nehta

# Shared Health Summary CDA® Implementation Guide Version 1.4

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# Document Information

## Key information

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## Product version history

| Product version | Date | Release comments |
|---|---|---|
| 1.3 | 7 Mar 2012 | Initial public release. |
| 1.4 | 10 Apr 2015 | This version implements changes authorised in September 2014 (by CCB-0345). |

## Related documents

| Name | Version/Release Date |
|---|---|
| *Shared Health Summary Structured Content Specification* | Version 1.2, Issued 10 April 2015 |
| *Shared Health Summary Information Requirements* | Version 1.1, Issued 10 April 2015 |
| *Participation Data Specification* | Version 3.2, Issued 20 July 2011 |
| *CDA Rendering Specification* | Version 1.0, Issued 07 March 2012 |

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# Acknowledgements

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# List of Examples

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# 1 Introduction

## 1.1 Document Purpose and Scope

This document provides a guide to implementing the logical model detailed by NEHTA's Shared Health Summary (SHS) Structured Content Specification (SCS) as an HL7® Clinical Document Architecture Release 2 (CDA®) XML document. This implementation guide is based on Version 1.2 of the SHS SCS [NEHT2015d]. The primary aim of the implementation guide is to take implementers step by step through mapping each data component of the SHS SCS to a corresponding CDA® attribute or element.

This implementation guide contains descriptions of both constraints on the CDA® and, where necessary, custom extensions to the CDA®, for the purposes of fulfilling the requirements for Australian implementations of SHS. The resulting CDA® document can be used for the electronic exchange of SHS information between healthcare providers.

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

This release is intended to inform, and seek feedback from, prospective software system designers and their clinical consultants.

The National Clinical Terminology and Information Service (NCTIS) values your questions, comments and suggestions about this document. Please direct your questions or feedback to <help@nehta.gov.au>.

## 1.2 Shared Health Summary Definition

A Shared Health Summary is defined in the SHS SCS [NEHT2015d] as:

> A clinical document written by the nominated provider, which contains key pieces of information about an individual's health status and is useful to a wide range of providers in assessing individuals and delivering care.

## 1.3 HL7® Clinical Document Architecture

The CDA® is a document markup standard that specifies the structure and semantics of clinical documents for the purpose of supporting interoperable exchange and use at human and system levels.

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

Some of the advantages of CDA® are:

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

- terminologies such as SNOMED CT®.[1]

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

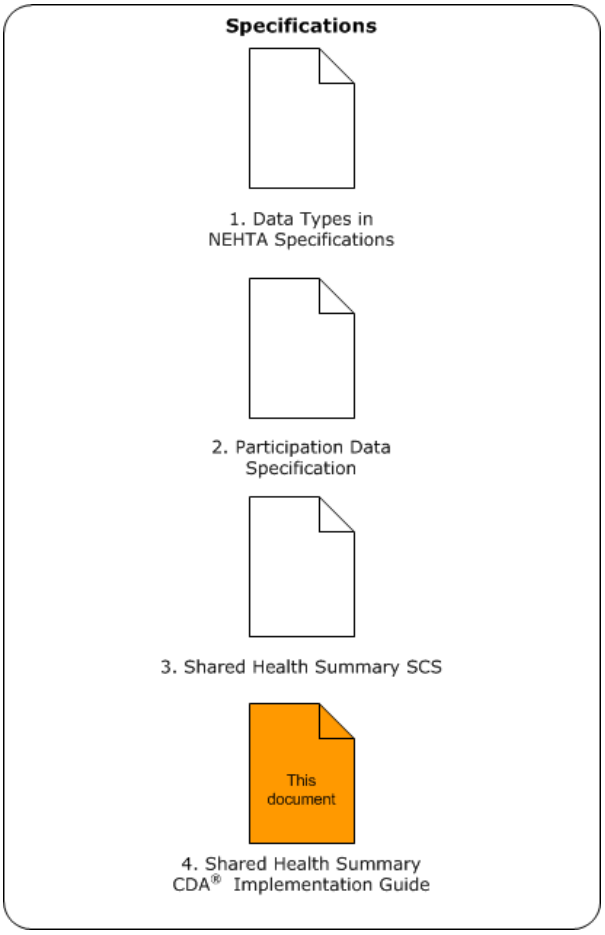
# 1.4 Intended Audience

This document is 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.

This document and related artefacts are technical in nature and the audience is expected to be familiar with the language of health data specifications and to have some familiarity with health information standards and specifications, such as CDA® and Standards Australia IT-014 documents. Definitions and examples are provided to clarify relevant terminology usage and intent.

# 1.5 Document Map

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




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

1. *Data Types in NEHTA Specifications: A Profile of the ISO 21090 Specification [NEHT2010c]* is a detailed description of the data types used within the structured content specification.

2. *Participation Data Specification [NEHT2011v]* contains the full specification which forms the basis of all participations contained in NEHTA structured content specifications.

3. *Shared Health Summary Structured Content Specification [NEHT2015d]* is a clinical content specification describing the logical data structures, data components, and value domains which constitute a Shared Health Summary.

# 1.6 Acronyms

| | |
|---|---|
| CDA® | Clinical Document Architecture |
| HL7® | Health Level Seven |
| OID | Object Identifier |
| RIM | Reference Information Model |
| SCS | Structured Content Specification |
| SHS | Shared Health Summary |
| UUID | Universally Unique Identifier |
| XHTML | Extensible Hypertext Markup Language |
| XML | Extensible Markup Language |
| XSD | XML Schema Definition |
| XSL | Extensible Stylesheet Language |

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

# 1.7 Keywords

Where used in this document, the keywords **SHALL**, **SHOULD**, **MAY**, **SHALL NOT** and **SHOULD NOT** are to be interpreted as described in *RFC2119 - Key words for use in RFCs to Indicate Requirement Levels [RFC2119]*.

### Keywords used in this document

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

| Keyword | Interpretation |
|---|---|
| **SHOULD NOT** | This phrase, or the phrase **NOT RECOMMENDED** means that there may exist valid reasons in particular circumstances when the particular behaviour is acceptable or even useful, but the full implications should be understood and the case carefully weighed before implementing any behaviour described with this label. |

# 1.8 Conformance

This document describes how the SHS SCS is implemented as a CDA® document. Conformance claims are not made against this implementation guide directly; rather, they are made against additional conformance profiles documented elsewhere. Any document that claims conformance to any derived conformance profile **SHALL** meet these base requirements:

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

  NS = In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the HL7® code set registration procedure[2] with an appropriate object identifier (OID), and **SHALL** be publicly available.

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

- It **SHALL** be valid against the additional conformance requirements that are established in this document (i.e. any normative use of the word 'shall' identified by the term presented in uppercase and bold typeface).
- The narrative **SHALL** conform to the requirements described in this implementation guide.
- The document **SHALL** conform to the requirements specified in the CDA Rendering Specification [NEHT2012s].
- The data as contained in the data types **SHALL** conform to the additional data type specification [NEHT2010c].
- Any additional content included in the CDA® document that is not described by this implementation guide **SHALL NOT** qualify or negate content described by this implementation guide and it **SHALL** be clinically safe for receivers of the document to ignore the non-narrative additions when interpreting the existing content.

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

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

Conformance profiles of this document **MAY** make additional rules that override this document in regard to:

- Allowing the use of alternative value sets in place of the value sets specified in this document.
- Allowing the use of alternative identifiers in place of the Healthcare Identifiers Service identifiers.
- Making required data elements and section divisions optional.

# 1.9 Known Issues

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

| Reference | Description |
|---|---|
| Throughout document: XML Examples | While every effort has been taken to ensure that the examples are consistent with the normative mappings in this message specification, care needs to be taken when copying XML examples for implementation and validation.<br><br>Where there are conflicts with the written message specification or schema and the xml examples, the specification or schema takes precedence. |
| Throughout document: R-MIMs | While every effort has been taken to ensure that the R-MIM diagrams are consistent with the normative mappings in this message specification, there may be a few discrepancies between R-MIM diagrams and CDA® mapping tables. The CDA® mapping takes precedence if there are discrepancies. |
| Throughout document: Participation types | The participation types in the OID register are not exhaustive, hence the absence of a participation type is not an error. |
| Throughout document | Australian vs American spelling - in cases where definitions have been taken from HL7® documentation, the American spelling has been preserved, e.g. organization rather than organisation. |
| Document Recipients | Document Recipients were not specified in the Structured Content Specification but most likely need to be added in the CDA® Header section. |
| AS 5017-2006: Health Care Client Identifier Geographic Area | The Health Care Client Identifier Geographic Area vocabulary table lists displayName, code, codeSystemName and codeSystem, while only the displayName is used in the mapping. Verification of using only the displayName needs to be performed. |

| Reference | Description |
|---|---|
| 6.1.1 DOCUMENT AUTHOR :: Participation Period | The constraint requiring the participation period of the *DOCUMENT AUTHOR* to hold the same value as *Date Time Attested* is not universally applicable. The document author and legal authenticator are typically expected to be different participants, and would therefore have different participation periods.<br><br>The SCS notes that many other specifications do not include Date Time Attested and that the intent of this logical data element requires clarification.<br><br>It is expected that this constraint will be removed in later versions of this specification. |
| 7.1.1.1 EXCLUSION STATEMENT - ADVERSE REACTIONS | Only the *Global Statement* logical data element is mapped. The other logical model data elements are deliberately not mapped; representing these elements in would effect a normative change to current implementation which is beyond the scope of the release of this document.<br><br>The exclusion statement logical models are the subject of ongoing development and review and are expected to be revised. |
| 7.1.1.2 ADVERSE REACTION :: Substance/Agent | The value of typeCode is fixed to “CAGNT” when not all relationships or associations between the agent and the reaction can be deemed to be “causative” in nature. An additional appropriate typeCode might be “EXPAGNT” (exposure agent). |
| 7.1.1.2 ADVERSE REACTION :: Reaction Type and REACTION EVENT | The current mapping of *REACTION EVENT* is not aligned with the logical model, which, as a consequence, impacts the mapping choices for *Reaction Type*. *REACTION EVENT* should be mapped to an Act or an Organizer with *Reaction Type* as the code. |
| 7.1.2.1 EXCLUSION STATEMENT - MEDICATIONS | Only the *Global Statement* logical data element is mapped. The other logical model data elements are deliberately not mapped; representing these elements in would effect a normative change to current implementation which is beyond the scope of the release of this document.<br><br>The exclusion statement logical models are the subject of ongoing development and review and are expected to be revised. |
| 7.1.2.2 Known Medication (MEDICATION INSTRUCTION) :: Medication Instruction Comment | The value for displayName of @code=”103.16044” in this version of the specification is fixed as “Additional Comments”. The correct value is “Medication Instruction Comment”. Correcting this value is beyond the scope of release of this document. |

| Reference | Description |
|---|---|
| 7.1.3.1 PROBLEM/DIAGNOSIS :: Date of Resolution/Remission | The mappings for *Date of Resolution/Remission* do not link back the *Date of Onset*, however the *Date of Resolution/Remission* is not necessarily the end of the problem (or diagnosis) described.<br><br>The mappings depend on how an instance of the *Problem/Diagnosis* DCM is defined. If it is defined as an episode of a problem then using effectiveTime.high for *Date of Resolution/Remission* (thereby linking it to *Date of Onset*) would be fine because then a recurrence of the same problem would be a separate instance of *Problem/Diagnosis*. If, however, it is defined as covering the full duration of a problem in a person's life, then several remissions and relapses may occur and effectiveTime.high cannot be used as the *Date of Resolution/Remission*.<br><br>It is intended that the *Problem/Diagnosis* DCM will be modified to represent a single episode of a problem or diagnosis and, when it is, the mappings for *Date of Resolution/Remission* will change. |
| 7.1.3.2 EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES | Only the *Global Statement* logical data element is mapped. The other logical model data elements are deliberately not mapped; representing these elements in would effect a normative change to current implementation which is beyond the scope of the release of this document.<br><br>The exclusion statement logical models are the subject of on-going development and review and are expected to be revised. |
| 7.1.3.4 EXCLUSION STATEMENT - PROCEDURES | Only the *Global Statement* logical data element is mapped. The other logical model data elements are deliberately not mapped; representing these elements in would effect a normative change to current implementation which is beyond the scope of the release of this document.<br><br>The exclusion statement logical models are the subject of on-going development and review and are expected to be revised. |
| 7.1.4.2 Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) | Only the *Global Statement* logical data element is mapped. The other logical model data elements are deliberately not mapped; representing these elements in would effect a normative change to current implementation which is beyond the scope of the release of this document.<br><br>The exclusion statement logical models are the subject of on-going development and review and are expected to be revised. |
| 8.5 Person Name :: Preferred Name Indicator code | The "PRF" code for "preferred name" has been approved by the HL7® Patient Administration Workgroup to be added to Table 0200 Name Type. The updated table will be published in HL7® v2.8.2 after ballot in November 2014. |
| 10 Vocabularies and Code Sets: AS 4846-2006 and AS 5017-2006 superseded | AS 4846-2014 *Person and provider identification in healthcare* has been published and supersedes both AS 4846-2006 *Healthcare provider identification* and AS 5017-2006 *Healthcare client identification*. |

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# 2 Guide for Use

This document describes how to properly implement the SHS SCS [NEHT2015d] as a conformant HL7® CDA® XML document. The SHS specification is contained in two publications:

1) A logical specification, which, in conjunction with its related documents (see Document Map), describes the Shared Health Summary in a form that is consistent with other NEHTA specifications. It has the potential to be implemented in multiple different exchange formats as is most suitable for a particular context. It describes the data content of a Shared Health Summary as a hierarchy of data components and provides documentation concerning their use and meaning.

2) An implementation guide (this document), which specifies how the data described in the SCS is properly represented in a CDA® document.

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

For further information regarding NEHTA structured content specifications, see the links in Document Map.

## 2.1 Clinical Document Architecture Release 2

A CDA® document is an XML document built following the rules described in the CDA® specification, which conforms to the HL7® CDA® Schema provided by HL7®. The CDA® document is based on the semantics provided by the *HL7 V3 RIM, Data types and Vocabulary [HL7V3DT]*.

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

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

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

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

It is a conformance requirement that the rendered narrative **SHALL** be able to stand alone as a source of authenticated information for consuming parties. Content from the CDA® body **SHALL NOT** be omitted from the narrative.

