTION AND HANDLING

Identification

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

Definition

Definition	Collection and handling requirements.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

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

Children

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

10.70 Sampling Preconditions

Identification

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

Definition

Definition	Any conditions to be met before the sample should be taken.
Definition Source	NEHTA
Synonymous Names	
Notes	Can also be used to document any known deviations from collection or handling instructions, e.g. patient was not fasted. Examples include fasting, 'full bladder', 'sterile field' or any special instructions on the handling or immediate processing of the sample e.g. centrifuge on receipt.
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[10] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

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

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

10.71 HANDLING AND PROCESSING

Identification

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

Definition

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

Relationships

Parents

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

Children

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

10.72 Collection DateTime

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.73 Collection Setting

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.74 DateTime Received

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.75 IDENTIFIERS

Identification

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

Definition

Definition	Sample identifications.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

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

Children

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

10.76 Specimen Identifier

Identification

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

Definition

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

Usage

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

Relationships

Parents

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

10.77 Parent Specimen Identifier

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.78 Container Identifier

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.79 Pathological Diagnosis

Identification

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

Definition

Definition	Single word, phrase or brief description representing the diagnostic statement as asserted by the reporting pathologist.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[11] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

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

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

10.80 Pathology Test Conclusion

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.81 Test Result Representation

Identification

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

Definition

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

Usage

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

Relationships

Parents

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

10.82 Test Comment

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.83 TEST REQUEST DETAILS

Identification

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

Definition

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

Relationships

Parents

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

Children

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

10.84 Test Requested Name

Identification

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

Definition

Definition	Identification of pathology test requested, where the test requested differs from the test actually performed.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[12] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

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

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

10.85 Laboratory Test Result Identifier

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

10.86 Pathology Test Result DateTime

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

11 Imaging Examination Result Data Group

11.1 Purpose

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

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 echocardiaograms or Bone density scans) may be represented using templates or specialised DCMs where additional report content is appropriate.

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

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 must be recorded using the Procedure DCM for the operative findings. This DCM will only be used to record the findings from the imaging.

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

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

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

Usage

Conditions of Use	This is a reuse of the IMAGING EXAMINATION RESULT data group, which is described in Imaging Examination Result Detailed Clinical Model Specification [NEHT2011y].
Conditions of Use Source	NEHTA

Relationships

Parents

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

Children

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

Data Type	Name	Occur-rences	Condi-tion
	~~Imaging Examination Result Duration~~	~~0..0~~	-

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	

Relationships

Parents

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

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

11.6 Imaging Modality

Identification

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

Definition

Definition	The imaging method used to perform the examination.
Definition Source	NEHTA
Synonymous Names	
Context	For identification/description of the diagnostic imaging modalities that are: • Available for request; or • Used in reporting.
Context Source	NEHTA
Notes	The imaging method, including the electro-magnetic energy type, applied to produce diagnostic quality images of body structures or internal organs performed during a diagnostic imaging procedure. If the modality is specified by a code in the Examination result name, then this field is not required.
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[2] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. X-ray. 2. CT scan. 3. MRI. 4. PET scan.

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

Relationships

Parents

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

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

Relationships

Parents

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

Children

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

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	Occur-rences	Condi-tion
	Anatomical Site (ANATOMICAL LOCATION)	0..1	

Children

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

11.9 Anatomical Location Name

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

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	Occur-rences	Condi-tion
	Name of Location (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 an anatomical location.
Definition Source	NEHTA
Synonymous Names	Laterality
Data Type	CodedText
Value Domain	Laterality Reference Set

Usage

Examples	1. Right. 2. Left. 3. Bilalteral.

Relationships

Parents

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

11.12 Laterality Reference Set

Identification

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

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

11.13 Anatomical Location Description

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

11.14 Anatomical Location Image

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

11.15 Imaging Examination Result Status

Identification

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

Definition

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

Usage

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

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

Relationships

Parents

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

11.16 Clinical Information Provided

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

11.17 Findings

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

11.18 IMAGING EXAMINATION RESULT GROUP

Identification

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

Definition

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

Relationships

Parents

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

Children

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

11.19 Imaging Examination Result Group Name

Identification

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

Definition

Definition	The name of a group of structured results.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodedText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[4] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

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

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

11.20 INDIVIDUAL IMAGING EXAMINATION RESULT

Identification

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

Definition

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

Relationships

Parents

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

Children

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

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

11.21 Individual Imaging Examination Result Name

Identification

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

Definition

Definition	The name of a specific detailed result.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodedText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[5] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Cardiac ejection fraction. 2. Bone density.

Relationships

Parents

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

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

11.22 Imaging Examination Result Value

Identification

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

Definition

Definition	Actual value of the result.
Definition Source	NEHTA
Synonymous Names	
Notes	Most result values will be numerical measurements, but others may be coded concepts or free text.
Data Type	CodeableText QuantityRange Quantity
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[6] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

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

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

Relationships

Parents

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

11.23 Imaging Examination Result Value Normal Status

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

11.24 Imaging Examination Result Value Normal Status Values

Identification

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

Definition

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

Value Domain

Source	HL7 V3: ObservationInterpretationNormality code set

Relationships

Parents

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

11.25 IMAGING EXAMINATION RESULT VALUE REFERENCE RANGE DETAILS

Identification

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

Definition

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

Usage

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

Relationships

Parents

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

Children

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

11.26 Imaging Examination Result Value Reference Range Meaning

Identification

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

Definition

Definition	Term whose value indicates the meaning of this range.
Definition Source	NEHTA
Synonymous Names	
Notes	Default value is "normal".
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[7] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. "Normal". 2. "Critical". 3. "Therapeutic".

Relationships

Parents

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

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

11.27 Imaging Examination Result Value Reference Range

Identification

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

Definition

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

Usage

Examples	1. Critical.

Relationships

Parents

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

11.28 Result Comment

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

11.29 ANATOMICAL LOCATION

Identification

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

Definition

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

Relationships

Parents

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

Children

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

11.30 SPECIFIC LOCATION

Identification

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

Definition

Definition	Specific and identified anatomical location.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

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

Children

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

11.31 Anatomical Location Name

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

11.32 Body Structure Foundation Reference Set

Identification

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

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

11.33 Side

Identification

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

Definition

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

Usage

Examples	1. Right. 2. Left. 3. Bilalteral.

Relationships

Parents

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

11.34 Laterality Reference Set

Identification

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

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

11.35 Anatomical Location Description

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

11.36 Anatomical Location Image

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

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

11.37 Examination Result Representation

Identification

Label	Examination Result Representation
Metadata Type	Data Element
Identifier	DE-16509
OID	1.2.36.1.2001.1001.101.103.16509

Definition

Definition	Rich text representation of the entire result as issued by the diagnostic service.
Definition Source	NEHTA
Synonymous Names	
Notes	Multiple formats are allowed but they must be semantically equivalent.
Data Type	EncapsulatedData

Usage

Examples	

Relationships

Parents

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

11.38 EXAMINATION REQUEST DETAILS

Identification

Label	EXAMINATION REQUEST DETAILS
Metadata Type	Data Group
Identifier	DG-16511
OID	1.2.36.1.2001.1001.101.102.16511

Definition

Definition	Details concerning a single examination requested.
Definition Source	NEHTA
Synonymous Names	
Notes	Usually there is one examination request for each result, however in some circumstances multiple examination requests may be represented using a single Imaging examination result.