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

The following references are recommended to gain a better understanding of CDA®:

- *HL7 Clinical Document Architecture [HL7CDAR2]*
- *HL7 V3 RIM, Data types and Vocabulary [HL7V3DT]*
- *CDA Examples [RING2009]*
- *CDA Validation Tools: infoway_release_2_2X_18.zip [INFO2009]*

# 2.2 Mapping Interpretation

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

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

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

An example of a mapping section of this implementation guide is illustrated below.

## x.x ITEM NAME

## Identification (normative)

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

## Relationships (normative)

**Children**

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

### Parent

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

# CDA® R-MIM Representation

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

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

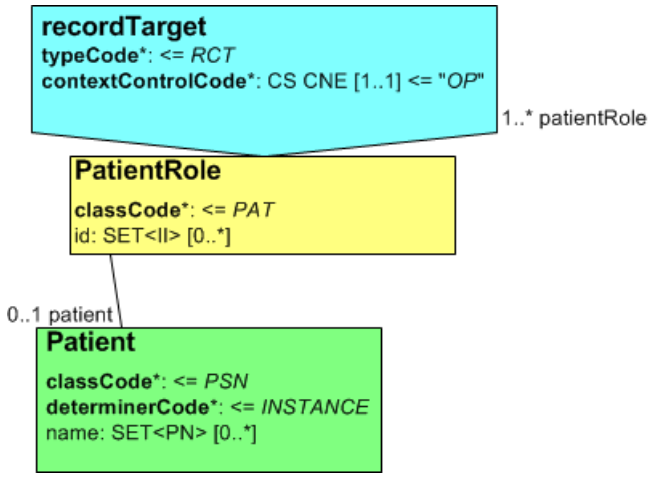


**Figure 2.1. Example - Header Part**

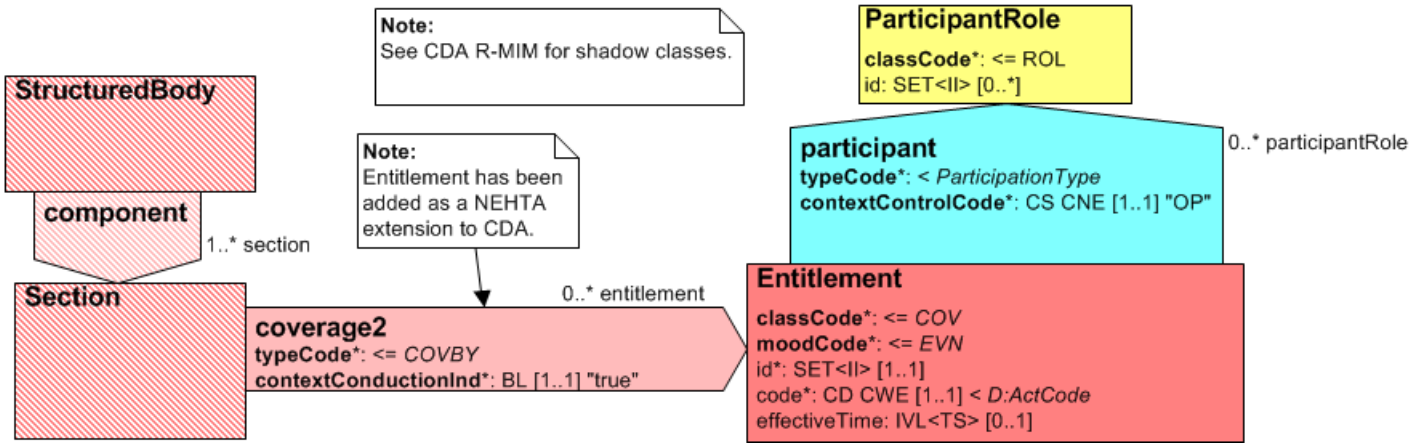


**Figure 2.2. Example - Body Part**

# CDA® Mapping (normative)

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

**How to interpret the following example mapping:**

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

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

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

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

1) ClinicalDocument/recordTarget/patientRole

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

See comments in the example below.

### Example 2.1. Mapping Interpretation

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

      …

   <!-- Begin Subject of Care - Header Part -->
   <recordTarget>
```

```
      <!-- 1 Corresponds to:
            '//recordTarget/patientRole'
         in the mapping. -->
      <patientRole>
         <!-- 2 Corresponds to:
                  '//recordTarget/patientRole/id'
               in the mapping -->
         <id root="04A103C4-7924-11DF-A383-FC69DFD72085"/>

         …

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

            …

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

…

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

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

               …

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

```
                        '//ext:coverage2/ext:entitlement/ext:effectiveTime'
                     in the mapping -->
                  <ext:effectiveTime>
                     <low value="200701010101+1000"/>
                     <high value="202701010101+1000"/>
                  </ext:effectiveTime>
                  <!-- 9 Corresponds to:
                        '//ext:coverage2/ext:entitlement/ext:participant/@typeCode="BEN"'
                     in the mapping -->
                  <ext:participant typeCode="BEN">
                     <!-- 10 Corresponds to:
                           '//ext:coverage2/ext:entitlement/ext:participant/ext:participantRole/@classCode="PAT"'
                        in the mapping -->
                     <ext:participantRole classCode="PAT">
                        <!-- 11 Corresponds to:
                              '//ext:coverage2/ext:entitlement/ext:participant/ext:participantRole/ext:id'
                           in the mapping -->
                        <!-- Same as recordTarget/patientRole/id -->
                        <ext:id root="04A103C4-7924-11DF-A383-FC69DFD72085"/>
                     </ext:participantRole>
                  </ext:participant>
               </ext:Entitlement>
            </ext:coverage2>
            <!-- End Entitlement -->

            …

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

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

# 2.3 CDA® Extensions

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

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

- Extensions have a namespace other than the standard HL7®v3 namespace.
- The extension cannot alter the intent of the standard CDA® document. For example, an extension cannot be used to indicate that an observation does not apply where the CDA® document requires it.
- HL7® encourages users to get their requirements formalised in a subsequent version of the standard so as to maximise the use of shared semantics.

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

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

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

# 2.4 W3C XML Schema

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

- NEHTA CDA® extensions have been added to the NEHTA CDA® Schema.

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

A Shared Health Summary document that conforms to this specification **SHALL** validate against the NEHTA CDA® Schema that accompanies this specification, and **SHALL** validate against the HL7® CDA® Schema once the extensions have been removed. Note that merely passing schema validation does not ensure conformance. For more information, refer to Conformance.

# 2.5 Schematron

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

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

# 2.6 Implementation Strategies

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

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

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

# 3 Shared Health Summary Data Hierarchy

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

The data hierarchy is a logical representation of the data components of a Shared Health Summary, and is not intended to represent how the data contents are represented in a CDA® document.

## Note

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

| | | | | | |
|---|---|---|---|---|---|
| | SHARED HEALTH SUMMARY | | | | |
| CONTEXT | | | | | |
| | SUBJECT OF CARE | | | | 1..1 |
| | DOCUMENT AUTHOR | | | | 1..1 |
| | Document Instance Identifier | | | | 1..1 |
| | Document Type | | | | 1..1 |
| | DateTime Attested | | | | 1..1 |
| CONTENT | | | | | |
| | ADVERSE REACTIONS | | | | 1..1 |
| | | EXCLUSION STATEMENT - ADVERSE REACTIONS | | | 0..1 |
| | | | Global Statement | | 1..1 |
| | | | Detailed Clinical Model Identifier | | 1..1 |
| | | ADVERSE REACTION | | | 0..* |
| | | | Substance/Agent | | 1..1 |
| | | | REACTION EVENT | | 0..1 |
| | | | | Manifestation | 1..* |
| | | | | Reaction Type | 0..1 |
| | | | Adverse Reaction Instance Identifier | | 1..1 |
| | | | Detailed Clinical Model Identifier | | 1..1 |

| | | | | | |
|---|---|---|---|---|---|
| | | | Adverse Reactions Instance Identifier | | 0..1 |
| | | | Section Type | | 1..1 |
| | | Medications (MEDICATION ORDERS) | | | 1..1 |
| | | | EXCLUSION STATEMENT - MEDICATIONS | | 0..1 |
| | | | | Global Statement | 1..1 |
| | | | | Detailed Clinical Model Identifier | 1..1 |
| | | | Known Medication (MEDICATION INSTRUCTION) | | 0..* |
| | | | | Therapeutic Good Identification | 1..1 |
| | | | | Directions | 1..1 |
| | | | | Clinical Indication | 0..1 |
| | | | | Medication Instruction Comment | 0..1 |
| | | | | Medication Instruction Instance Identifier | 1..1 |
| | | | | Detailed Clinical Model Identifier | 1..1 |
| | | | Medication Orders Instance Identifier | | 0..1 |
| | | | Section Type | | 1..1 |
| | | Past and Current Medical History (MEDICAL HISTORY) | | | 1..1 |
| | | | PROBLEM/DIAGNOSIS | | 0..* |
| | | | | Problem/Diagnosis Identification | 1..1 |
| | | | | Date of Onset | 0..1 |
| | | | | Date of Resolution/Remission | 0..1 |
| | | | | Problem/Diagnosis Comment | 0..1 |
| | | | | Problem/Diagnosis Instance Identifier | 1..1 |
| | | | | Detailed Clinical Model Identifier | 1..1 |
| | | | EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES | | 0..1 |
| | | | | Global Statement | 1..1 |

| | | | | | |
|---|---|---|---|---|---|
| | | | | Detailed Clinical Model Identifier | 1..1 |
| | | | PROCEDURE | | 0..* |
| | | | | Procedure Name | 1..1 |
| | | | | Procedure Comment | 0..1 |
| | | | | Procedure DateTime | 1..1 |
| | | | | Procedure Instance Identifier | 1..1 |
| | | | | Detailed Clinical Model Identifier | 1..1 |
| | | | EXCLUSION STATEMENT - PROCEDURES | | 0..1 |
| | | | | Global Statement | 1..1 |
| | | | | Detailed Clinical Model Identifier | 1..1 |
| | | | UNCATEGORISED MEDICAL HISTORY ITEM | | 0..* |
| | | | | Medical History Item Description | 1..1 |
| | | | | Medical History Item TimeInterval | 0..1 |
| | | | | Medical History Item Comment | 0..1 |
| | | | | Uncategorised Medical History Item Instance Identifier | 1..1 |
| | | | | Detailed Clinical Model Identifier | 1..1 |
| | | | Medical History Instance Identifier | | 0..1 |
| | | | Section Type | | 1..1 |
| | | IMMUNISATIONS | | | 1..1 |
| | | | Administered Immunisation (MEDICATION ACTION) | | 0..* |
| | | | | Therapeutic Good Identification | 1..1 |
| | | | | Vaccine Sequence Number (Sequence Number) | 0..1 |
| | | | | Medication Action DateTime | 1..1 |
| | | | | Medication Action Instance Identifier | 1..1 |
| | | | | Detailed Clinical Model Identifier | 1..1 |

| | | | | | |
|---|---|---|---|---|---|
| | | | Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) | | 0..1 |
| | | | 001011001 | Global Statement | 1..1 |
| | | | | Detailed Clinical Model Identifier | 1..1 |
| | | | Immunisations Instance Identifier | | 0..1 |
| | | | Section Type | | 1..1 |

# 4 Administrative Observations

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

# CDA® R-MIM Representation

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

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

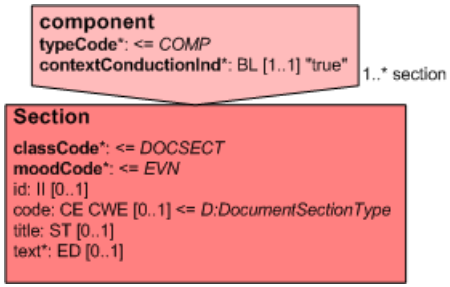


**Figure 4.1. Administrative Observations**

# CDA® Mapping

At most one instance of Administrative Observation section **SHOULD** be present in a CDA® document. The cardinality of this section comes from its linking context data elements (e.g. CDA® context data element(s) mapped to Administrative Observation Section). If any of the linking context data elements are mandatory, then this section **SHALL** be marked as a mandatory section.

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

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

All data elements (with the exception of narrative text) within this section **SHALL** be deemed as CDA® Header data elements for conformance assessment.

The <text> data element is **OPTIONAL** and **SHALL** be treated as a Level 2 CDA® data element.

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 2 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/ | | |
| n/a | n/a | Cardinality comes from linking context data elements | **component/section[admin_obs]** | | |
| | | 0..1 | component/section[admin_obs]/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| | | 1..1 | component/section[admin_obs]/**code** | | |
| | | | component/section[admin_obs]/code/**@code="102.16080"** | | |
| | | | component/section[admin_obs]/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | component/section[admin_obs]/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | component/section[admin_obs]/code/**@displayName="Administrative Observations"** | | |
| | | | component/section[admin_obs]/**title="Administrative Observations"** | | |
| | | 0..1 | component/section[admin_obs]/**text** | | See Appendix A, *CDA® Narratives*. |

## Example 4.1. Administrative Observations XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   …

   <!-- End CDA Header -->

   <!-- Begin CDA Body -->
   …

   <component>
      <structuredBody>
         …

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

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

               …

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

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

</ClinicalDocument>
```

# 5 CDA® Header

This chapter contains CDA®-specific header elements (both **REQUIRED** and **OPTIONAL**) that are not specified in the SHS SCS specification. The CDA® Schema Data Element describes each element.

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

## 5.1 ClinicalDocument

### Identification

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

### Relationships

#### Children

| Name | Occurrence |
|---|---|
| LegalAuthenticator | 1..1 |
| Custodian | 1..1 |

# CDA® R-MIM Representation

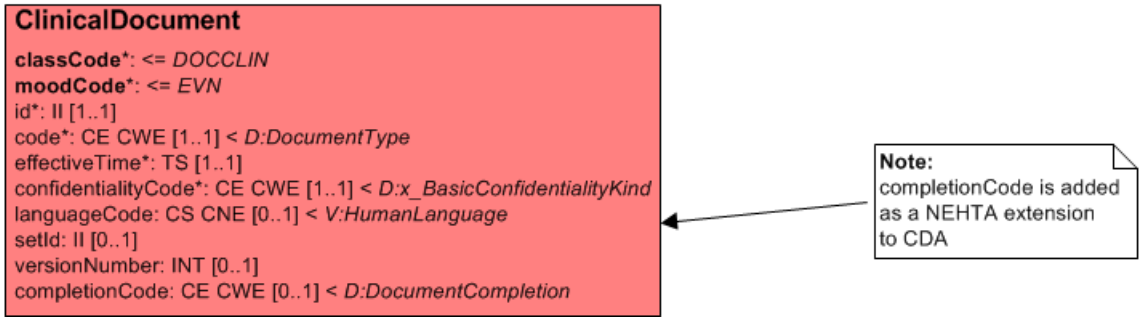


**Figure 5.1. ClinicalDocument**

# CDA® Mapping

| CDA® Schema Data Element | Definition | Card | Vocab | Comments |
|---|---|---|---|---|
| Context: / | | | | |
| **ClinicalDocument** | The ClinicalDocument class is the entry point into the CDA® R-MIM, and corresponds to the <ClinicalDocument> XML element that is the root element of a CDA® document. | 1..1 | | |
| ClinicalDocument/**typeId** | A technology-neutral explicit reference to the CDA® Release 2 specification. | 1..1 | | |
| ClinicalDocument/typeId/**@extension="POCD_HD000040"** | | 1..1 | | The unique identifier for the CDA® Release 2 Hierarchical Description. |
| ClinicalDocument/typeId/**@root="2.16.840.1.113883.1.3"** | | 1..1 | | The OID for HL7® Registered models. |
| ClinicalDocument/**templateId** | | 1..* | | One or more template identifiers that indicate constraints on the CDA® document that this document conforms to. One of the identifiers must be the templateId that identifies this specification (see immediately below). Additional template identifiers may be required by other specifications, such as the CDA® Rendering Specification.<br><br>Systems are not required to recognise any other template identifiers than the one below in order to understand the document as a [type] but these identifiers may influence how the document must be handled. |
| ClinicalDocument/templateId/**@root="1.2.36.1.2001.1001.101.100.1002.120"** | | 1..1 | | The healthcare context-specific name of the published Shared Health Summary CDA® Implementation Guide. |
| ClinicalDocument/templateId/**@extension="1.4"** | | 1..1 | | The identifier of the version that was used to create the document instance. |
| ClinicalDocument/**id** | Represents the unique instance identifier of a clinical document. | 1..1 | | See common pattern: id. |
| ClinicalDocument/**code** | The code specifying the particular kind of document (e.g. History and Physical, Discharge Summary, Progress Note). | 1..1 | | See common pattern: code. |
| ClinicalDocument/code/**@code="60591-5"** | | | | A clinical document written by the nominated provider, which contains key pieces of information about an individual's health status and is useful to a wide range of providers in assessing individuals and delivering care. |
| ClinicalDocument/code/**@codeSystem="2.16.840.1.113883.6.1"** | | | | |
| ClinicalDocument/code/**@codeSystemName** | | | The value **SHOULD** be "LOINC".<br><br>See CodeSystem OIDs. | |
| ClinicalDocument/code/**@displayName="Patient summary"** | | | | |

| CDA® Schema Data Element | Definition | Card | Vocab | Comments |
|---|---|---|---|---|
| ClinicalDocument/**effectiveTime** | Signifies the document creation time, when the document first came into being. Where the CDA® document is a transform from an original document in some other format, the ClinicalDocument.effectiveTime is the time the original document is created. | 1..1 | | See common pattern: time. |
| ClinicalDocument/**confidentialityCode/@nullFlavor="NA"** | Codes that identify how sensitive a piece of information is and/or that indicate how the information may be made available or disclosed. | 1..1 | | |
| ClinicalDocument/**languageCode** | | 0..1 | [RFC3066] – Tags for the Identification of Languages | <Language Code> – <DIALECT><br><br>The <Language Code> **SHALL** be "en". The <DIALECT> **SHOULD** be "AU". |
| ClinicalDocument/**setId** | Represents an identifier that is common across all document revisions. | 0..1 | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | |
| ClinicalDocument/**versionNumber/@value** | An integer value used to version successive replacement documents. | 0..1 | | |
| ClinicalDocument/**ext:completionCode** | The lifecycle status of a document. | 1..1 | NCTIS: Admin Codes - Document Status | See NEHTA CDA® extension: ClinicalDocument.completionCode. |

## Example 5.1. ClinicalDocument Body XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 xmlns:xs="http://www.w3.org/2001/XMLSchema"
 xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
 xsi:schemaLocation="CDA-SS-V1_4.xsd">

 <!--Document header -->
 <typeId extension="POCD_HD000040" root="2.16.840.1.113883.1.3"/>
 <templateId root="1.2.36.1.2001.1001.101.100.1002.120" extension="1.4"/>
 <id root="8BC3406A-B93F-11DE-8A2B-6A1C56D89593"/>

 <!-- Document code system -->
 <code code="60591-5"
  codeSystem="2.16.840.1.113883.6.1"
  codeSystemName="LOINC"
  displayName="Patient Summary"/>
 <effectiveTime value="201211061639+1100"/>
 <confidentialityCode nullFlavor="NA"/>
 <languageCode code="en-AU"/>
 <setId root="fc7fecc0-8255-11e3-baa7-0800200c9a66"/>
 <versionNumber value="1"/>
 <ext:completionCode code="F"
  codeSystem="1.2.36.1.2001.1001.101.104.20104"
  codeSystemName="NCTIS Document Status Values"
  displayName="Final"/>

 <!-- Begin CDA Header -->
 …
 <!-- End CDA Header -->

 <!-- Begin CDA Body -->
 …
 <!-- End CDA Body -->

</ClinicalDocument>
```

# 5.1.1 LegalAuthenticator

## Identification

| | |
|---|---|
| **Name** | LegalAuthenticator |
| **Definition** | Represents a participant who has legally authenticated the document. |

## Relationships

### Parent

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

# CDA® R-MIM Representation

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

The LegalAuthenticator maps to the CDA® Header element legalAuthenticator. The legalAuthenticator participation class represents who has legally authenticated the document. The role is AssignedEntity and is represented by the Person and/or Organization entities.

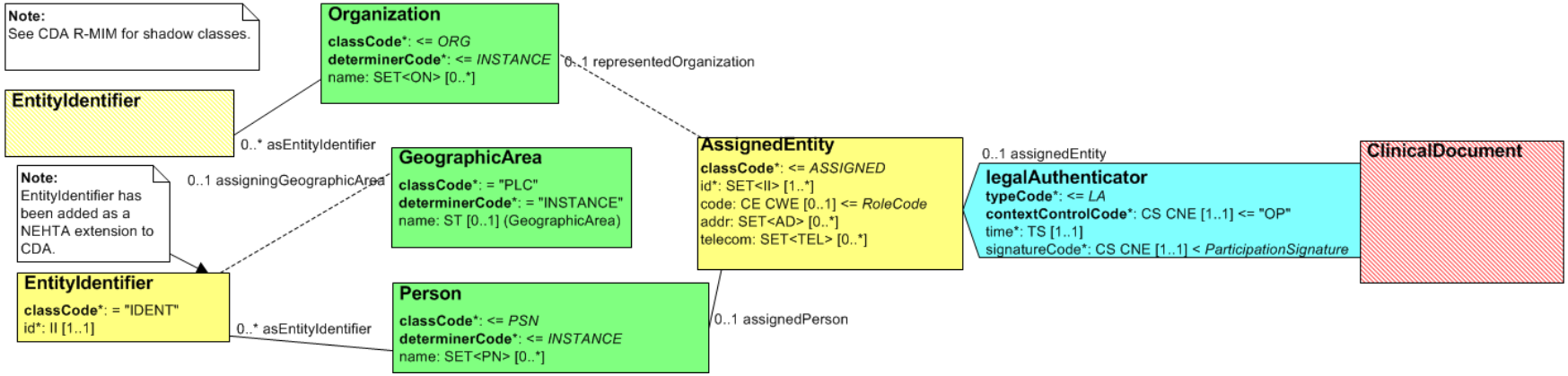


**Figure 5.2. LegalAuthenticator**

# CDA® Mapping

## Note

NS = In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the HL7® code set registration procedure[1] with an appropriate object identifier (OID), and **SHALL** be publicly available.

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

| CDA® Schema Data Element | Definition | Card | Vocab | Comments |
|---|---|---|---|---|
| Context: ClinicalDocument/ | | | | |
| **legalAuthenticator** | Represents a participant who has legally authenticated the document. | 1..1 | | |
| legalAuthenticator/**time/@value** | Indicates the time of authentication. | 1..1 | | The time/@value **SHALL** include both a time and a date. |
| legalAuthenticator/**signatureCode/@code="S"** | Indicates that the signature has been affixed and is on file. | 1..1 | | |
| legalAuthenticator/**assignedEntity** | A legalAuthenticator is a person in the role of an assigned entity (AssignedEntity class). An assigned entity is a person assigned to the role by the scoping organization. The entity playing the role is a person (Person class). The entity scoping the role is an organization (Organization class). | 1..1 | | |
| legalAuthenticator/assignedEntity/**code** | The specific kind of role. | 0..1 | NS | See <code> for available attributes. |
| legalAuthenticator/assignedEntity/**id** | A unique identifier for the player entity in this role. | 1..1 | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| legalAuthenticator/assignedEntity/**assignedPerson** | The entity playing the role (assignedEntity) is a person. | 0..1 | | |
| legalAuthenticator/assignedEntity/assignedPerson/**<Entity Identifier>** | The entity identifier of the person. | 0..* | | See common pattern: Entity Identifier. |
| legalAuthenticator/assignedEntity/**<Address>** | A postal address for the entity (assignedPerson) while in the role (assignedEntity). | 0..* | | See common pattern: Address. |
| legalAuthenticator/assignedEntity/**<Electronic Communication Detail>** | A telecommunication address for the entity (assignedPerson) while in the role (assignedEntity). | 0..* | | See common pattern: Electronic Communication Detail. |
| legalAuthenticator/assignedEntity/assignedPerson/**<Person Name>** | A non-unique textual identifier or moniker for the entity (assignedPerson). | 0..* | | See common pattern: Person Name. |

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

| CDA® Schema Data Element | Definition | Card | Vocab | Comments |
|---|---|---|---|---|
| legalAuthenticator/assignedEntity/**representedOrganization** | The entity scoping the role (assignedEntity). | 0..1 | | |
| legalAuthenticator/assignedEntity/representedOrganization/**<Entity Identifier>** | A unique identifier for the scoping entity (represented organization) in this role (assignedEntity). | 0..* | | See common pattern: Entity Identifier. |
| legalAuthenticator/assignedEntity/representedOrganization/**name** | A non-unique textual identifier or moniker for the entity (representedOrganization). | 0..* | | |

### Example 5.2. LegalAuthenticator XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

 <!-- Begin CDA Header -->
 …

 <!-- Begin legalAuthenticator -->
 <legalAuthenticator>
  <time value="200910201235+1000"/>
  <signatureCode code="S"/>
  <assignedEntity>
   <id root="123F9366-78EC-11DF-861B-EE24DFD72085"/>
   <code code="253111" codeSystem="2.16.840.1.113883.13.62"
    codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
    displayName="General Medical Practitioner"/>

   <!-- Address -->
   <addr use="WP">
    <streetAddressLine>1 Clinician Street</streetAddressLine>
    <city>Nehtaville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568931</additionalLocator>
   </addr>

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

   <assignedPerson>
    <!-- Person Name -->
    <name>
     <prefix>Dr.</prefix>
     <given>General</given>
     <family>Doctor</family>
    </name>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
     <ext:id assigningAuthorityName="HPI-I" root="1.2.36.1.2001.1003.0.8003611566682112"/>
     <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
     </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>
   </assignedPerson>

   <representedOrganization>
    <!-- Organisation Name -->
    <name>Good Health Clinic</name>
```

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

  </assignedEntity>
 </legalAuthenticator>
 <!-- End legalAuthenticator -->
 …

 <!-- End CDA Header -->

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

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

</ClinicalDocument>
```

# 5.1.2 Custodian

## Identification

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

## Relationships

### Parent

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

# CDA® R-MIM Representation

Figure 5.3 Custodian shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Header elements.

The Custodian maps to the CDA® Header element custodian. The custodian participation class represents the organisation that is in charge of maintaining the document. The role is AssignedCustodian and is represented by the CustodianOrganization entity.

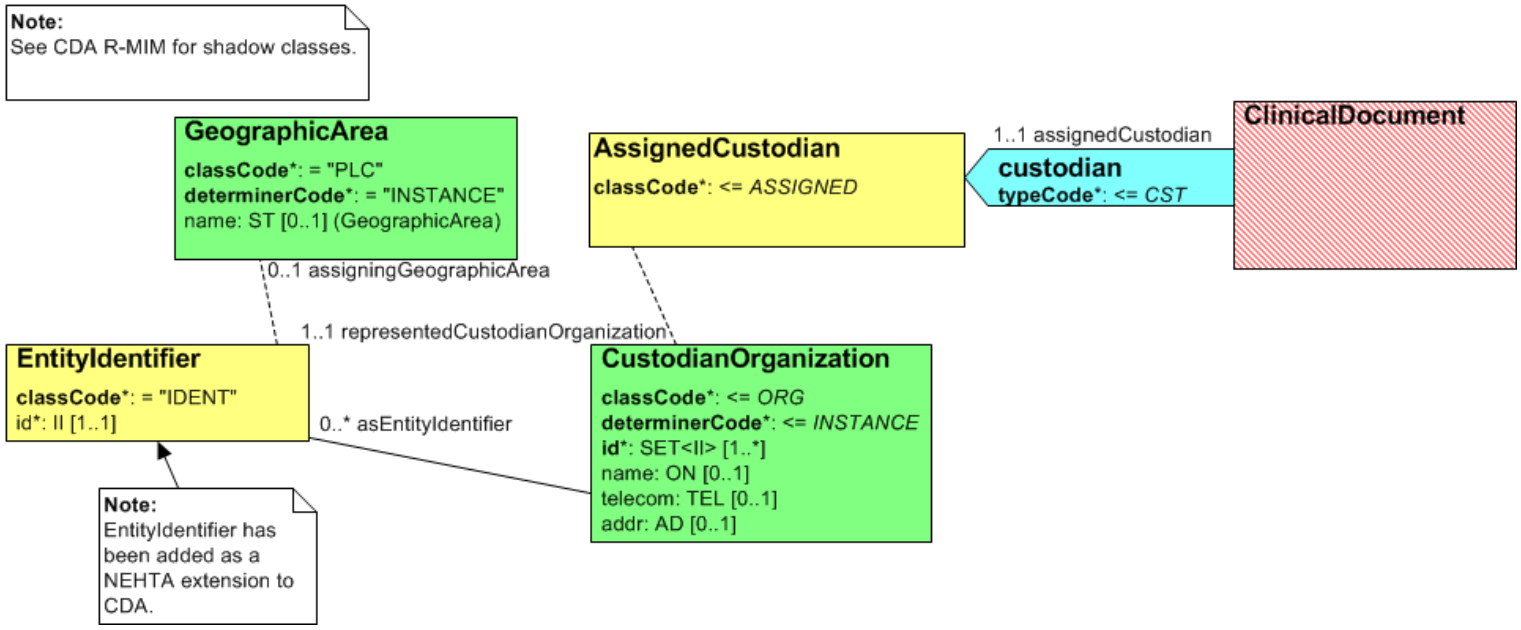


**Figure 5.3. Custodian**

# CDA® Mapping

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

## Example 5.3. Custodian Body XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

 <!-- Begin CDA Header -->
 …

 <!-- Begin Custodian -->
 <custodian>
  <assignedCustodian>
   <representedCustodianOrganization>

    <!-- ID is used for system purposes such as matching -->
    <id root="c9c04faf-d7a8-4802-8c69-980b0ce4d798"/>
    <name>Custodian</name>

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

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

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

   </representedCustodianOrganization>
  </assignedCustodian>
 </custodian>
 <!-- End Custodian -->
 …

 <!-- End CDA Header -->

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

  </structuredBody>
```