Relationships

Parents

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

Children

Data Type	Name	Occur-rences	Condi-tion
	~~Requester Order Identifier~~	~~0..0~~	-
	Examination Requested Name	0..*	
	~~REQUESTER~~	~~0..0~~	-
	~~Receiver Order Identifier~~	~~0..0~~	-
	DICOM Study Identifier	0..1	
	Report Identifier	0..1	
	IMAGE DETAILS	0..*	

11.39 Examination Requested Name

Identification

Label	Examination Requested Name
Metadata Type	Data Element
Identifier	DE-16512
OID	1.2.36.1.2001.1001.101.103.16512

Definition

Definition	Identification of imaging examination or procedure requested, where the examination requested differs from the examination actually performed.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	

Relationships

Parents

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

11.40 DICOM Study Identifier

Identification

Label	DICOM Study Identifier
Metadata Type	Data Element
Identifier	DE-16513
OID	1.2.36.1.2001.1001.101.103.16513

Definition

Definition	Unique identifier of this study allocated by the imaging service.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Examples	

Relationships

Parents

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

11.41 Report Identifier

Identification

Label	Report Identifier
Metadata Type	Data Element
Identifier	DE-16514
OID	1.2.36.1.2001.1001.101.103.16514

Definition

Definition	The local identifier given to the imaging examination report.
Definition Source	NEHTA
Synonymous Names	Diagnostic imaging report identifier.
Context	Unique identification of a diagnostic imaging procedure/study report. Unique system identifier that uniquely identifies a procedure or study report being created. It is recommended that the Report Instance Identifier value should be globally unique. The global uniqueness of the value of this Identifier may be achieved by: System ID (instance ID generated by System) + state identifier + organisation identifier If unique national healthcare provider organisation identifiers (e.g. HPI-O) are available, uniqueness of the value of this Identifier may be achieved by: System ID (instance ID generated by System) + HPI-O + Report Identifier For a single study, the "Study Identifier", "Report Identifier" and "Report Version Number" values provide the version tracking facility for related reports that belong to a specific study set.
Context Source	NEHTA
Assumptions	The value of "Report Identifier" is intended for machine/computer consumption. It does not need to be used/consumed by the human user, e.g. reporting provider or the recipient of a test report.
Assumptions Source	NEHTA
Data Type	UniqueIdentifier

Usage

Examples	

Relationships

Parents

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

11.42 IMAGE DETAILS

Identification

Label	IMAGE DETAILS
Metadata Type	Data Group
Identifier	DG-16515
OID	1.2.36.1.2001.1001.101.102.16515

Definition

Definition	Images referred to, or provided, to assist clinical understanding of the examination.
Definition Source	NEHTA
Synonymous Names	
Notes	If attached image is in DICOM format, all the fields below should be populated so the values are available to software that does not process DICOM images.

Relationships

Parents

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

Children

Data Type	Name	Occur-rences	Condi-tion
	Image Identifier	0..1	
	DICOM Series Identifier	0..1	
	View (Image View Name)	0..1	
	Position (Subject Position)	0..1	
	Image DateTime	0..1	
	Image	0..1	

11.43 Image Identifier

Identification

Label	Image Identifier
Metadata Type	Data Element
Identifier	DE-16516
OID	1.2.36.1.2001.1001.101.103.16516

Definition

Definition	Unique identifier of this image allocated by the imaging service (often the DICOM image instance UID).
Definition Source	NEHTA
Synonymous Names	Diagnostic Image Identifier.
Context	The "image identifier" value uniquely identifies an image object (DICOM or non-DICOM image). This allows software to easily determine if an image is already present, rather than having to compare a large number of (DICOM/image) tags. Example: X-ray skull AP and lateral views study produces two images each with a unique image identifier assigned by the system. Source - The DICOM Standard White Paper - DICOM Part 1: Introduction and Overview, National Electrical Manufacturers Association, Rosslyn, VA, USA, 2000.
Context Source	NEHTA
Assumptions	It is assumed that the Diagnostic Imaging information system or Picture Archive and Communicating System (PACS) generates a unique identifier for each diagnostic image produced from the test procedure performed. To ensure global uniqueness, the "image identifier" value may have to be used/associated with the unique "Organisation identifier" value.
Assumptions Source	NEHTA
Data Type	UniqueIdentifier

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	IMAGE DETAILS	0..1	

11.44 DICOM Series Identifier

Identification

Label	DICOM Series Identifier
Metadata Type	Data Element
Identifier	DE-16517
OID	1.2.36.1.2001.1001.101.103.16517

Definition

Definition	Unique identifier of this series allocated by the imaging service.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	IMAGE DETAILS	0..1	

11.45 Image View Name

Identification

Label	View
Metadata Type	Data Element
Identifier	DE-16198
OID	1.2.36.1.2001.1001.101.103.16198

Definition

Definition	The name of the imaging view e.g. Lateral or Antero-posterior (AP).
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[8] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	IMAGE DETAILS	0..1	

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

11.46 Subject Position

Identification

Label	Position
Metadata Type	Data Element
Identifier	DE-16519
OID	1.2.36.1.2001.1001.101.103.16519

Definition

Definition	Description of the subject of care's position when the image was performed.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	IMAGE DETAILS	0..1	

11.47 Image DateTime

Identification

Label	Image DateTime
Metadata Type	Data Element
Identifier	DE-16520
OID	1.2.36.1.2001.1001.101.103.16520

Definition

Definition	Specific date/time the imaging examination was performed.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	IMAGE DETAILS	0..1	

11.48 Image

Identification

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

Definition

Definition	An attached or referenced image of a current view.
Definition Source	NEHTA
Synonymous Names	
Data Type	EncapsulatedData

Usage

Examples	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	IMAGE DETAILS	0..1	

11.49 Imaging Examination Result DateTime

Identification

Label	Imaging Examination Result DateTime
Metadata Type	Data Element
Identifier	DE-16589
OID	1.2.36.1.2001.1001.101.103.16589

Definition

Definition	The date and, optionally, time when the Imaging Examination Result became available.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

Examples	

Relationships

Parents

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

12 Requested Service (Action) Data Group

12.1 Purpose

Describes the types of service requested for, or provided to, the subject of care.

12.2 Misuse

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, the service date and/or provider may not be recorded.

Usage

Conditions of Use	This is a reuse of the REQUESTED SERVICE data group, which is described in Miscellaneous Detailed Clinical Model Specification [NEHT2011ag].
Conditions of Use Source	NEHTA
Misuse	Requesting a service other than a diagnostic investigation.

Relationships

Parents

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

Children

Data Type	Name	Occur-rences	Condi-tion
	~~Reason for Service~~	~~0..0~~	-
	Requested Service Description	1..1	

Data Type	Name	Occur-rences	Condi-tion
	~~Intent of Request~~	~~0..0~~	-
	~~Request Urgency~~	~~0..0~~	-
	DateTime Service Scheduled	0..1	
	Service Commencement Window	0..1	
	Service Booking Status	1..1	
	~~Supplementary Information to Follow~~	~~0..0~~	-
	~~Supplementary Information Expected~~	~~0..0~~	-
	Subject of Care Instruction Description	0..1	
	~~DISTRIBUTION LIST~~	~~0..0~~	-
	~~SERVICE REQUESTER~~	~~0..0~~	-
	SERVICE PROVIDER	0..1	
	~~Request Validity Period~~	~~0..0~~	-
	~~INFORMATION PROVIDER~~	~~0..0~~	-
	~~SUBJECT~~	~~0..0~~	-
	Requested Service DateTime	1..1	

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 healthcare setting. Used to identify diagnostic, clinical procedures or clinical management requested by the healthcare provider to be undertaken on/provided to the subject of care.
Context Source	NEHTA
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[1] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Elective Orthopaedic surgery for TKR 2. Dialysis 3. Adjustment of heart failure/hypertensive medications 4. Adjust INR to therapeutic range, etc

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

Relationships

Parents

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

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 datetime at which the arranged service is scheduled to be provided to the Subject of Care.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

Examples	

Relationships

Parents

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

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/during which the arranged service is scheduled to be provided to the Subject of Care.
Definition Source	NEHTA
Synonymous Names	Service Commences
Notes	Specifies the range of time within which the requesting provider is expecting the arranged service to be provided to the subject of care.
Data Type	TimeInterval

Usage

Examples	

Relationships

Parents

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

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	

Relationships

Parents

Data Type	Name	Occur-rences	Condi-tion
	Requested Service (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 for an indication of the booking status of the arranged service.
Definition Source	NEHTA

Value Domain

Source	HL7 v3 CDA: Act.moodCode.
Permissible Values	APT Appointment ARQ Appointment Request EVN Event INT Intent PRMS Promise PRP Proposal RQO Request

Relationships

Parents

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

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 and information that have been given to the subject of care from a healthcare provider in relation to the requested service.
Definition Source	NEHTA
Synonymous Names	Patient instructions
Data Type	Text

Usage

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

Relationships

Parents

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

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]. The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in B: *Specification Guide for Use*. Additional obligation and occurrence constraints where 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**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**. Other additional constraints where the service provider is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON): • Participation Type **SHALL** have an implementation-specific value equivalent to “Service Provider”. • Role **SHALL** have a value chosen from 1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, 2006 - METeOR 350899.

	• The value of Entity Identifier **SHALL** be an Australian HPI-I. • AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON. Additional obligation and occurrence constraints when the service provider is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as a ORGANISATION): • Entity Identifier is **ESSENTIAL**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**. Other additional constraints when the service provider is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as a ORGANISATION): • Participation Type **SHALL** have an implementation-specific value equivalent to “Service Provider”. • Role **SHALL** have a value representing the type of Facility e.g. Hospital, Clinic. • The value of Entity Identifier **SHALL** be an Australian HPI-O. • AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a ORGANISATION.
Conditions of Use Source	NEHTA

Relationships

Parents

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

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	The point in time at which the Requested Service action is completed.
Definition Source	NEHTA
Synonymous Names	
Notes	For a request to supply a service, this is the date/time of the request. For supply of a service this is the date/time of completion of supply.
Data Type	DateTime

Usage

Examples	

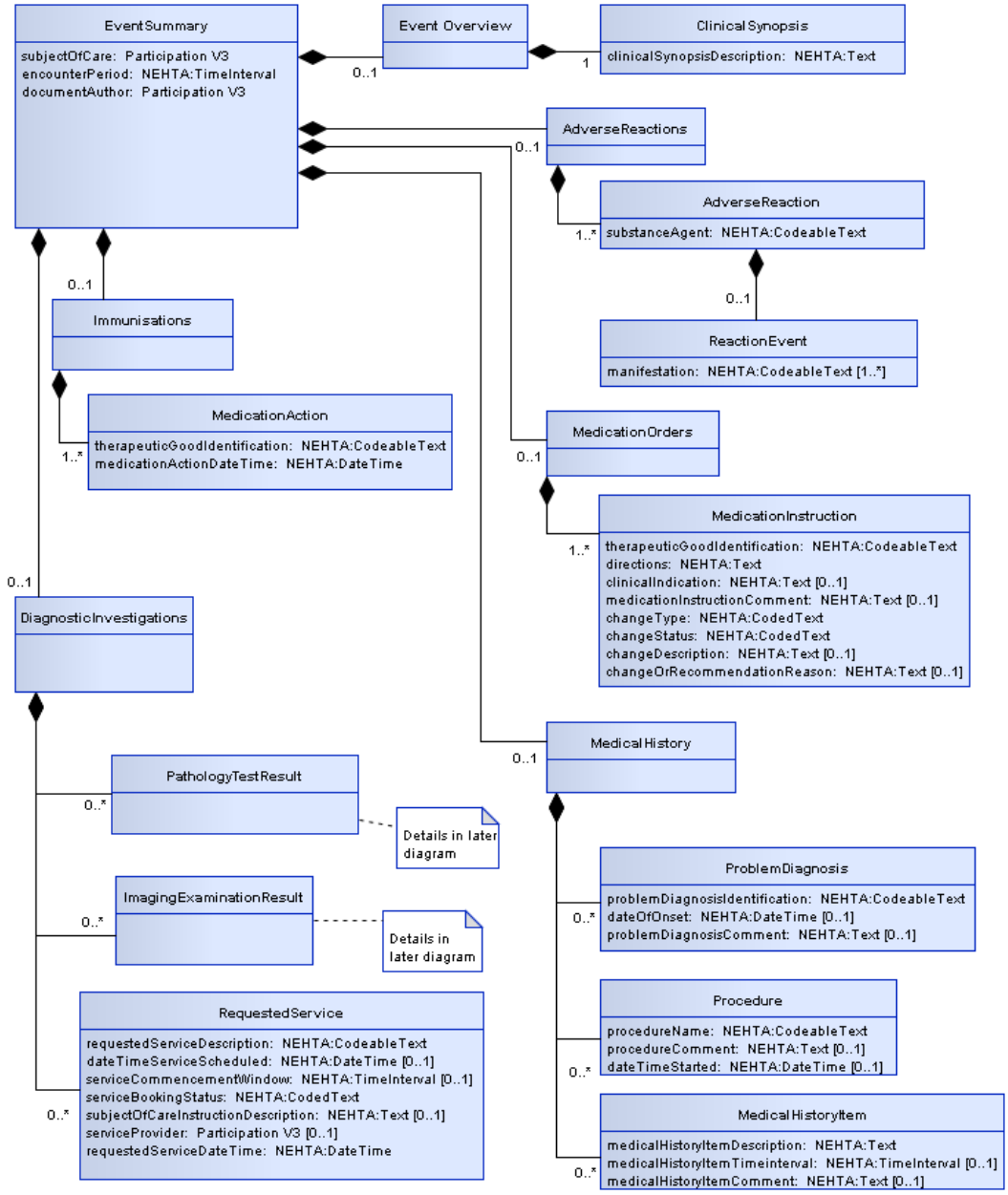
Relationships

Parents

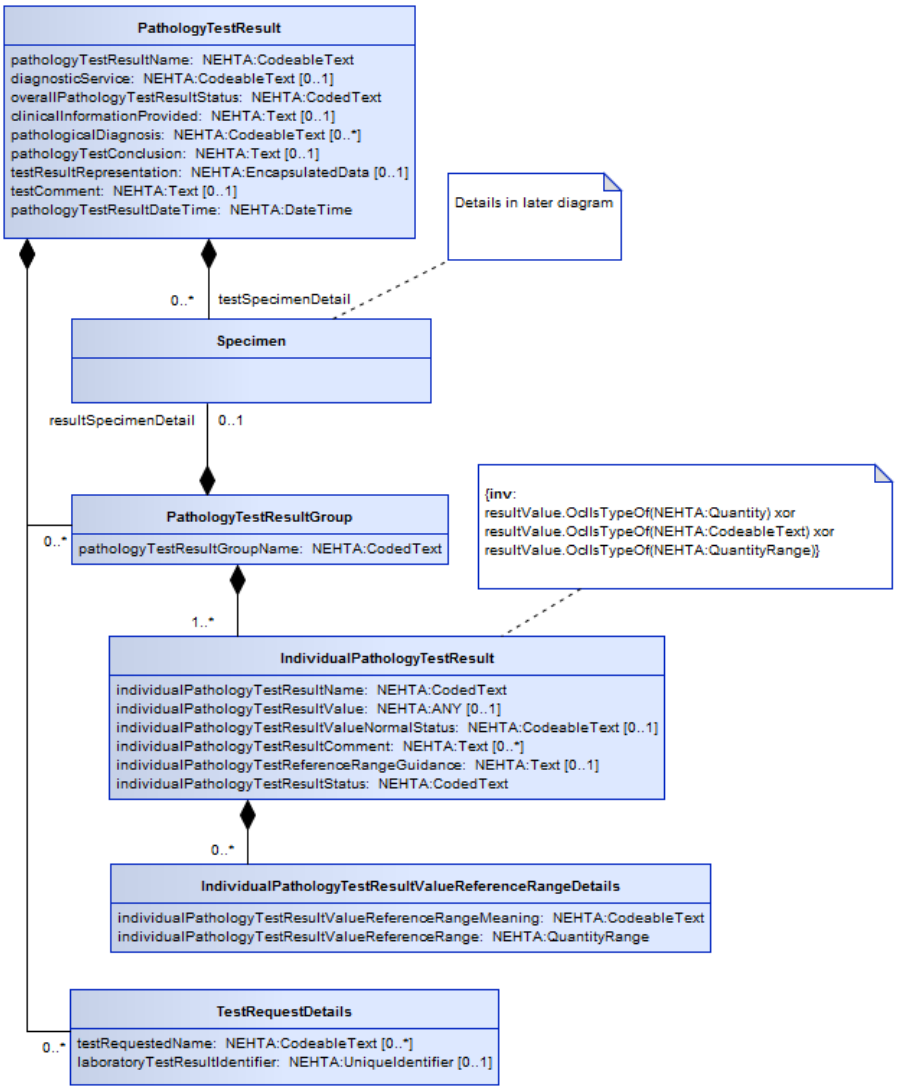
Data Type	Name	Occur-rences	Condi-tion
	Requested Service (REQUESTED SERVICE)	1..1	