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

</ClinicalDocument>
```

# 6 Context Data Specification - CDA® Mapping

## 6.1 SHARED HEALTH SUMMARY

### Identification

| | |
|---|---|
| **Name** | SHARED HEALTH SUMMARY |
| **Metadata Type** | Structured Document |
| **Identifier** | SD-16565 |

### Relationships

**Children**

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

### CDA® R-MIM Representation

Figure 6.1 CDA Header Model for Shared Health Summary Context shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Header elements.

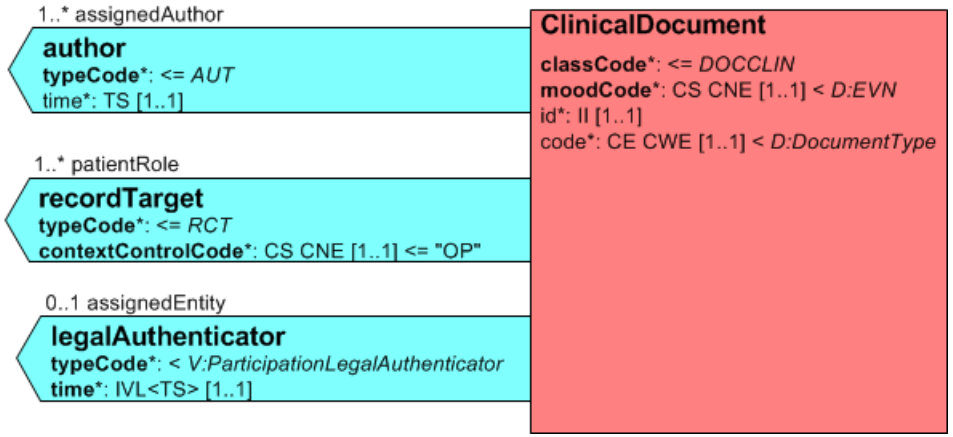


**Figure 6.1. CDA Header Model for Shared Health Summary Context**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Header Data Elements** | | | | | |
| **Shared Health Summary** | A clinical document written by the nominated provider, which contains key pieces of information about an individual's health status and is useful to a wide range of providers in assessing individuals and delivering care. | 1..1 | **ClinicalDocument** | | |
| Shared Health Summary > **SUBJECT OF CARE** | Person who receives healthcare services. | 1..1 | See: SUBJECT OF CARE | | |
| Shared Health Summary > **DOCUMENT AUTHOR** | Composer of the document. | 1..1 | See: DOCUMENT AUTHOR | | |
| Shared Health Summary > **DateTime Attested** | The date and time that the document author or document authoriser or approver confirms that a document is complete and genuine. | 1..1 | ClinicalDocument/**legalAuthenticator/time/@value** | The time/@value **SHALL** include both a time and a date. | See <time> for available attributes. |
| Shared Health Summary > **Document Instance Identifier** | A globally unique identifier for each instance of a Shared Health Summary document. | 1..1 | ClinicalDocument/**id** | | See <id> for available attributes. |
| Shared Health Summary > **Document Type** | Type of document. | 1..1 | ClinicalDocument/**code** | | See <code> for available attributes. |
| | | | ClinicalDocument/code/**@code="60591-5"** | | |
| | | | ClinicalDocument/code/**@codeSystem="2.16.840.1.113883.6.1"** | | |
| | | | ClinicalDocument/code/**@codeSystemName** | The value **SHOULD** be "LOINC".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | ClinicalDocument/code/**@displayName="Patient summary"** | | |

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

### Example 6.1. Shared Health Summary Context XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

 <!-- Document Instance Identifier -->
 <id root="8f281000-498d-11e2-bcfd-0800200c9a66"/>
 <!-- Document Type -->
 <code code="60591-5"
  codeSystem="2.16.840.1.113883.6.1"
  codeSystemName="LOINC"
  displayName="Patient summary"/>
 …

 <!-- Begin CDA Header -->
 <!-- Begin SUBJECT OF CARE -->
 <recordTarget>
  …
 </recordTarget>
 <!-- End SUBJECT OF CARE -->

 <!-- Begin DOCUMENT AUTHOR -->
 <author>
  …
 </author>
 <!-- End DOCUMENT AUTHOR -->

 <!-- Begin LegalAuthenticator -->
 <legalAuthenticator>

  <!-- DateTime Attested -->
  <time value="200910201235+1100"/>

 </legalAuthenticator>
 <!-- End LegalAuthenticator -->
 …

 <!-- End CDA Header -->

 <!-- Begin CDA Body -->
 <component>
  <section>
   …

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

# 6.1.1 DOCUMENT AUTHOR

## Identification

| | |
|---|---|
| **Name** | DOCUMENT AUTHOR |
| **Metadata Type** | Data Group |
| **Identifier** | DG-10296 |

## Relationships

### Parent

| Data Type | Name | Occurrences (child within parent) |
|---|---|---|
|  | SHARED HEALTH SUMMARY | 1..1 |

# CDA® R-MIM Representation

Figure 6.2 DOCUMENT AUTHOR shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Header elements.

The DOCUMENT AUTHOR data group instantiated as PERSON (Healthcare Provider) is related to its context of ClinicalDocument by the author participation class. An author is a person in the role of assignedAuthor (AssignedAuthor class). The entity playing the role is assignedAuthorChoice (Person class). The entity identifier of the participant is mapped to the EntityIdentifier class (NEHTA CDA® extension) and is associated to the assignedAuthorChoice.

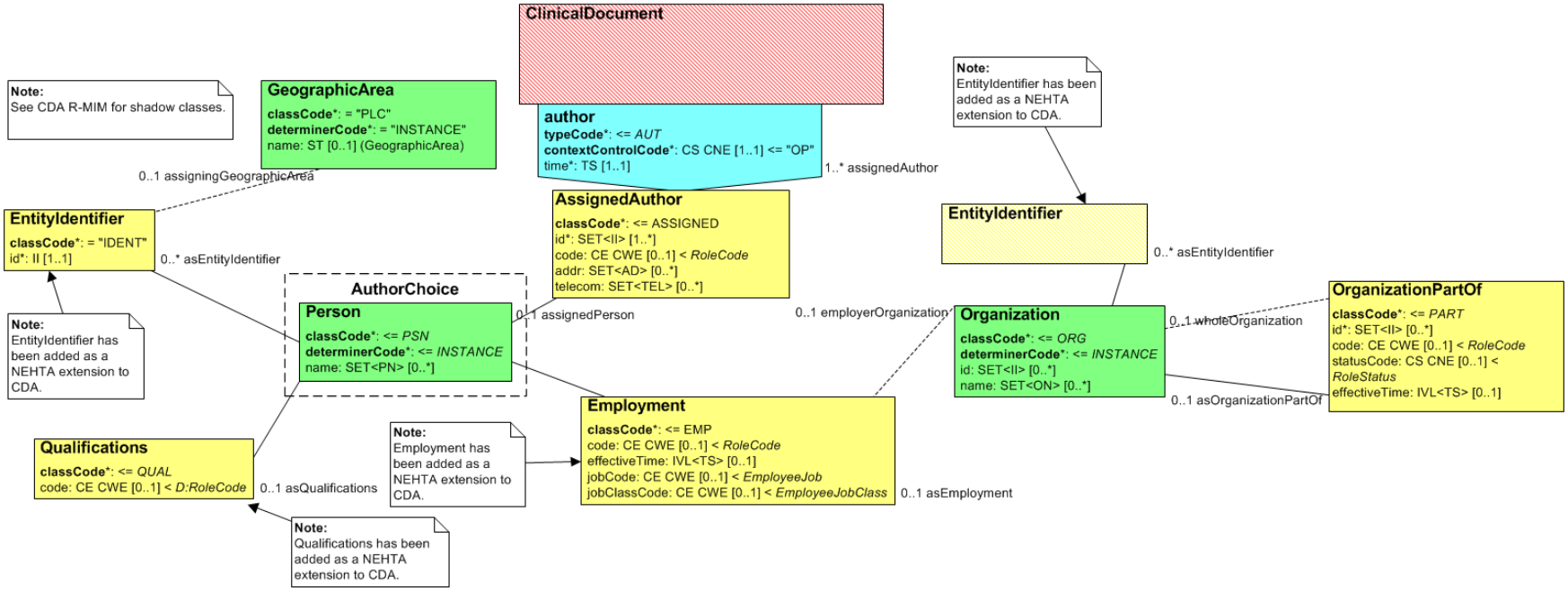


**Figure 6.2. DOCUMENT AUTHOR**

Figure 6.3 DOCUMENT AUTHOR - Entitlement shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

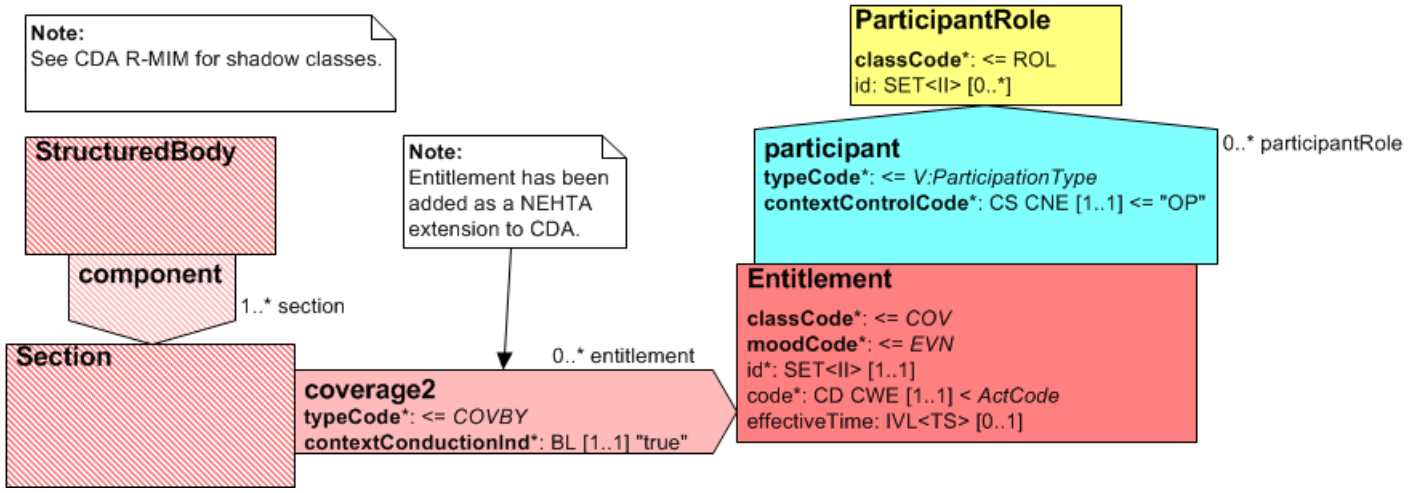


**Figure 6.3. DOCUMENT AUTHOR - Entitlement**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Header Data Elements** | | | Context: ClinicalDocument/ | | |
| **DOCUMENT AUTHOR** | Composer of the document. | 1..1 | **author** | | Document Author **SHALL** be filled with the Healthcare Provider who authored the document. |
| DOCUMENT AUTHOR > **Participation Period** | The time interval during which the participation in the health care event occurred. | 1..1 | author/**time** | This element **SHALL** hold the same value as Shared Health Summary > DateTime Attested (ClinicalDocument/legalAuthenticator/time).<br><br>Although the definition of this element states that it is a time interval, the following applies: "The end of the participation period of a Document Author participation is the time associated with the completion of editing the content of a document.". Thus only the end time need be recorded. | Required CDA® element.<br><br>The author/time element **SHALL** be implemented as either:<br>• a value attribute (populated with the end time of the authorship or encounter, as appropriate); or<br>• a high element AND a low element, both with value attributes and neither with a nullFlavor attribute. |
| DOCUMENT AUTHOR > **Participation Type** | The categorisation of the nature of the participant's involvement in the healthcare event described by this participation. | 1..1 | n/a | Participation Type **SHALL** have an implementation-specific value equivalent to "Document Author". | Not mapped directly; encompassed implicitly in author/typeCode="AUT" (optional, fixed value). |
| DOCUMENT AUTHOR > **Role** | The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective. | 1..1 | author/**assignedAuthor/code** | Role **SHOULD** have a value chosen from *1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 [ABS2009]*.<br><br>However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7® and publicly available **MAY** be used. | See <code> for available attributes. |
| n/a | n/a | 1..1 | author/assignedAuthor/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | Required CDA® element. |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| DOCUMENT AUTHOR > **Participant** | Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction. | 1..1 | author/assignedAuthor/**assignedPerson** | | |
| DOCUMENT AUTHOR > Participant > **Entity Identifier** | A number or code issued for the purpose of identifying a participant within a healthcare context. | 1..* | author/assignedAuthor/assignedPerson/**<Entity Identifier>** | The value of one Entity Identifier **SHALL** be an Australian HPI-I. | See common pattern: Entity Identifier. |
| DOCUMENT AUTHOR > Participant > **Address** | The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity. | 0..* | author/assignedAuthor/**<Address>** | AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.<br><br>Address Purpose (addr/@use) **SHALL** be set to Business (see AS 5017-2006: Health Care Client Identifier Address Purpose). | See common pattern: Address. |
| DOCUMENT AUTHOR > Participant > **Electronic Communication Detail** | The electronic communication details of entities. | 0..* | author/assignedAuthor/**<Electronic Communication Detail>** | Electronic Communication Usage Code (telecom/@use) **SHALL** be set to Workplace (see HL7®: TelecommunicationAddressUse). | See common pattern: Electronic Communication Detail. |