13 UML Class Diagram

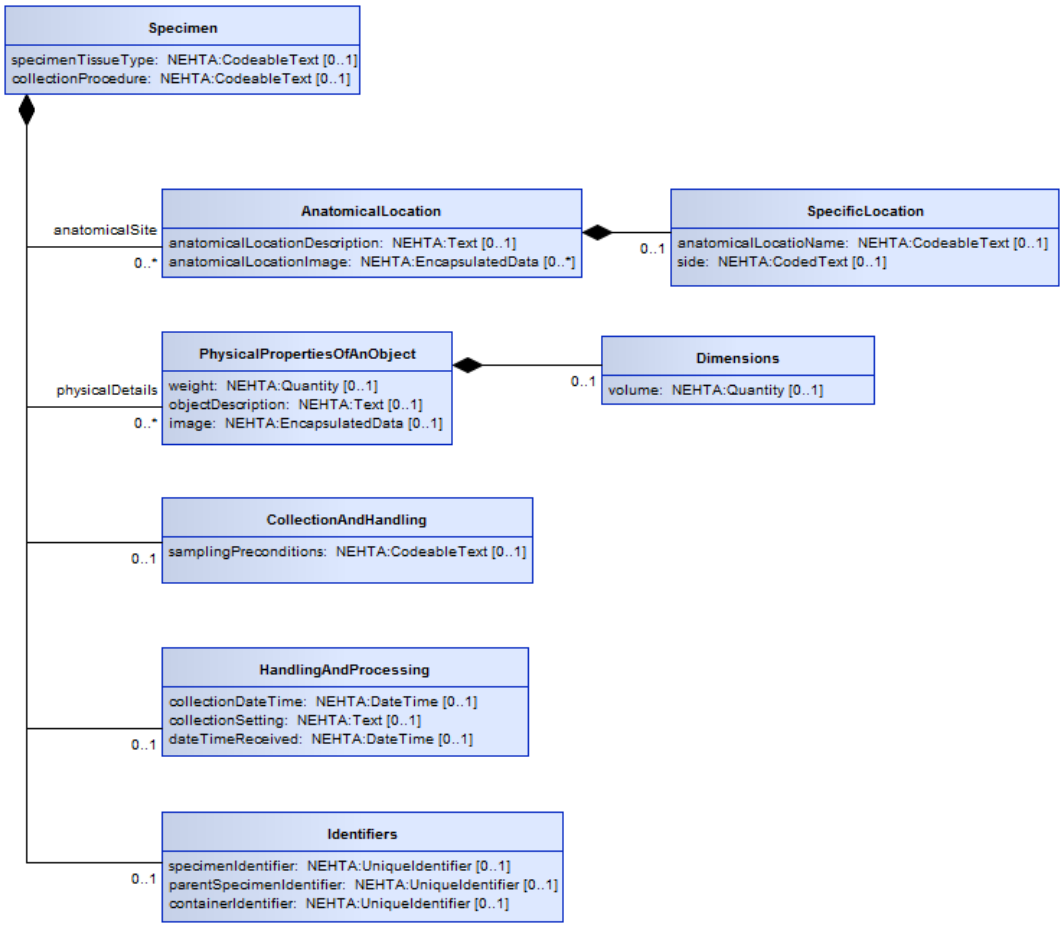
The following figure presents the data hierarchy using a UML 2.0 class diagram. The diagram displays data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes. Data groups are displayed as classes, their names are represented as association role names. Association role names are only displayed if they differ from the associated class name. The diagram shows the data hierarchy excluding the details of participation. The default multiplicity is 1..1.



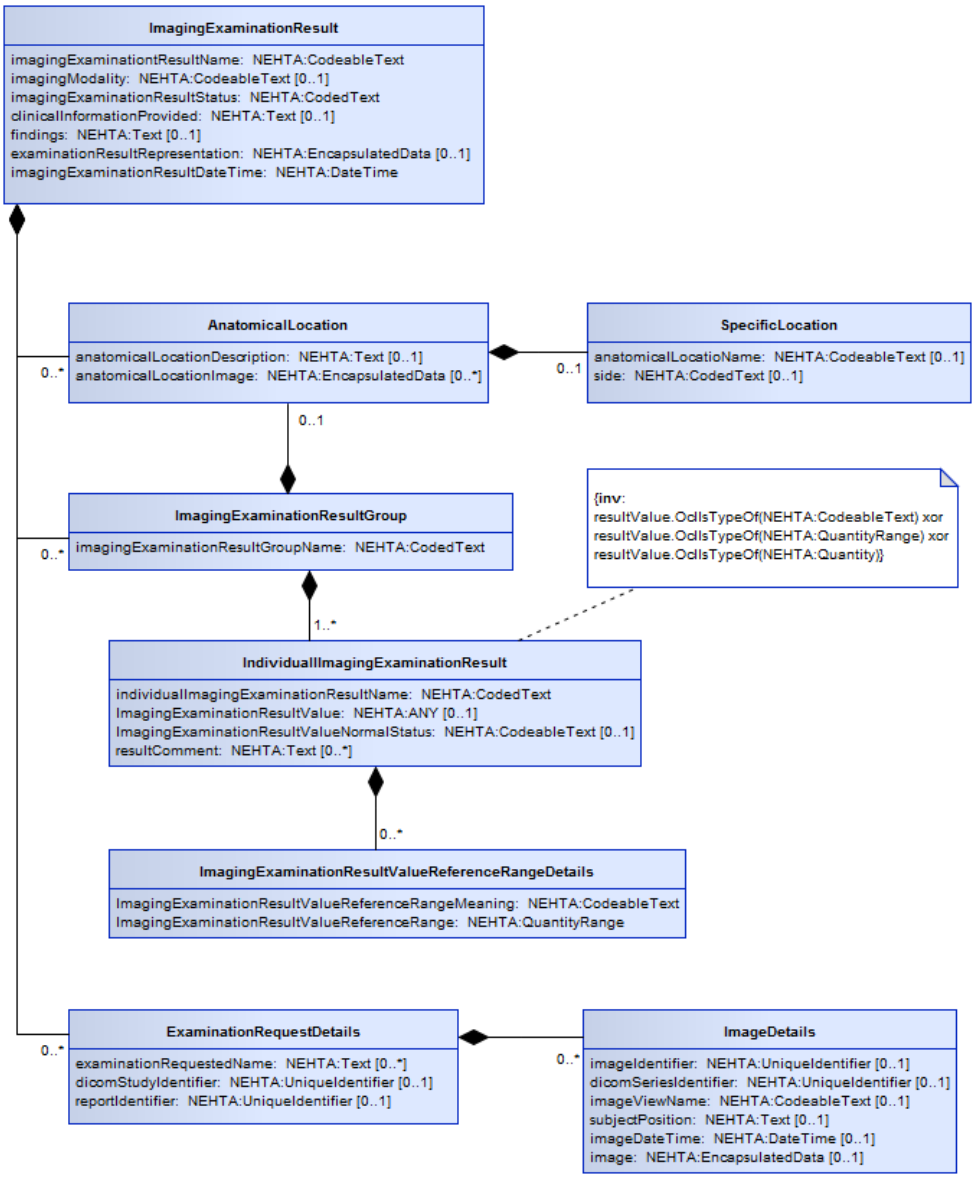
UML class diagram of the Event Summary data hierarchy.



UML class diagram of the Pathology Test Result for the Event Summary data hierarchy.



UML class diagram of the Specimen for the Event Summary data hierarchy.



UML class diagram of the Imaging Examination Result for the Event Summary data hierarchy.

Reference List

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

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

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

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

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

[NEHT2009t] National E-Health Transition Authority, *Reason for Encounter Data Specification*, Version 2.0, accessed 10 September 2009. http://nehta.gov.au/component/docman/doc_download/826-reason-for-encounter-data-specification-v20

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

[NEHT2011aa] National E-Health Transition Authority, 01 September 2011, *Medication Instruction And Action Detailed Clinical Model Specification*, Version 2.0, accessed 01 September 2011. http://nehta.gov.au/component/docman/doc_download/1353-medication-instruction-and-action-detailed-clinical-specification-v20

[NEHT2011ab] National E-Health Transition Authority, 01 September 2011, *Problem Diagnosis Detailed Clinical Model Specification*, Version 3.0, accessed 01 September 2011. http://nehta.gov.au/component/docman/doc_download/1356-problem-diagnosis-detailed-clinical-model-specification-v30

[NEHT2011ac] National E-Health Transition Authority, 01 September 2011, *Procedure Detailed Clinical Model Specification*, Version 3.0, accessed 01 September 2011. http://nehta.gov.au/component/docman/doc_download/1354-procedure-detailed-clinical-model-specification-v30

[NEHT2011ae] National E-Health Transition Authority, 01 September 2011, *Pathology Test Result Detailed Clinical Model Specification*, Version 2.0, accessed 01 September 2011. http://nehta.gov.au/component/docman/doc_download/1352-pathology-test-result-detailed-clinical-model-specification-v20

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

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

[NEHT2011w] National E-Health Transition Authority, 31 October 2011, *Information Requirements - Event Summary*, Version 1.1, accessed 22 November 2011.
http://www.nehta.gov.au/vendor-documents/CTI/ES-000-21-01-ES%20Information%20Requirements-v1.1-20111024.pdf

[NEHT2011x] National E-Health Transition Authority, To be published, *Event Summary CDA Implementation Guide*, Version 1.0.

[NEHT2011y] National E-Health Transition Authority, 01 September 2011, *Imaging Examination Result Detailed Clinical Model Specification*, Version 2.0, accessed 01 September 2011.
http://nehta.gov.au/component/docman/doc_download/1351-imaging-examination-result-detailed-clinical-model-specification-v20

[NEHT2011z] National E-Health Transition Authority, 01 September 2011, *Adverse Reaction Detailed Clinical Model Specification*, Version 3.0, accessed 01 September 2011.
http://nehta.gov.au/component/docman/doc_download/1350-adverse-reaction-detailed-clinical-model-specification-v30

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

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

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

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

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

Appendix A. Known Issues

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

Reference	Description
Document Status	As a NEHTA Managed Specification, the contents of this document are the result of extensive clinical collaboration and editorial review, and the specification is considered to be “Final”. Nonetheless, as software implementations and standards review of this specification progress, normative updates may be required.
Links to external resources	If a link (usually in references section) spans across 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 Comment data element.
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 Problems/Diagnosis 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 Problem/Diagnosis.Problem/Diagnosis Comment.
Procedure DateTime Ended	The Procedure DCM does not include a data element 'DateTime Ended', so such a data element cannot be used here. This will be fixed in the next release.
Administered Immunisations	The term "Administered Immunisations", used as the label for the IMMUNISATIONS section, is not strictly accurate, as it is vaccines which are administered, immunisation is a process.
Newly Identified Adverse Reactions	There is no provision in Newly Identified Adverse Reactions (ADVERSE REACTIONS) section to record a patient's repudiation of a previously recorded adverse reaction statement.
Specimen	The Test Specimen Detail (SPECIMEN) and Result Group Specimen Detail (SPECIMEN) data groups contain a large number of data components which are unlikely to be used in an Event Summary. The scope should be clarified.
Clinical Manifestation Values	A reference set for the Clinical Manifestation Values value domain has not been defined. Until it is defined use the Clinical finding foundation reference set (SNOMED CT-AU Concept ID: 32570071000036102).

Appendix B. Specification Guide for Use

B.1 Overview

Each Detailed Clinical Model (DCM) and Structured Content Specification (SCS) is designed to be a shared basis for data interpretation. It specifies rigorous business and technical definitions of data which systems may need to share. It is intended to be a logical specification of the data to be persisted within or communicated between systems. It is also the foundation for conformance, compliance and accreditation testing of implemented systems. NEHTA's CDA implementation guides are guides to the implementation of HL7 CDA R2 messages based upon these DCMs and SCSs.

Each DCM specifies all of the data components required for any use of a clinical concept, for instance an entry in a medical record such as a procedure or an imaging test. As such they are maximal data sets. DCMs are building blocks which are trimmed to size for use in construction of SCSs.

Each SCS specifies the data for a single type of clinical document or information exchange, such as a discharge summary. It is assembled using DCMs which have been constrained to eliminate data components not relevant to the particular context. For example, procedure in a discharge summary uses only some of the data components required by procedure in a specialist report.

B.2 The Structured Content Specification Metamodel

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

A DCM can be considered as a Data Group with no parent.

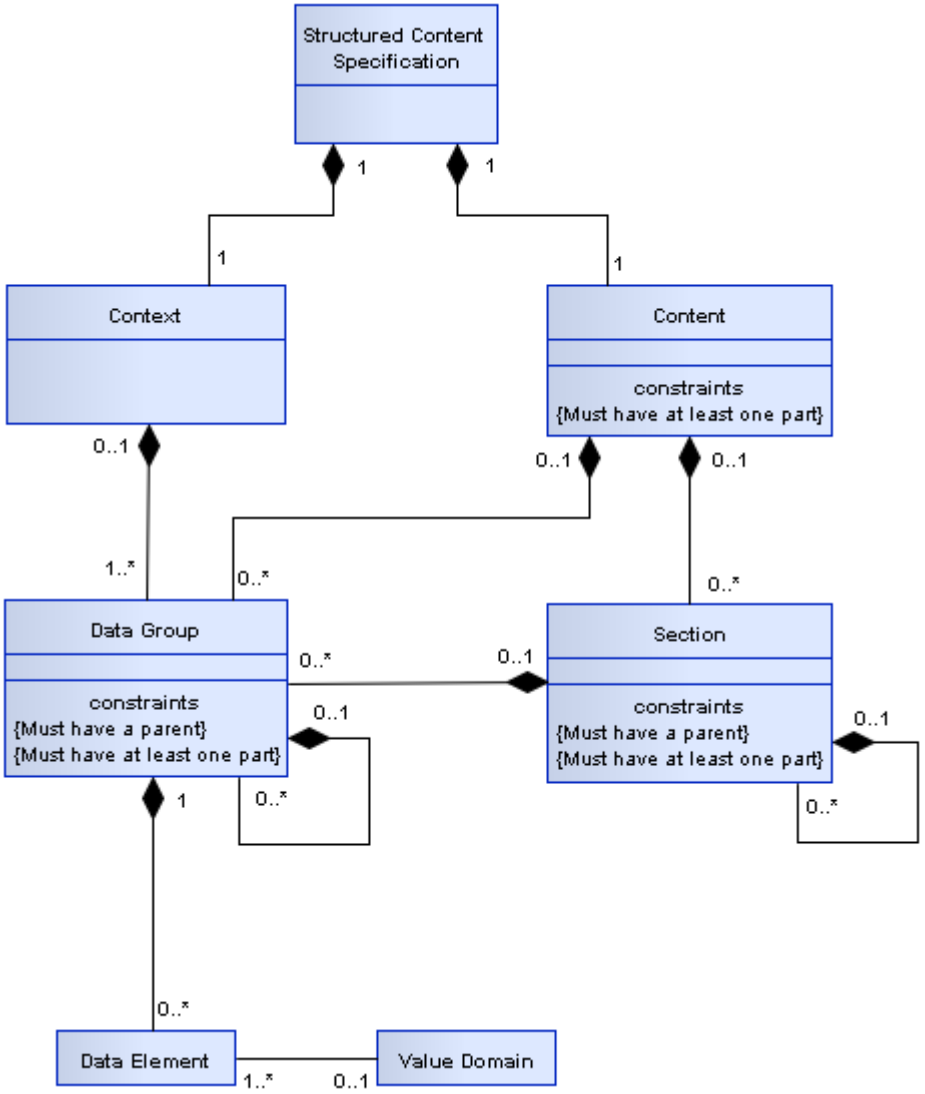


Figure 1: SCS Metamodel

There are two main components used to organise information within a Structured Content Specification (SCS) as follows:

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

Content: This contains information, which changes between different SCSs, but is always structured as shown, and consists of the following components:

- Section
- Data Group
- Data Element
- Value Domain

These components are described in more detail below.

Context

The purpose of the Context is to identify and classify the document and to provide subjects of care and involved healthcare providers with the information related to the relevant healthcare events.

Content

The Content contains a collection of health information pertinent to a subject of care which is derived from the healthcare event described in the document. The detail **MAY** be organised into one or more sections, each of which contains one or more data groups and/or possible data elements.

Section

The contents of the structured document Content **MAY** be subdivided into one or more sections. A section is an organising container that gives a reader a clue as to the expected content. The primary purpose of a section is to organise information in the manner that is suitable for the primary purpose for which it is collected, and that provides a way to navigate through the data components within the document, thereby enabling more efficient querying. It **SHOULD** also support safe re-use for secondary purposes, e.g. clinical coding or inclusion in a summarised form in an electronic health record. A section is context-specific to the document in which it resides.

Data Group

Each data group is used to represent one concept. A data group consists of other data groups and/or data elements. Some data groups are reused across detailed clinical models.

Participation

Participation is a special case of a data group that is based on a data group template, which is reused throughout the detailed clinical models (DCMs) and SCSs. Participations are an amalgam of the Actors (see below) operating within a defined healthcare domain and the Roles that they are playing within that domain.

A Participant has been defined to align with the concepts of the NEHTA interoperability framework. It equates to an *Entity* that is related to the action described in an SCS as an *Actor*. A participant can be a human, an organisation or an IT system.

[NEHT2011v] defines the full Participation specification.

Choice

Choice represents a decision to be made at run-time between a disjunctive mandatory set of data groups defined at design-time, i.e. one and only one member of the set **SHALL** be chosen.