| DOCUMENT AUTHOR > Participant > **Person or Organisation or Device** | Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE. | 1..1 | n/a | PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON. | This logical NEHTA data component has no mapping to CDA®.<br><br>The cardinality of this component propagates to its children. |
| DOCUMENT AUTHOR > Participant > Person or Organisation or Device > **Person** | An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient). | 1..1 | n/a | | Not mapped directly; encompassed implicitly in author/assignedAuthor/assignedPerson. |
| DOCUMENT AUTHOR > Participant > Person or Organisation or Device > Person > **Person Name** | The appellation by which an individual may be identified separately from any other within a social context. | 1..* | author/assignedAuthor/assignedPerson/**<Person Name>** | | See common pattern: Person Name. |
| DOCUMENT AUTHOR > Participant > Person or Organisation or Device > Person > **Employment Detail** | A person's occupation and employer. | 1..1 | author/assignedAuthor/assignedPerson/**<Employment>** | | See common pattern: Employment. |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 3 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/component[admin_obs]/section/ | | |
| DOCUMENT AUTHOR > Participant > **Entitlement** | The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context. | 0..* | **ext:coverage2/@typeCode="COVBY"** | | |
| | | | ext:coverage2/**ext:entitlement** | | |
| | | | ext:coverage2/ext:entitlement/**@classCode="COV"** | | |
| | | | ext:coverage2/ext:entitlement/**@moodCode="EVN"** | | |
| | | | ext:coverage2/ext:entitlement/**ext:participant/@typeCode="HLD"** | | |
| | | | ext:coverage2/ext:entitlement/ext:participant/**ext:participantRole/ @classCode="ASSIGNED"** | | |
| | | | ext:coverage2/ext:entitlement/ext:participant/ext:participantRole/**ext:id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | This **SHALL** hold the same value as author/assignedAuthor/id. |
| DOCUMENT AUTHOR > Participant > Entitlement > **Entitlement Number** | A number or code issued for the purpose of identifying the entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context. | 1..1 | ext:coverage2/ext:entitlement/**ext:id** | | See <id> for available attributes. |
| DOCUMENT AUTHOR > Participant > Entitlement > **Entitlement Type** | The description of the scope of an entitlement. | 1..1 | ext:coverage2/ext:entitlement/**ext:code** | NCTIS: Admin Codes - Entitlement Type | |
| DOCUMENT AUTHOR > Participant > Entitlement > **Entitlement Validity Duration** | The time interval for which an entitlement is valid. | 0..1 | ext:coverage2/ext:entitlement/**ext:effectiveTime** | | See <time> for available attributes. |
| **CDA® Header Data Elements** | | | Context: ClinicalDocument/ | | |
| DOCUMENT AUTHOR > Participant > **Qualifications** | A list of professional certifications, and certificates recognising having passed a course. | 0..1 | author/assignedAuthor/assignedPerson/**ext:asQualifications** | | See NEHTA CDA® extension: Qualifications. |
| | | | author/assignedAuthor/assignedPerson/ext:asQualifications/**@classCode= "QUAL"** | | |
| | | | author/assignedAuthor/assignedPerson/ext:asQualifications/**ext:code/ originalText** | Qualifications is a text field, so the text list is entered in the originalText field of the code element. | |

## Example 6.2. DOCUMENT AUTHOR XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   …

   <!-- Begin DOCUMENT AUTHOR -->
 <author>

  <!-- Must hold same value as DateTime attested (ClinicalDocument.legalAuthenticator.time) -->
  <time value="200910201235+1000"/>

  <assignedAuthor>

   <!-- ID is used for system purposes such as matching -->
   <id root="7FCB0EC4-0CD0-11E0-9DFC-8F50DFD72085"/>

   <!-- Role -->
   <code code="253111" codeSystem="2.16.840.1.113883.13.62"
    codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
    displayName="General Medical Practitioner" />

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

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

   <!-- Participant -->
   <assignedPerson>

    <!-- Person Name -->
    <name>
     <prefix>Dr.</prefix>
     <given>Good</given>
     <family>Doctor</family>
    </name>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
     <ext:id assigningAuthorityName="HPI-I" root="1.2.36.1.2001.1003.0.8003619900015717" />
     <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
```

```
    </ext:assigningGeographicArea>
   </ext:asEntityIdentifier>

   <!-- Employment Details -->
   <ext:asEmployment classCode="EMP">
    <!-- Position In Organisation -->
    <ext:code>
     <originalText>GP</originalText>
    </ext:code>

    <!-- Occupation -->
    <code code="253111" codeSystem="2.16.840.1.113883.13.62"
     codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
     displayName="General Medical Practitioner" />

    <!-- Employment Type -->
    <ext:jobClassCode code="FT" codeSystem="2.16.840.1.113883.5.1059"
     codeSystemName="HL7:EmployeeJobClass"
     displayName="full-time" />

    <!-- Employer Organisation -->
    <ext:employerOrganization>
     <!-- Department/Unit -->
     <name>Acme Hospital One</name>
     <asOrganizationPartOf>
      <wholeOrganization>
       <!-- Organisation Name -->
       <name use="ORGB">Acme Hospital Group</name>
       <!-- Entity Identifier -->
       <ext:asEntityIdentifier classCode="IDENT">
        <ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />
        <ext:assigningGeographicArea classCode="PLC">
         <ext:name>National Identifier</ext:name>
        </ext:assigningGeographicArea>
       </ext:asEntityIdentifier>
       <!-- Address -->
       <addr use="WP">
        <streetAddressLine>1 Clinician Street</streetAddressLine>
        <city>Nehtaville</city>
        <state>QLD</state>
        <postalCode>5555</postalCode>
        <additionalLocator>32568931</additionalLocator>
       </addr>
       <!-- Electronic Communication Detail -->
       <telecom use="WP" value="tel:0712341234" />
      </wholeOrganization>
     </asOrganizationPartOf>
    </ext:employerOrganization>
   </ext:asEmployment>

   <ext:asQualifications classCode="QUAL">
    <ext:code>
     <originalText>M.B.B.S</originalText>
    </ext:code>
   </ext:asQualifications>

  </assignedPerson>

 </assignedAuthor>
</author>
<!-- End DOCUMENT AUTHOR -->

  …
```

```
   <component>
      <structuredBody>
       <!-- Begin Section Administrative Observations -->
  <component>
   <section>
    <id root="88CDBCA4-EFD1-11DF-8DE4-E4CDDFD72085"/>
    <code code="102.16080" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Administrative Observations"/>
    <title>Administrative Observations</title>
    <!-- Begin Narrative text -->
    <text>
     <table>
      <tbody>
       <tr>
        <th>Australian Medicare Prescriber Number</th>
        <td>049960CT</td>
       </tr>
      </tbody>
     </table>
    </text>
    <!-- End Narrative text -->
    …

    <!-- Begin Document Author Healthcare Provider Entitlement -->
    <ext:coverage2 typeCode="COVBY">
     <ext:entitlement classCode="COV" moodCode="EVN">
      <ext:id assigningAuthorityName="Medicare Prescriber number" root="1.2.36.174030967.0.3" extension="049960CT" />
      <ext:code code="10" codeSystem="1.2.36.1.2001.1001.101.104.16047" codeSystemName="NCTIS Entitlement Type Values"
       displayName="Medicare Prescriber Number" />
      <ext:effectiveTime>
       <low value="200501010101+1100" />
       <high value="202501010101+1100" />
      </ext:effectiveTime>
      <ext:participant typeCode="HLD">
       <ext:participantRole classCode="ASSIGNED">
        <!-- Same as the author (assignedAuthor) id -->
        <ext:id root="7FCB0EC4-0CD0-11E0-9DFC-8F50DFD72085" />
       </ext:participantRole>
      </ext:participant>
     </ext:entitlement>
    </ext:coverage2>
    <!-- End Document Author Healthcare Provider Entitlement -->

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

      </structuredBody>
   </component>
</ClinicalDocument>
```