For example, at design time a Healthcare Provider provides a service but it is not until run-time that a decision can be made as to whether the provider is a person or an organisation. Hence when a Healthcare Provider Participant is instantiated, it **SHALL** be done with the choice of either the *Person* data group or the *Organisation* data group.

Data Element

A data element is the smallest named unit of information in the model that can be assigned a value. For example, 'DateTime of Observation' and 'Observation Note'. Data elements are bound to data types (see Data Types Legend). Some data elements are reused in different data groups.

Whilst all data elements are constrained by their data type, some data elements are further constrained by value domains (see Value Domain below).

Value Domain

A value domain constrains the permissible values for a data element. The values **MAY** be a subset of values based on a generic data type.

Value domains are reusable components and therefore, the same value domain can be referred to by different data elements in different contexts. Value domains are often specified as a reference set. A reference set (or a subset) is a constrained list of SNOMED CT-AU, AMT or LOINC concepts that are appropriate to a particular context. It **SHOULD** be noted that many of these reference sets have been developed specifically for the context in which they appear. An assessment of fitness for purpose **SHOULD** therefore be undertaken before using any of the reference sets in another context.

Value domains constrain by either specifying a lower and/or upper bound on the range of permissible values or else by specifying a finite set of prescribed values. Such a set of prescribed values can be specified directly within the definition of the data element, or in a separate but associated specification or else by reference to one or more vocabulary/terminology reference sets. The table below provides some examples of value domains.

<table>
<tr><th>Data Element</th><th>Data Type</th><th>Example of Value Domain</th></tr>
<tr><td>Sex</td><td>CodedText</td><td>[SA2006a] and [SA2006b] derive their values from METeOR 270263 which includes values such as:
<table><tr><th>Value</th><th>Meaning</th></tr><tr><td>1</td><td>Male</td></tr><tr><td>2</td><td>Female</td></tr><tr><td>3</td><td>Intersex or Indeterminate</td></tr><tr><td>9</td><td>Not Stated/Inadequately Described</td></tr></table></td></tr>
<tr><td>Diagnosis</td><td>CodeableText</td><td>A SNOMED CT-AU reference set which references concepts such as 'Bronchitis' (Concept ID: 32398004)</td></tr>
<tr><td>Therapeutic Good Identification</td><td>CodeableText</td><td>An AMT reference set which references concepts such as 'Ibuprofen Blue (Herron) (ibuprofen 200 mg) tablet: film-coated, 1 tablet' (Concept ID: 54363011000036107)</td></tr>
<tr><td>To Be Advised</td><td>CodeableText</td><td>A LOINC subset which references concepts such as 'Cholesterol [Moles/volume] in Serum or Plasma' (ID: 14647-2)</td></tr>
</table>

Table 1: Value Domain Examples

B.3 Icon Legend

These legends describe all icons that are used within the various NEHTA information specifications.

Metadata Types Legend

The following table explains each of the icons used to represent the metadata types within DCMs and SCSs.

Icon	Metadata Types
	Structured Document
	Section
	Data Group
	Participation
	Choice

Table 2: Metadata Types Legend

Data Types Legend

The following table explains each of the icons used to represent the data types bound to each data element in the SCSs. These data types are a profile of the **ISO 21090-2011** data types as specified in [NEHT2010c].

Icon	Data type	Explanation
	Boolean (ISO 21090: BL)	A primitive data type, sometimes called the logical data type, having one of two values: *true* and *false*. Many systems represent true as *non-zero* (often 1, or -1) and false as *zero*. **Usage/Examples** • An actual value entered by a user might be 'yes' or could be chosen by a mouse click on an icon such as ☑.

CodeableText

(ISO 21090: CD)

Coded text *with* exceptions; flexible data type to support various ways of holding text, both free text and coded text. Commonly used to support compliance for early adopters of the Structured Content Specifications. Whilst it is recommended that the values in this data type come from the bound value domain, it allows other value domains to also be used (with or without translations to the bound value domain) or free text alternatives. This is a recognition that it **MAY** not be possible to define an entire value domain for a complex concept (e.g. *Diagnosis*) or that there **MAY** be competing code sets in existence. Note that within exchange specifications and/or message profiles this data type **MAY** be constrained to mandate compliance with the bound value domain.

Usage/Examples

- AIHW Separation Mode specifies the status at separation of a person from an organisation. An early adopter **MAY** have a similar concept (coded or otherwise) that maps to this data element but does not strictly comply with the AIHW values.
- A SNOMED CT-AU coded/complex expression that embodies single or multiple concepts. The SNOMED CT-AU concepts behind these CodeableText components are specified in the Structured Content Specification value domains.

CodedText

(ISO 21090: CD)

Coded text *without* exceptions; text with code mappings. Values in this data type **SHALL** come from the bound value domain, with no exceptions. Often used for reference sets with only a small number of applicable values, e.g. Gender and Document Status.

Usage/Examples

[SA2006b] specifies the following value domain representing a type of address:

Value	Meaning
1	Business
2	Mailing or Postal
3	Temporary Accommodation
4	Residential (permanent)
9	Not Stated/Unknown/Inadequately Described

DateTime

(ISO 21090: TS)

Used for specifying a single date and/or time. Has the ability to indicate a level of precision, but not whether the date/time is estimated. String representations of known dates **SHALL** conform to the nonextended format within the **ISO 21090-2011** standard, i.e. YYYYMMDDHHMMSS.UUUU[+]-ZZzz.

Usage/Examples

- Partial dates: 2008, 20081001.
- To indicate 1:20 pm on May the 31st, 1999 for a time zone which is 5 hours behind Coordinated Universal Time (UTC): 19990531132000-0500.

	Duration (ISO 21090: PQ.TIME)	The period of time during which something continues. Consists of a value and a unit which represents the time value, e.g. hours, months. Compound durations are not allowed, e.g. 10 days 3 weeks 5 hours. **Usage/Examples** • 3 hours • 6 months • 1 year
	Any (ISO 21090: ANY)	Represents a data element where the data type to be used is conditional upon another data component. The values that can be required will vary considerably depending on the context. Note that this is an abstract data type that is the basis for all data types and **SHOULD NOT** be used in an actual implementation.
	EncapsulatedData (ISO 21090: ED)	Data that is primarily intended for human interpretation or for further machine processing outside the scope of this specification. This includes unformatted or formatted written language, multimedia data, or structured information as defined by a different standard (e.g., XML signatures). **Usage/Examples** • JPEG images • HTML documents • [RFC1521] MIME types
	Integer (ISO 21090: INT)	The mathematical data type comprising the exact integral values (according to [NEHT2010c]). **Usage/Examples** • 1 • -50 • 125
	Link (ISO 21090: TEL)	This is a general link, reference or pointer to an object, data or application that exists logically or is stored electronically in a computer system. **Usage/Examples** • URL (Uniform Resource Locator) – the World Wide Web address of a site on the internet, such as the URL for the Google internet search engine – *'http://www.google.com'*. • An absolute or relative path within a file/directory structure – e.g. in the Windows® operating system, the "link" or absolute path to a particular letter could be *C:\Documents and Settings\GuestUser\MyDocuments\letter.doc*

 Quantity (ISO 21090: PQ)	Used for recording many real world measurements and observations. Includes the magnitude value and the units. **Usage/Examples** • 100 centimetres • 25.5 grams
 QuantityRatio (ISO 21090: RTO)	The relative magnitudes of two *Quantity* values (usually expressed as a quotient). **Usage/Examples** • 25 mg/500 ml • 200 mmol per litre
 QuantityRange (ISO 21090: IVL)	Two *Quantity* values that define the minimum and maximum values, i.e. lower and upper bounds. This is typically used for defining the valid range of values for a particular measurement or observation. Unbounded quantity ranges can be defined by not including a minimum and/or a maximum quantity value. **Usage/Examples** • -20 to 100 Celsius • 30-50 mg • >10 kg
 RealNumber (ISO 21090: REAL)	A computational approximation to the standard mathematical concept of real numbers. These are often called floating point numbers. **Usage/Examples** • 1.075 • -325.1 • 3.14157
 Text (ISO 21090: ST)	Character strings (with optional language). Unless otherwise constrained by an implementation, can be any combination of alpha, numeric or symbols from the Unicode character set. Sometimes referred to as free text. **Usage/Examples** “The patient is a 37 year old man who was referred for cardiac evaluation after complaining of occasional palpitations, racing heart beats and occasional dizziness.”
 TimeInterval (ISO 21090:TS)	An interval in time, with (optionally) a start date/time and (optionally) an end date/time and/or a duration/width. **Usage/Examples** • 01/01/2008 – 31/12/2008 • 1:30 a.m. – 6:00 p.m., duration/width = 16.5 hours