# 6.1.2 SUBJECT OF CARE

## Identification

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

## Relationships

### Parent

| Data Type | Name | Occurrences (child within parent) |
|---|---|---|
|  | SHARED HEALTH SUMMARY | 1..1 |

# CDA® R-MIM Representation

Figure 6.4 SUBJECT OF CARE - Header Data Elements and Figure 6.5 SUBJECT OF CARE - Body Data Elements show a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to both CDA® Header and CDA® Body elements.

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

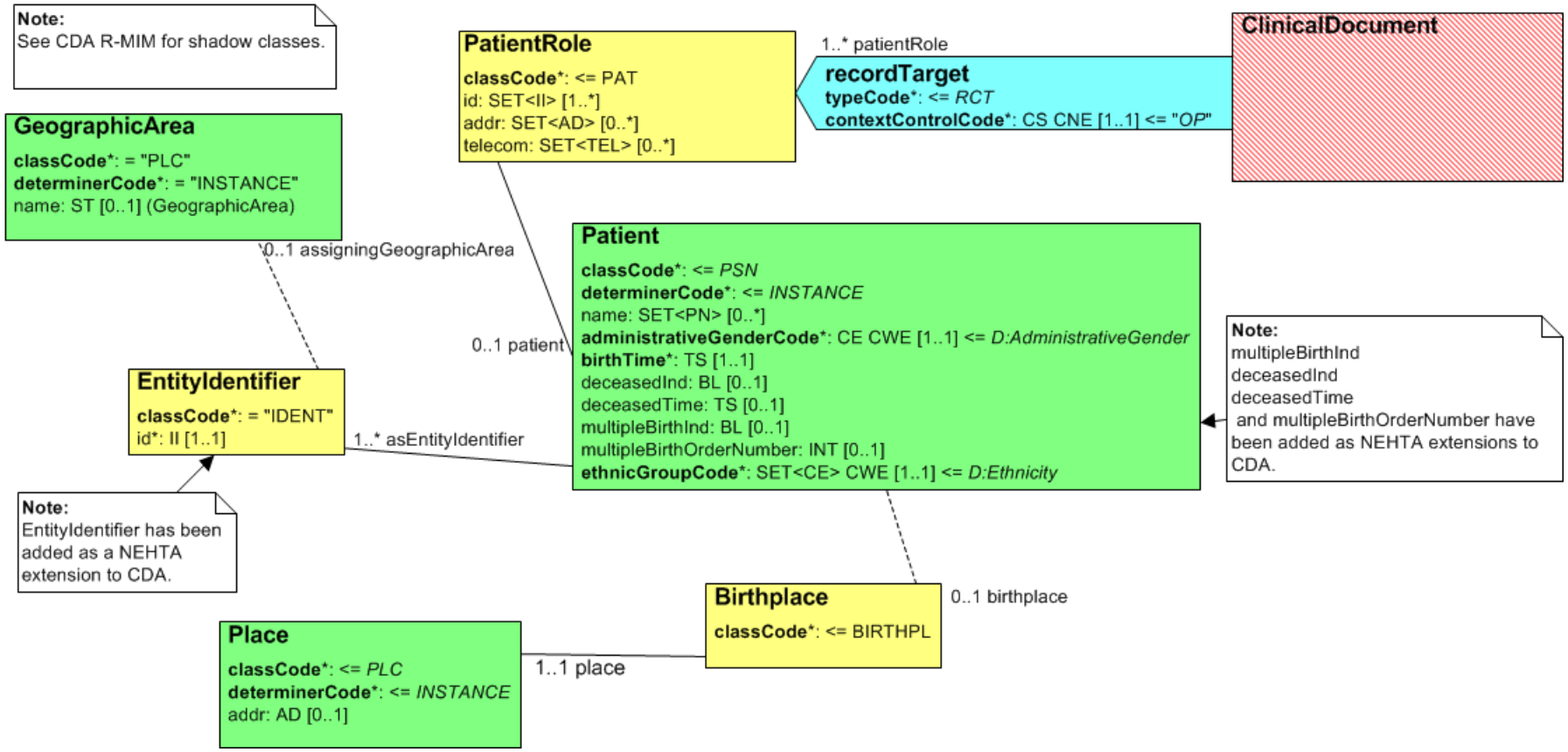


**Figure 6.4. SUBJECT OF CARE - Header Data Elements**

## Note

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

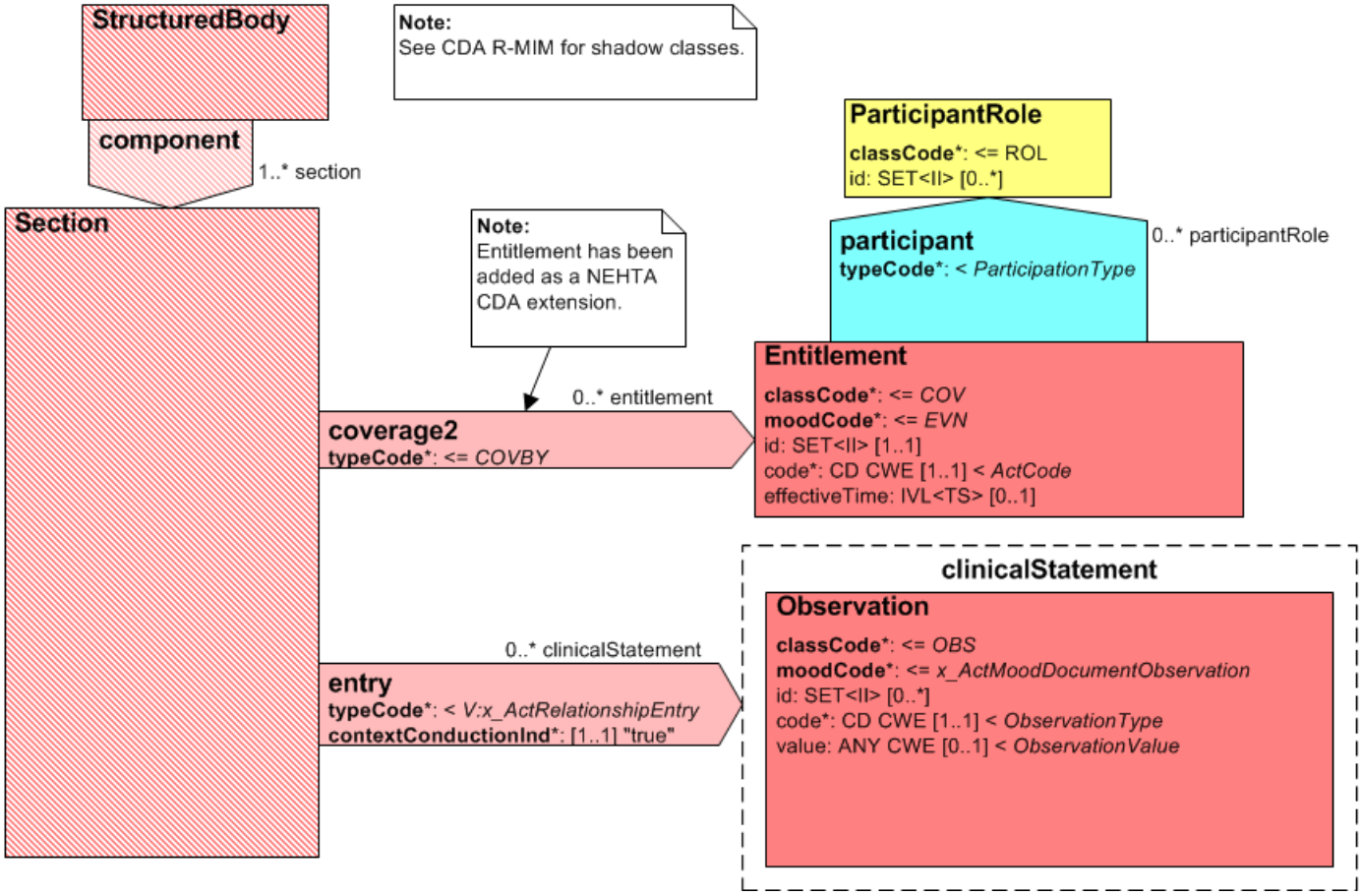


**Figure 6.5. SUBJECT OF CARE - Body Data Elements**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Header Data Elements** | | | Context: ClinicalDocument/ | | |
| **SUBJECT OF CARE** | Person who receives healthcare services. | 1..1 | recordTarget/**patientRole** | | |
| n/a | n/a | 1..1 | recordTarget/patientRole/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | Required CDA® element. |
| SUBJECT OF CARE > **Participation Type** | The categorisation of the nature of the participant's involvement in the healthcare event described by this participation. | 1..1 | n/a | Participation Type **SHALL** have an implementation-specific value equivalent to "Subject of Care". | Not mapped directly, encompassed implicitly in recordTarget/typeCode = "RCT" (optional, fixed value). |
| SUBJECT OF CARE > **Role** | The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective. | 1..1 | n/a | Role **SHALL** have an implementation-specific value equivalent to "Patient". | Not mapped directly, encompassed implicitly in recordTarget/patientRole/classCode = "PAT". |
| SUBJECT OF CARE > **Participant** | Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction. | 1..1 | recordTarget/patientRole/**patient** | | |
| SUBJECT OF CARE > Participant > **Entity Identifier** | A number or code issued for the purpose of identifying a participant within a healthcare context. | 1..* | recordTarget/patientRole/patient/**<Entity Identifier>** | The value of one Entity Identifier **SHALL** be an Australian IHI. | See common pattern: Entity Identifier.<br><br>The Subject of Care's Medicare card number is recorded in Entitlement, not Entity Identifier. |
| SUBJECT OF CARE > Participant > **Address** | The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity. | 1..* | recordTarget/patientRole/**<Address>** | | See common pattern: Address. |
| SUBJECT OF CARE > Participant > **Electronic Communication Detail** | The electronic communication details of entities. | 0..* | recordTarget/patientRole/**<Electronic Communication Detail>** | | See common pattern: Electronic Communication Detail. |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| SUBJECT OF CARE > Participant > **Person or Organisation or Device** | Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE. | 1..1 | n/a | PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON. | This logical NEHTA data component has no mapping to CDA®.<br><br>The cardinality of this component propagates to its children. |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > **Person** | An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient). | 1..1 | n/a | | Not mapped directly, encompassed implicitly in recordTarget/ patientRole/ patient. |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > **Person Name** | The appellation by which an individual may be identified separately from any other within a social context. | 1..* | recordTarget/patientRole/patient/**<Person Name>** | | See common pattern: Person Name. |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > **Demographic Data** | Additional characteristics of a person that may be useful for identification or other clinical purposes. | 1..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>The cardinality of this component propagates to its children. |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > **Sex** | The biological distinction between male and female. Where there is inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics. | 1..1 | recordTarget/patientRole/patient/**administrativeGenderCode** | AS 5017-2006 Health Care Client Identifier Sex | |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > **Date of Birth Detail** | Details of the accuracy, origin and value of a person's date of birth. | 1..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>The cardinality of this component propagates to its children. |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > Date of Birth Detail > **Date of Birth** | The date of birth of the person. | 1..1 | recordTarget/patientRole/patient/**birthTime** | | See <time> for available attributes. |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 3 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*) | | |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > Date of Birth Detail > **Date of Birth is Calculated From Age** | Indicates whether or not a person's date of birth has been derived from the value in the Age data element. | 0..1 | **entry[calc_age]** | | |
| | | | entry[calc_age]/**observation** | | |
| | | | entry[calc_age]/observation/**@classCode="OBS"** | | |
| | | | entry[calc_age]/observation/**@moodCode="EVN"** | | |
| | | | entry[calc_age]/observation/**code** | | |
| | | | entry[calc_age]/observation/code/**@code="103.16233"** | | |
| | | | entry[calc_age]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[calc_age]/observation/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[calc_age]/observation/code/**@displayName="Date of Birth is Calculated From Age"** | | |
| | | | entry[calc_age]/observation/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| | | | entry[calc_age]/observation/**value:BL** | | If the date of birth has been calculated from age this is true, otherwise it is false. |

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

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > Date of Birth Detail > Date of Birth Accuracy Indicator > **Date of Birth Year Accuracy Indicator** | The accuracy of the year component of a person's date of birth. | 1..1 | n/a | | Encompassed in the mapping for Date of Birth Accuracy Indicator (above). |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > **Age Detail** | Details of the accuracy and value of a person's age. | 0..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>The cardinality of this component propagates to its children. |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > Age Detail > **Age** | The age of a person/subject of care at the time. | 1..1 | **entry[age]** | | |
| | | | entry[age]/**observation** | | |
| | | | entry[age]/observation/**@classCode="OBS"** | | |
| | | | entry[age]/observation/**@moodCode="EVN"** | | |
| | | | entry[age]/observation/**code** | | |
| | | | entry[age]/observation/code/**@code="103.20109"** | | |
| | | | entry[age]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[age]/observation/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[age]/observation/code/**@displayName="Age"** | | |
| | | | entry[age]/observation/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| | | | entry[age]/observation/**value:PQ** | | |

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

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > **Birth Plurality** | An indicator of multiple birth, showing the total number of births resulting from a single pregnancy. | 0..1 | **entry[brth_plr]** | | |
| | | | entry[brth_plr]/**observation** | | |
| | | | entry[brth_plr]/observation/**@classCode="OBS"** | | |
| | | | entry[brth_plr]/observation/**@moodCode="EVN"** | | |
| | | | entry[brth_plr]/observation/**code** | | |
| | | | entry[brth_plr]/observation/code/**@code="103.16249"** | | |
| | | | entry[brth_plr]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[brth_plr]/observation/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[brth_plr]/observation/code/**@displayName="Birth Plurality"** | | |
| | | | entry[brth_plr]/observation/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| | | | entry[brth_plr]/observation/**value:INT** | | |
| **CDA® Header Data Elements** | | | Context: ClinicalDocument/ | | |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > **Birth Order** | The sequential order of each baby of a multiple birth regardless of live or still birth. | 0..1 | recordTarget/patientRole/patient/**ext:multipleBirthInd** | | See NEHTA CDA® extension: Multiple Birth. |
| | | | recordTarget/patientRole/patient/**ext:multipleBirthOrderNumber** | | |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > **Date of Death Detail** | Details of the accuracy and value of a person's date of death. | 0..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>The cardinality of this component propagates to its children. |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > Date of Death Detail > **Date of Death** | The date or date and time at which a person was estimated or certified to have died. | 1..1 | recordTarget/patientRole/patient/**ext:deceasedInd** | | See NEHTA CDA® extension: Deceased Time. |
| | | | recordTarget/patientRole/patient/**ext:deceasedTime** | | See <time> for available attributes. |
| **CDA® Body Level 3 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*) | | |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > Date of Death Detail > **Date of Death Accuracy Indicator** | The level of certainty or estimation of a person's date of death. | 0..1 | **entry[dod_acc]** | | This logical NEHTA data component has no mapping to CDA®.<br><br>The cardinality of this component propagates to its children. |
| | | | entry[dod_acc]/**observation** | | |
| | | | entry[dod_acc]/observation/**@classCode="OBS"** | | |
| | | | entry[dod_acc]/observation/**@moodCode="EVN"** | | |
| | | | entry[dod_acc]/observation/**code** | | |
| | | | entry[dod_acc]/observation/code/**@code="102.16252"** | | |
| | | | entry[dod_acc]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[dod_acc]/observation/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[dod_acc]/observation/code/**@displayName="Date of Death Accuracy Indicator"** | | |
| | | | entry[dod_acc]/observation/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| | | | entry[doc_acc]/observation/**value:CS** | AS 5017-2006 Health Care Client Identifier Date Accuracy Indicator | |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > Date of Death Detail > Date of Death Accuracy Indicator > **Date of Death Day Accuracy Indicator** | The accuracy of the day component of a person's date of death. | 1..1 | n/a | | Encompassed in the mapping for Date of Death Accuracy Indicator (above). |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > Date of Death Detail > Date of Death Accuracy Indicator > **Date of Death Month Accuracy Indicator** | The accuracy of the month component of a person's date of death. | 1..1 | n/a | | Encompassed in the mapping for Date of Death Accuracy Indicator (above). |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > Date of Death Detail > Date of Death Accuracy Indicator > **Date of Death Year Accuracy Indicator** | The accuracy of the year component of a person's date of death. | 1..1 | n/a | | Encompassed in the mapping for Date of Death Accuracy Indicator (above). |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > **Source of Death Notification** | The person, location, organisation or other originator of information relating to the date of death. | 0..1 | **entry[src_notif]** | | |
| | | | entry[src_notif]/**observation** | | |
| | | | entry[src_notif]/observation/**@classCode="OBS"** | | |
| | | | entry[src_notif]/observation/**@moodCode="EVN"** | | |
| | | | entry[src_notif]/observation/**code** | | |
| | | | entry[src_notif]/observation/code/**@code="103.10243"** | | |
| | | | entry[src_notif]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[src_notif]/observation/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[src_notif]/observation/code/**@displayName="Source of Death Notification"** | | |
| | | | entry[src_notif]/observation/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| | | | entry[src_notif]/observation/**value:CD** | AS 5017-2006: Health Care Client Source of Death Notification | See <code> for available attributes. |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > **Mother's Original Family Name** | The original family name of the person's mother. | 0..1 | **entry[mothers_name]** | | |
| | | | entry[mothers_name]/**observation** | | |
| | | | entry[mothers_name]/observation/**@classCode="OBS"** | | |
| | | | entry[mothers_name]/observation/**@moodCode="EVN"** | | |
| | | | entry[mothers_name]/observation/**code** | | |
| | | | entry[mothers_name]/observation/code/**@code="103.10245"** | | |
| | | | entry[mothers_name]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[mothers_name]/observation/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[mothers_name]/observation/code/**@displayName="Mother's Original Family Name"** | | |
| | | | entry[mothers_name]/observation/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| | | | entry[mothers_name]/observation/**value:PN** | | |
| **CDA® Header Data Elements** | | | Context: ClinicalDocument/ | | |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > **Country of Birth** | The country in which the person was born. | 0..1 | recordTarget/patientRole/patient/**birthplace/place/addr/country** | *Standard Australian Classification of Countries (SACC) Cat. No. 1269 [ABS2008]* | Use the name, not the numbered code. |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > **State/Territory of Birth** | The identifier of the Australian state or territory where a person is born. | 0..1 | recordTarget/patientRole/patient/**birthplace/place/addr/state** | AS 5017-2006 Australian State/Territory Identifier - Postal | |
| SUBJECT OF CARE > Participant > Person or Organisation or Device > Person > Demographic Data > **Indigenous Status** | Indigenous Status is a measure of whether a person identifies as being of Aboriginal or Torres Strait Islander origin. | 1..1 | recordTarget/patientRole/patient/**ethnicGroupCode** | METeOR 291036: Indigenous Status | |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 3 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/component[admin_obs]/section/ | | |
| SUBJECT OF CARE > Participant > **Entitlement** | The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context. | 0..* | **ext:coverage2/@typeCode="COVBY"** | | See NEHTA CDA® extension: Entitlement. |
| | | | ext:coverage2/**ext:entitlement** | | |
| | | | ext:coverage2/ext:entitlement/**@classCode="COV"** | | |
| | | | ext:coverage2/ext:entitlement/**@moodCode="EVN"** | | |
| | | | ext:coverage2/ext:entitlement/**ext:participant/@typeCode="BEN"** | | |
| | | | ext:coverage2/ext:entitlement/ext:participant/**ext:participantRole/@classCode="PAT"** | | |
| | | | ext:coverage2/ext:entitlement/ext:participant/ext:participantRole/**ext:id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | **SHALL** hold the same value as ClinicalDocument/ recordTarget/ patientRole/ **id**. |
| SUBJECT OF CARE > Participant > Entitlement > **Entitlement Number** | A number or code issued for the purpose of identifying the entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context. | 1..1 | ext:coverage2/ext:entitlement/**ext:id** | | |
| SUBJECT OF CARE > Participant > Entitlement > **Entitlement Type** | The description of the scope of an entitlement. | 1..1 | ext:coverage2/ext:entitlement/**ext:code** | NCTIS: Admin Codes - Entitlement Type | See <code> for available attributes. |
| SUBJECT OF CARE > Participant > Entitlement > **Entitlement Validity Duration** | The time interval for which an entitlement is valid. | 0..1 | ext:coverage2/ext:entitlement/**ext:effectiveTime** | | See <time> for available attributes. |

## Example 6.3. SUBJECT OF CARE XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin SUBJECT OF CARE - Header Part -->
 <recordTarget typeCode="RCT">
  <patientRole classCode="PAT">
   <!-- This system generated id is used for matching patient Entitlement -->
   <id root="7AA0BAAC-0CD0-11E0-9516-4350DFD72085"/>

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

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

   <!-- Participant -->
   <patient>

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

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

    <!-- Date of Birth -->
    <birthTime value="20110712"/>

    <!-- Indigenous Status -->
    <ethnicGroupCode code="4" codeSystem="2.16.840.1.113883.3.879.291036" codeSystemName="METeOR Indigenous Status"
     displayName="Neither Aboriginal nor Torres Strait Islander origin" />

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

```
    <!-- Date of Death -->
    <ext:deceasedInd value="true"/>
    <ext:deceasedTime value="20121112"/>

    <!-- Country of Birth/State of Birth -->
    <birthplace>
     <place>
      <addr>
       <country>Australia</country>
       <state>QLD</state>
      </addr>
     </place>
    </birthplace>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
     <ext:id assigningAuthorityName="IHI" root="1.2.36.1.2001.1003.0.8003608833357361"/>
     <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
     </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>
   </patient>
  </patientRole>
</recordTarget>
<!-- End SUBJECT OF CARE - Header Part -->
…

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

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

     <title>Administrative Observations</title>

     <!-- Narrative text -->
     <text>
      <table>
       <tbody>
        <tr>
         <th>Date of Birth is Calculated From Age</th>
         <td>True</td>
        </tr>
        <tr>
         <th>Date of Birth Accuracy Indicator</th>
         <td>AAA</td>
        </tr>
        <tr>
         <th>Age</th>
         <td>1</td>
        </tr>
        <tr>
         <th>Age Accuracy Indicator</th>
         <td>True</td>
        </tr>
```

```
    <tr>
     <th>Birth Plurality</th>
     <td>3</td>
    </tr>
    <tr>
     <th>Source of Death Notification</th>
     <td>Relative</td>
    </tr>
    <tr>
     <th>Mother's Maiden Name</th>
     <td>Smith</td>
    </tr>
    <tr>
     <th>Australian Medicare Card Number</th>
     <td>2296818481</td>
    </tr>

    …

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

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

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

<!-- Begin Age -->
<entry><!-- [age] -->
 <observation classCode="OBS" moodCode="EVN">
  <id root="CCF0D55C-EFD0-11DF-BEA2-A6CCDFD72085"/>
  <code code="103.20109"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Age"/>
  <value xsi:type="PQ" value="1" unit="a"/>
 </observation>
</entry><!-- [age] -->
<!-- End Age -->
```

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

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

<!-- Begin Source of Death Notification-->
<entry>
 <!-- [src_notif] -->
 <observation classCode="OBS" moodCode="EVN">

  <!-- ID is used for system purposes such as matching -->
  <id root="C749A146-2789-11E1-90AC-740648240198" />
  <code code="103.10243" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components"
   displayName="Source of Death Notification" />
  <value code="R" codeSystem="2.16.840.1.113883.13.64"
   codeSystemName="AS 5017-2006 Health Care Client Source of Death Notification" displayName="Relative"
   xsi:type="CD" />
 </observation>
</entry>
<!-- [src_notif] -->
<!-- End Source of Death Notification-->

<!-- Begin Mother's Original Family Name -->
<entry>
 <!-- [mothers_name] -->
 <observation classCode="OBS" moodCode="EVN">

  <!-- ID is used for system purposes such as matching -->
  <id root="E432CD48-278C-11E1-BDA1-0F0A4824019B" />
  <code code="103.10245" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components"
   displayName="Mother's Original Family Name" />
  <value xsi:type="PN">
   <family>Smith</family>
  </value>
 </observation>
</entry>
<!-- [mothers_name] -->
<!-- End Mother's Original Family Name -->

<!-- Begin Date of Death Accuracy Indicator-->
<entry>
 <!-- [dod_acc] -->
 <observation classCode="OBS" moodCode="EVN">
```

```
      <!-- ID is used for system purposes such as matching -->
      <id root="D253216C-EFD0-11DF-A686-ADCCDFD72085" />
      <code code="102.16252" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components"
       displayName="Date of Death Accuracy Indicator" />
      <value code="AAA" xsi:type="CS" />
     </observation>
    </entry>
    <!-- [dod_acc] -->
    <!-- End Date of Death Accuracy Indicator-->

    <!-- Begin Entitlement -->
    <ext:coverage2 typeCode="COVBY">
     <ext:entitlement classCode="COV" moodCode="EVN">
                        <ext:id assigningAuthorityName="Medicare Card Number" root="1.2.36.1.5001.1.0.7.1" extension="2296818481" />
      <ext:code code="1" codeSystem="1.2.36.1.2001.1001.101.104.16047" codeSystemName="NCTIS Entitlement Type Values" displayName="Medicare Benefits"/>
      <ext:effectiveTime>
       <high value="20110101"/>
      </ext:effectiveTime>
      <ext:participant typeCode="BEN">
       <ext:participantRole classCode="PAT">
        <ext:id root="7AA0BAAC-0CD0-11E0-9516-4350DFD72085" />
       </ext:participantRole>
      </ext:participant>
     </ext:entitlement>
    </ext:coverage2>
    <!-- End Entitlement -->

    <!-- End SUBJECT OF CARE – Body -->
    …

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

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

# 7 Content Data Specification - CDA® Mapping

## 7.1 Shared Health Summary

### Identification

| | |
|---|---|
| **Name** | SHARED HEALTH SUMMARY |
| **Metadata Type** | Structured Document |
| **Identifier** | SD-16565 |

### Relationships

**Children**

| Data Type | Name | Occurrence |
|---|---|---|
|  | ADVERSE REACTIONS | 1..1 |
|  | Medications (MEDICATION ORDERS) | 1..1 |
|  | Past and Current Medical History (MEDICAL HISTORY) | 1..1 |
|  | IMMUNISATIONS | 1..1 |

# CDA® R-MIM Representation

Figure 7.1 Shared Health Summary shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

The Shared Health Summary is composed of a ClinicalDocument class, which is the entry point into the CDA® R-MIM. The ClinicalDocument is associated with the bodyChoice through the component relationship. The StructuredBody class represents a CDA® document body that is comprised of one or more document sections.

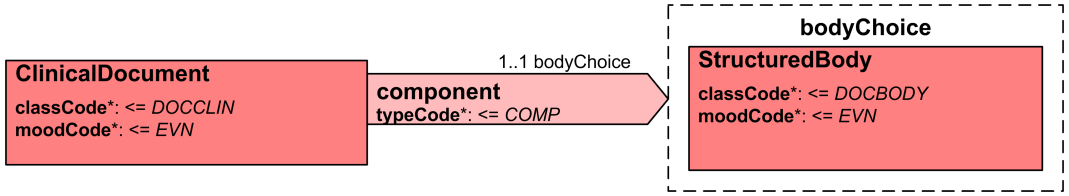


**Figure 7.1. Shared Health Summary**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Header Data Elements** | | | | | |
| **Shared Health Summary** | A clinical document written by the nominated provider, which contains key pieces of information about an individual's health status and is useful to a wide range of providers in assessing individuals and delivering care. | 1..1 | **ClinicalDocument** | | |
| **CDA® Body Level 2 Data Elements** | | | | | |
| Shared Health Summary (Body) | See above. | 1..1 | ClinicalDocument/**component/structuredBody** | | |

## Example 7.1. Shared Health Summary Body XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin CDA Header -->
   …

   <!-- End CDA Header -->

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

         <!-- Begin ADVERSE REACTIONS -->
         …
         <!-- End ADVERSE REACTIONS -->

         <!-- Begin Medications (MEDICATION ORDERS) -->
         …
         <!-- End Medications (MEDICATION ORDERS) -->

         <!-- Begin Past and Current Medical History (MEDICAL HISTORY) -->
         …
         <!-- End Past and Current Medical History (MEDICAL HISTORY) -->

         <!-- Begin IMMUNISATIONS -->
         …
         <!-- End IMMUNISATIONS -->

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

# 7.1.1 ADVERSE REACTIONS

## Identification

| | |
|---|---|
| **Name** | ADVERSE REACTIONS |
| **Metadata Type** | Section |
| **Identifier** | S-20113 |

## Relationships

### Parent

| Data Type | Name | Occurrences (child within parent) |
|---|---|---|
|  | Shared Health Summary | 1..1 |

### Children

| Data Type | Name | Occurrence |
|---|---|---|
|  | EXCLUSION STATEMENT - ADVERSE REACTIONS | 0..1 |
|  | ADVERSE REACTION | 0..* |

# CDA® R-MIM Representation

Figure 7.2 ADVERSE REACTIONS shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

The ADVERSE REACTIONS section is composed of a Section class related to its context ClinicalDocument.structuredBody by a component.

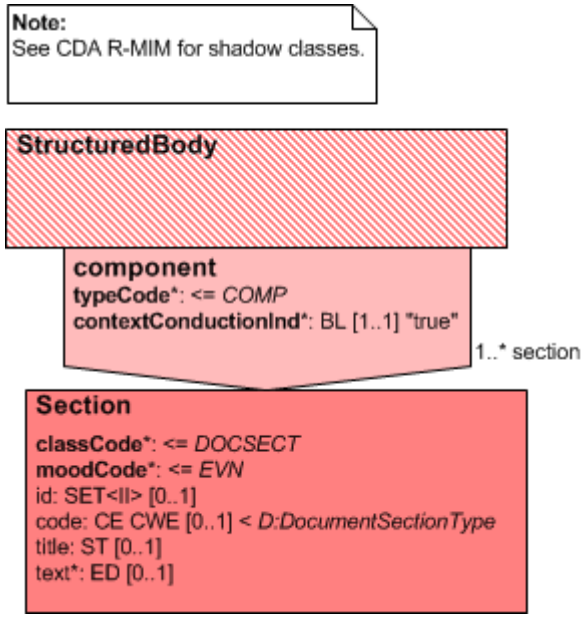


**Figure 7.2. ADVERSE REACTIONS**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 2 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/ | | |
| **ADVERSE REACTIONS** | 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. | 1..1 | component[adv_reacts]/**section** | | This component[adv_reacts] **SHALL NOT** contain both an instance of EXCLUSION STATEMENT - ADVERSE REACTIONS and an instance of ADVERSE REACTION. |
| | | | component[adv_reacts]/section/**title="Adverse Reactions"** | | |
| | | | component[adv_reacts]/section/**text** | | Required CDA® element.<br><br>See Appendix A, *CDA® Narratives*. |
| ADVERSE REACTIONS > **Adverse Reactions Instance Identifier** | A globally unique identifier for each instance of an Adverse Reactions section. | 0..1 | component[adv_reacts]/section/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| ADVERSE REACTIONS > **Section Type** | Type of section. | 1..1 | component[adv_reacts]/section/**code** | | |
| | | | component[adv_reacts]/section/code/**@code="101.20113"** | | |
| | | | component[adv_reacts]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | component[adv_reacts]/section/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | component[adv_reacts]/section/code/**@displayName="Adverse Reactions"** | | |
| ADVERSE REACTIONS > **EXCLUSION STATEMENT - ADVERSE REACTIONS** | Statements about adverse reactions that need to be positively recorded as absent or excluded. | 0..1 | See: EXCLUSION STATEMENT - ADVERSE REACTIONS | | |
| ADVERSE REACTIONS > **ADVERSE REACTION** | A harmful or undesirable effect associated with exposure to any substance or agent. | 0..* | See: ADVERSE REACTION | | |

## Example 7.2. ADVERSE REACTIONS XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin CDA Header -->
   …
   <!-- End CDA Header -->

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

         <!-- Begin ADVERSE REACTIONS -->
         <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     <!-- Adverse Reactions Instance Identifier -->
     <id root="50846572-EFC7-11E0-8337-65094924019B" />
     <!-- Section Type -->
     <code code="101.20113"
      codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components"
      displayName="Adverse Reactions" />

     <title>Adverse Reactions</title>
     <!-- Narrative text -->
     <text>Narrative.</text>

     <!-- NOTE: This Exclusion Statement is provided for illustrative purpose only. This section cannot contain both an entry for Exclusion Statement and any other entry. -->
     <!-- Begin EXCLUSION STATEMENT - ADVERSE REACTIONS -->
     <entry>
      <observation>
       …
      </observation>
     </entry>
     <!-- End EXCLUSION STATEMENT - ADVERSE REACTIONS -->

     <!-- Begin ADVERSE REACTION -->
     <entry>
      <act>
       …
      </act>
     </entry>
     <!-- End ADVERSE REACTION -->
    </section>
   </component>
         <!-- End ADVERSE REACTIONS -->