	UniqueIdentifier (ISO 21090: II)	A general unique value to identify a physical or virtual object or concept. In using this data type, the attributes of the UniqueIdentifier data type **SHOULD** be populated from the identifiers as defined in AS 4846 (2006) [SA2006a] and AS 5017 (2006) [SA2006b] as follows: *root*: a globally unique object identifier that identifies the combination of geographic area, issuer and type. If no such globally unique object identifier exists, it **SHALL** be created. *extension*: a unique identifier within the scope of the root that is directly equivalent to the identifier designation element. *identifierName*: a human readable name for the namespace represented by the root that is populated with the issuer or identifier type values, or a concatenation of both as appropriate. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used as such. *identifierScope*: the geographic span or coverage that applies to or constrains the identifier. It is directly equivalent to the geographic area element. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used as such. Also, the following constraints apply on the UniqueIdentifier data type: The *root* attribute **SHALL** be used. For an entity identifier the *root* attribute **SHALL** be an OID that consists of a node in a hierarchically-assigned namespace, formally defined using the ITU-T's ASN.1 standard. For an entity identifier the *root* attribute **SHALL NOT** be a UUID. The *extension* attribute **SHALL** be used. **Usage/Examples** IHIs, HPI-Is, HPI-Os and patient hospital medical record numbers are examples of identifiers that **MAY** be carried by this data type.

Table 3: Data Types Legend

Keywords Legend

Where used in this document and in DCMs and SCSs, the keywords **SHALL, SHOULD, MAY, SHALL NOT** and **SHOULD NOT** are to be interpreted as described in [RFC2119].

The following table defines these keywords

Keyword	Interpretation
SHALL	This word, or the terms ‘required’ or ‘must’, means that the definition is an absolute requirement of the specification.
SHOULD	This word, or the adjective ‘recommended’, means that there **MAY** exist valid reasons in particular circumstances to ignore a particular component, but the full implications **SHALL** be understood and carefully weighed before choosing a different course.

MAY	This word, or the adjective 'optional', means that a component is truly optional. One implementer **MAY** choose to include the component because a particular implementation requires it, or because the implementer determines that it enhances the implementation while another implementer **MAY** omit the same component. An implementation which does not include a particular option **SHALL** be prepared to interoperate with another implementation which does include the option, perhaps with reduced functionality. In the same vein, an implementation which does include a particular option **SHALL** be prepared to interoperate with another implementation which does not include the option (except of course, for the feature the option provides).
SHALL NOT	This phrase, or the phrase 'must not' means that the definition is an absolute prohibition of the specification.
SHOULD NOT	This phrase, or the phrase 'not recommended' means that there **MAY** exist valid reasons in particular circumstances when the particular behaviour is acceptable or even useful, but the full implications **SHOULD** be understood and the case carefully weighed before implementing any behaviour described with this label.

Table 4: Keywords Legend

Obligation Legend

Obligation in DCMs or SCSs specifies whether or not a data component **SHALL** be populated in the logical record architecture of a message. NEHTA intends that all data components will be implemented.

Implementation guides specify the rules and formats for implementing and populating data components in specific messaging formats.

The following table defines the obligations.

Keyword	Interpretation
Essential	Indicates that the data component is considered a mandatory component of information and **SHALL** be populated. **Usage/Examples:** The Participant component for a Subject of Care **SHALL** include an Entity Identifier data component in order to hold the IHI.
Optional	Indicates that the data component is not considered a mandatory component of information and **MAY** be populated. **Usage/Examples:** This is only needed when a DCM incorrectly asserts that a data component is Essential. It will be used with a note stating that the DCM needs revision.
Prohibited	Indicates that the data component is considered a forbidden component of information and **SHALL NOT** be populated. **Usage/Examples:** Within a Participation data group depicting a Subject of Care, the Participation Healthcare Role **SHALL NOT** be completed.

Conditional	Indicates that a data component is considered Essential only on satisfaction of a given condition. Individual data components specify the obligation of the data component when the condition is not met. When a condition is met, the data component is considered to be essential and **SHALL** be populated. When a condition is not met, the data component may be considered as Prohibited, or the data component may be considered Optional. **Usage/Examples:** Within a Pathology Result Report, the *Specimen Detail* data group is Essential if the requested test is to be performed on a specimen, otherwise it **SHALL NOT** be populated.

Table 5: Obligations Legend

Where Essential child data components are contained within Optional parent data components, the child data components only need to be populated when the parent is populated.

B.4 Information Model Specification Parts Legends

This section illustrates the format and parts used to define each Section, Data Group and Data Element within NEHTA's information model specifications and identifies when each part is applicable.

Data Hierarchy

The top-level component contains a data hierarchy. Each row contains information about a single data component. The entries are nested to represent inclusion of one component in another. Each entry contains three occupied cells. One contains an icon to indicate its data type. One contains the label and description of the component (if the label is different from the name, the name is displayed in brackets after the label). One contains the multiplicity range for the data component.

In a SCS a component may be prohibited, that is it occurs in the referenced DCM but it **SHALL** not be included in documents created according to the SCS. This is represented by a multiplicity range of 0..0, the text of the entry is also in a ~~strike-through~~ font and it has a grey background.

Chapter Name

Each section, data group, data element, value domain or choice has its own eponymous chapter. The chapter name is used in all data hierarchies.

Identification Section Legend

The following table illustrates the layout of the Identification section and describes the various parts of the section.

Label	A suggested display name for the component. (Source NEHTA.)

Metadata Type	The metadata type of the component, e.g. section, data group or data element. (Source NEHTA.)
Identifier	A NEHTA assigned internal identifier of the concept represented by the component. (Source NEHTA.)
OID	An object identifier that uniquely identifies the concept represented by the data component. (Source NEHTA.)
External Identifier	An identifier of the concept represented by the data component which is assigned by an organisation other than NEHTA. (Source NEHTA.)

Table 6: Identification Section Legend

Definition Section Legend

The following table illustrates the layout of the Definition section and describes the various parts of the section.

Definition	The meaning, description and/or explanation of the data component. (Source NEHTA.) For data groups used in a particular context the definition **MAY** be a refinement of the generic data group definition.
Definition Source	The authoritative source for the Definition statement.
Synonymous Names	A list of any names the data component **MAY** also be known as. (Source NEHTA.) Implementers **MAY** prefer to use synonymous names to refer to the component in specific contexts.
Scope	Situations in which the data component may be used, i.e. the extent and capacity within which this data component may be used, including the circumstances under which the collection of specified data are required or recommended. For example, Medication Instruction (data group) has a scope which includes all prescribable therapeutic goods, both medicines and non-medicines. This attribute is not relevant to data elements or value domains. (Source NEHTA.)
Scope Source	The authoritative source for the Scope statement.
Context	The environment in which the data component is meaningful, i.e. the circumstance, purpose and perspective under which this data component is defined or used. For example, Street Name has a context of Address. (Source NEHTA.)
Assumptions	Suppositions and notions used in defining the data component. (Source NEHTA.)
Assumptions Source	The authoritative source for the Assumptions statement.
Notes	Informative text that further describes the data component, or assists in the understanding of how the data component can be used. (Source NEHTA.)
Notes Source	The authoritative source for the Notes statement.
Data Type	The data type of the data element, e.g. DateTime or Text. (Source NEHTA.)

	The Data type is applicable only to data elements. The valid data types are specified in the Data Types Legend.
Value Domain	The name and identifier of the terminologies, code sets and classifications to define the data element value range, or a statement describing what values to use in the absence of a defined value domain for the related data element. In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the HL7 code set registration procedure with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated. (Source NEHTA.) The Value Domain is applicable only to CodedText and CodeableText data elements.

Table 7: Definition Section Legend

Value Domain Section Legend

The following table illustrates the layout of the Value Domain section and describes the various parts of the section.

Source	The name of the terminology or vocabulary from which the value domain's permissible values are sourced, e.g. SNOMED CT-AU, LOINC.
Version Number	Version number of the value domain source.
Permissible Values	List of permissible values in the value domain.

Table 8: Value Domain Section Legend

Usage Section Legend

The following table illustrates the layout of the Usage section and describes the various parts of the section.

Examples	One or more demonstrations of the data that is catered for by the data element. (Source NEHTA.) Where a data element has an associated value domain examples representative of that domain are used where possible. Where the value domain is yet to be determined an indicative example is provided. Implementation guides **MAY** contain specific examples for how data elements **SHALL** be populated and how they relate to each other. The Value Domain is applicable only to CodedText and CodeableText data elements.
Conditions of Use	Prerequisites, provisos and/or restrictions for use of the component. (Source NEHTA.)

Conditions of Use Source	The authoritative source for the Conditions of Use statement.
Misuse	Incorrect, inappropriate and/or wrong uses of the component. (Source NEHTA.)
Default Value	A common denomination, or at least a usable denomination, from the Value Domain where available and/or applicable, typically assigned at the creation of an instance of the component. (Source NEHTA.)

Table 9: Usage Section Legend

Relationships Section Legend

The Relationships section specifies the cardinality and conditionality between parent and child data components.

The following table illustrates the layout of the Children relationships table.

Data Type	Name	Occurrences	Condition
Icon illustrating the Metadata type or Data type	Component Name	The maximum and minimum number of instances of this child component that **SHALL** occur.	The conditions that **SHALL** be met to include this child data element. Only applicable for elements with a Conditional obligation.

Table 10: Children Legend

The following table illustrates the layout of the Parent relationships table. Note that the relationships described by this table are from the parent to the child component.

Data Type	Name	Occurrences	Condition
Icon illustrating the Metadata or Data type	Component Name	The maximum and minimum number of instances of the component described on this page that **SHALL** occur.	The conditions that **SHALL** be met to include the data element. Only applicable for elements with a Conditional obligation.

Table 11: Parent Legend

Appendix C. Mappings from Requirements

This appendix lists data elements from the NEHTA Information Requirements - Event Summary [NEHT2011w] document and matches them to their associated data elements in this Structured Content Specification (SCS) augmented with NEHTA Participation Data Specification [NEHT2011v].

Some cells in the mapping table are empty. This is used to indicate that the cell has the same value as the cell immediately above it.

Requirement Section	Data Item	SCS Data Element
Individual	Component	SUBJECT OF CARE
	Person Name	SUBJECT OF CARE.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.PERSON NAME
	Person Identifier	SUBJECT OF CARE.PARTICIPANT.Entity Identifier
	Date of Birth	SUBJECT OF CARE.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.DEMOGRAPHIC DATA.DATE OF BIRTH DETAIL.Date of birth
	Date of Birth Estimated?	SUBJECT OF CARE.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.DEMOGRAPHIC DATA.DATE OF BIRTH DETAIL.DATE OF BIRTH ACCURACY INDICATOR
	Sex	SUBJECT OF CARE.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.DEMOGRAPHIC DATA.Sex
	Address	SUBJECT OF CARE.PARTICIPANT.Address
	Communication Details	SUBJECT OF CARE.PARTICIPANT.ELECTRONIC COMMUNICATION DETAIL
	Indigenous Status	SUBJECT OF CARE.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.DEMOGRAPHIC DATA.Indigenous Status
Event Details	Component	Event Details (CLINICAL SYNOPSIS)
	Reason for Visit	Event Details.Clinical Synopsis Description
	Event Date	Encounter Period
Event Summary Author	Component	DOCUMENT AUTHOR
	Person Name	DOCUMENT AUTHOR.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.PERSON NAME
	Person Identifier	DOCUMENT AUTHOR.PARTICIPANT.Entity Identifier
	Healthcare Role	DOCUMENT AUTHOR.Role
	Organisation Name	DOCUMENT AUTHOR.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.EMPLOYMENT DETAIL.EMPLOYER ORGANISATION.PERSON OR ORGANISATION OR DEVICE.ORGANISATION.Organisation Name

Requirement Section	Data Item	SCS Data Element
	Organisation Identifier	DOCUMENT AUTHOR.PARTICIPANT.PERSON OR ORGANISATION OR DEVICE.PERSON.EMPLOYMENT DETAIL.EMPLOYER ORGANISATION.Entity Identifier
	Address	DOCUMENT AUTHOR.PARTICIPANT.ADDRESS
	Communication Details	DOCUMENT AUTHOR.PARTICIPANT.ELECTRONIC COMMUNICATION DETAIL
Newly Identified Allergies and Adverse Reactions	Component	Newly Identified Adverse Reaction (ADVERSE REACTION)
	Agent Description	Newly Identified Adverse Reaction.Substance/Agent
	Reaction Description	Newly Identified Adverse Reaction.REACTION EVENT.Manifestation
Medicines	Component	Medication (MEDICATION INSTRUCTION)
	Item Description	Medication.Medicine (Therapeutic Good Identification)
	Dose Instructions	Medication.Directions
	Status	Medication.Change Type
		Medication.Change or Recommendation? (Change Status)
		Medication.Change Description
	Reason for Medicine	Medication.Clinical Indication
	Additional Comments	Medication.Comment (Medication Instruction Comment)
	Reason for Change	Medication.Change Reason (Change or Recommendation Reason)
Diagnoses / Interventions	Component	Diagnoses/Interventions (MEDICAL HISTORY)
	Diagnosis and Intervention Description	Diagnoses/Interventions.PROBLEM/DIAGNOSIS.Problem/Diagnosis (Problem/Diagnosis Identification)
		Diagnoses/Interventions.Procedure.Procedure Name
		Diagnoses/Interventions.MEDICAL HISTORY ITEM.Medical History Item Description
	Diagnosis and Intervention Comments	Diagnoses/Interventions.PROBLEM/DIAGNOSIS.Comment (Problem/Diagnosis Comment)
		Diagnoses/Interventions.Procedure.Comment (Procedure Comment)
		Diagnoses/Interventions.MEDICAL HISTORY ITEM.Medical History Item Comment
Immunisations	Component	Administered Immunisation (MEDICATION ACTION)

Requirement Section	Data Item	SCS Data Element
	Vaccine Name	Administered Immunisation.Medicine (Therapeutic Good Identification)
Diagnostic Investigations	Component	DIAGNOSTIC INVESTIGATIONS
	Investigation Type	Derived from type of data group = PATHOLOGY TEST RESULT or type of data group = IMAGING EXAMINATION RESULT or value of Requested Service.Requested Service Description
	Investigation Name	Derived from type of data group = PATHOLOGY TEST RESULT or type of data group = IMAGING EXAMINATION RESULT or value of Requested Service.Requested Service Description
	Result Status	DIAGNOSTIC INVESTIGATIONS.PATHOLOGY TEST RESULT.Overall Test Result Status (Overall Pathology Test Result Status)
		DIAGNOSTIC INVESTIGATIONS.IMAGING EXAMINATION RESULT.Overall Result Status (Imaging Examination Result Status)
		DIAGNOSTIC INVESTIGATIONS.Requested Service.Service Booking Status
	Data	DIAGNOSTIC INVESTIGATIONS.PATHOLOGY TEST RESULT.Test Result Representation *Note that a URL can be put into this data element.*
Document Control	Component	*This is described in the CDA Implementation Guide*
	Document Status	*This is described in the CDA Implementation Guide*
	DateTime Attested	*This is described in the CDA Implementation Guide*
Technical Document Control Requirements	Document Instance Identifier	*This is described in the CDA Implementation Guide*
	Document Set Identifier	*This is described in the CDA Implementation Guide*
	Version Number	*This is described in the CDA Implementation Guide*
	Document Originating System Identifier	*This is described in the CDA Implementation Guide*
	Business Document Type	*This is described in the CDA Implementation Guide*
	Business Document Type Version Number	*This is described in the CDA Implementation Guide*
	Language	*This is described in the CDA Implementation Guide*

Requirement Section	Data Item	SCS Data Element
	Structured/ Unstructured Clinical Document Flag	*This is described in the CDA Implementation Guide*

Appendix D. Log of Changes

This appendix details the changes since version 1.1.

Issue ID	Title	Requested Change/Feedback	Location/Change Made
CIDS-27	Patient, subject of care, person can be used in the same sentence	Pick one of the terms 'Patient' and 'Subject of Care' and use it consistently.	NEHTA's standard term 'Subject of Care' is now used in all cases.
SCS-463	Clinical Manifestation Values	Change the name of the Clinical Manifestation Values Reference Set value domain to be consistent with other Clinical Information Structured Content Specifications.	Name changed to Clinical Manifestation Values.
CIDS-80	Document Author constraints	Make the Document Author constraints consistent across all Clinical Information specifications (where appropriate).	Added prohibition of the LOCATION OF PARTICIPATION data group and specification of value domain for Role.

Index

E

F

H

I

L

M

N

O

P

R

S

T

V

W