         …
```

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

# 7.1.1.1 EXCLUSION STATEMENT - ADVERSE REACTIONS

## Identification

| | |
|---|---|
| **Name** | EXCLUSION STATEMENT - ADVERSE REACTIONS |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16137 |

## Relationships

### Parent

| Data Type | Name | Occurrences (child within parent) |
|---|---|---|
|  | ADVERSE REACTIONS | 0..1 |

## CDA® R-MIM Representation

Figure 7.3 EXCLUSION STATEMENT - ADVERSE REACTIONS shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

The EXCLUSION STATEMENT - ADVERSE REACTIONS data group is represented by an Observation class that is related to its containing Section class by an entry.

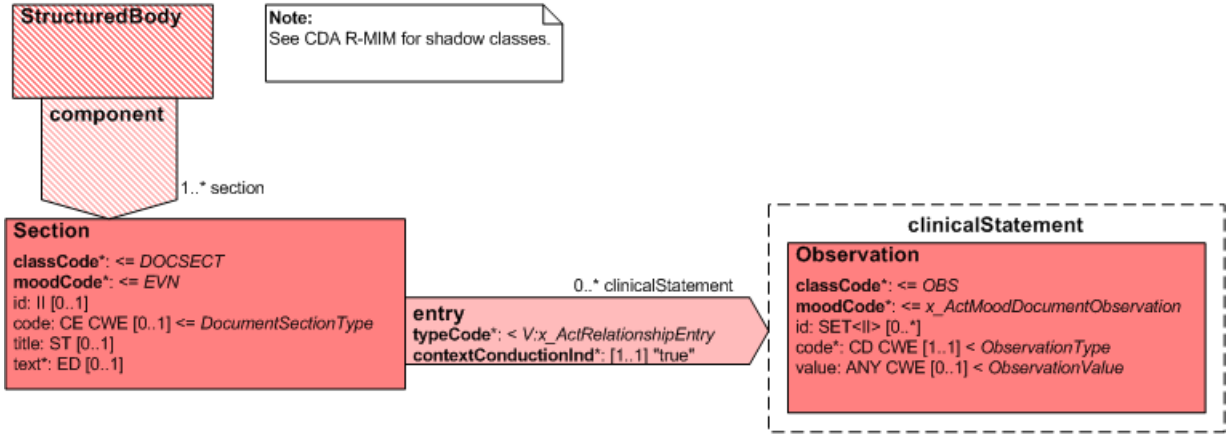


**Figure 7.3. EXCLUSION STATEMENT - ADVERSE REACTIONS**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 3 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/component[adv_reacts]/section | | |
| **EXCLUSION STATEMENT - ADVERSE REACTIONS** | Statements about adverse reactions that need to be positively recorded as absent or excluded. | 0..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>The cardinality of this component propagates to its children.<br><br>See Known Issues. |
| EXCLUSION STATEMENT - ADVERSE REACTIONS > **Global Statement** | The statement about the absence or exclusion. | 1..1 | **entry[gbl_adv]** | | |
| | | | entry[gbl_adv]/**observation** | | |
| | | | entry[gbl_adv]/observation/**@classCode="OBS"** | | |
| | | | entry[gbl_adv]/observation/**@moodCode="EVN"** | | |
| | | | entry[gbl_adv]/observation/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | Optional CDA® element.<br><br>See <id> for available attributes. |
| | | | entry[gbl_adv]/observation/**code** | | |
| | | | entry[gbl_adv]/observation/code/**@code="103.16302.120.1.1"** | | |
| | | | entry[gbl_adv]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[gbl_adv]/observation/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[gbl_adv]/observation/code/**@displayName="Global Statement"** | | |
| | | | entry[gbl_adv]/observation/**value:CD** | NCTIS: Admin Codes - Global Statement Values<br><br>The value/@code **SHALL NOT** be "02". | See <code> for available attributes. |
| EXCLUSION STATEMENT - ADVERSE REACTIONS > **Detailed Clinical Model Identifier** | A globally unique identifier for this Detailed Clinical Model. | 1..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>See Known Issues. |

## Example 7.3. EXCLUSION STATEMENT - ADVERSE REACTIONS XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin CDA Header -->
   …
   <!-- End CDA Header -->

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

         <!-- Begin ADVERSE REACTIONS -->
         <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin EXCLUSION STATEMENT - ADVERSE REACTIONS -->
     <entry>
      <!-- Begin Global Statement -->
      <observation classCode="OBS" moodCode="EVN">
       <!-- ID is used for system purposes such as matching -->
       <id root="55d57cf0-2c70-11e2-81c1-0800600c9a66" />
       <code code="103.16302.120.1.1" codeSystem="1.2.36.1.2001.1001.101"
        codeSystemName="NCTIS Data Components"
        displayName="Global Statement" />
       <value code="01" codeSystem="1.2.36.1.2001.1001.101.104.16299"
        codeSystemName="NCTIS Global Statement Values"
        displayName="None known" xsi:type="CD" />
      </observation>
      <!-- End Global Statement -->
     </entry>
     <!-- End EXCLUSION STATEMENT - ADVERSE REACTIONS -->

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

         …

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

# 7.1.1.2 ADVERSE REACTION

## Identification

| | |
|---|---|
| **Name** | ADVERSE REACTION |
| **Metadata Type** | Data Group |
| **Identifier** | DG-15517 |

## Relationships

### Parent

| Data Type | Name | Occurrences (child within parent) |
|---|---|---|
|  | ADVERSE REACTIONS | 0..* |

## CDA® R-MIM Representation

Figure 7.4 ADVERSE REACTION shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

The ADVERSE REACTION data group is represented by an Act class that is related to its containing Section class by an entry. Substance/Agent is represented by a ParticipantRole class related to the containing Act class by a participant.

Reaction Event is represented by an Observation class and is related to the containing Act class by an entryRelationship. Manifestation is represented by an Observation class related to the containing Observation (Reaction Event) class. Reaction Type is represented by the value attribute of the Manifestation Observation class.

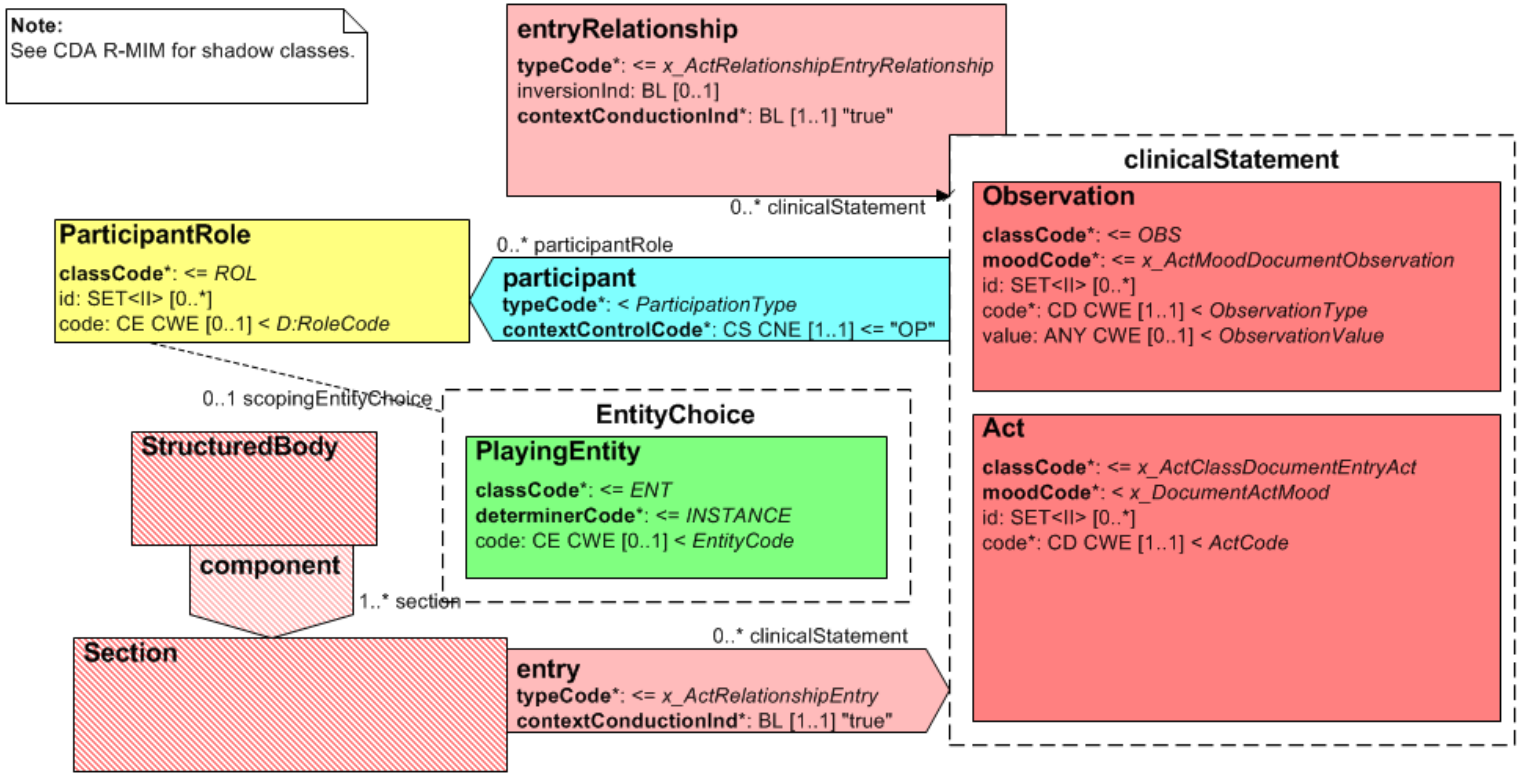


**Figure 7.4. ADVERSE REACTION**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 3 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/component[adv_reacts]/section/ | | |
| **ADVERSE REACTION** | A harmful or undesirable effect associated with exposure to any substance or agent. | 0..* | **entry[adv_react]** | | |
| | | | entry[adv_react]/**act** | | |
| | | | entry[adv_react]/act/**@classCode="ACT"** | | |
| | | | entry[adv_react]/act/**@moodCode="EVN"** | | |
| ADVERSE REACTION > **Adverse Reaction Instance Identifier** | A globally unique identifier for each instance of an Adverse Reaction evaluation. | 1..1 | entry[adv_react]/act/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| ADVERSE REACTION > **Detailed Clinical Model Identifier** | A globally unique identifier for this Detailed Clinical Model. | 1..1 | entry[adv_react]/act/**code** | | |
| | | | entry[adv_react]/act/code/**@code="102.15517"** | | |
| | | | entry[adv_react]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[adv_react]/act/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[adv_react]/act/code/**@displayName="Adverse Reaction"** | | |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| ADVERSE REACTION > **Substance/Agent** | Identification of a substance, agent, or a class of substance, that is considered to be responsible for the adverse reaction. | 1..1 | entry[adv_react]/act/**participant** | | |
| | | | entry[adv_react]/act/participant/**@typeCode="CAGNT"** | | |
| | | | entry[adv_react]/act/participant/**participantRole/playingEntity/code** | SNOMED CT-AU:<br>• 142321000036106 \|*Adverse reaction agent reference set*\|<br>• 32570211000036100 \|*Substance foundation reference set*\|<br>Australian Medicines Terminology (AMT):<br>• 929360061000036106 \|*Medicinal product reference set*\|<br>• 929360081000036101 \|*Medicinal product pack reference set*\|<br>• 929360071000036103 \|*Medicinal product unit of use reference set*\|<br>• 929360021000036102 \|*Trade product reference set*\|<br>• 929360041000036105 \|*Trade product pack reference set*\|<br>• 929360031000036100 \|*Trade product unit of use reference set*\|<br>• 929360051000036108 \|*Contained trade product pack reference set*\| | See <code> for available attributes. |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| ADVERSE REACTION > **REACTION EVENT** | Details about each adverse reaction event. | 0..1 | entry[adv_react]/act/**entryRelationship[rct_evnt]/@typeCode="CAUS"** | | |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/**observation** | | |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/**@classCode="OBS"** | | |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/**@moodCode="EVN"** | | |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/**code** | | |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/code/**@code="102.16474"** | | |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/code/**@displayName="Reaction Event"** | | |
| ADVERSE REACTION > REACTION EVENT > **Manifestation** | Presentation or exhibition of signs and symptoms of the adverse reaction expressed as a single word, phrase or brief description. | 1..* | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/**entryRelationship[mfst]/@typeCode="MFST"** | | |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/entryRelationship[mfst]/**@inversionInd="true"** | | |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/entryRelationship[mfst]/**observation** | | |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/entryRelationship[mfst]/observation/**@classCode="OBS"** | | |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/entryRelationship[mfst]/observation/**@moodCode="EVN"** | | |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/entryRelationship[mfst]/observation/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/entryRelationship[mfst]/observation/**code** | SNOMED CT-AU<br>• 142341000036103 \|*Clinical manifestation reference set*\|<br>• 32570071000036102 \|*Clinical finding foundation reference set*\| | See <code> for available attributes. |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| ADVERSE REACTION > REACTION EVENT > **Reaction Type** | The type of reaction, as determined by the clinician. | 0..1 | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/**value:CD** | SNOMED CT-AU:<br>• 11000036103 \|*Adverse reaction type reference set*\| | See <code> for available attributes. |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/value/**@code** | | |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/value/**@codeSystem= "2.16.840.1.113883.6.96"** | | |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/value/**@codeSystemName** | The value **SHOULD** be "SNOMED CT".<br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[adv_react]/act/entryRelationship[rct_evnt]/observation/value/**@displayName** | | |

## Example 7.4. ADVERSE REACTION XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin CDA Header -->
   …
   <!-- End CDA Header -->

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

         <!-- Begin ADVERSE REACTIONS -->
         <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin ADVERSE REACTION -->
     <entry>
      <act classCode="ACT" moodCode="EVN">
       <!-- Adverse Reaction Instance Identifier -->
       <id root="547FC5C0-7F8A-11E0-AE79-EE2B4924019B" />
       <!-- Detailed Clinical Model Identifier -->
       <code code="102.15517"
        codeSystem="1.2.36.1.2001.1001.101"
        codeSystemName="NCTIS Data Components"
        displayName="Adverse Reaction" />

       <!-- Begin Substance/Agent -->
       <participant typeCode="CAGNT">
        <participantRole>
         <playingEntity>
          <code code="385420005"
           codeSystem="2.16.840.1.113883.6.96"
           codeSystemName="SNOMED CT"
           displayName="Contrast media" />
         </playingEntity>
        </participantRole>
       </participant>
       <!-- End Substance/Agent -->

       <!-- Begin REACTION EVENT -->
       <entryRelationship typeCode="CAUS">
        <observation classCode="OBS" moodCode="EVN">
         <code code="102.16474"
          codeSystem="1.2.36.1.2001.1001.101"
          codeSystemName="NCTIS Data Components"
          displayName="Reaction Event" />
```

```
        <entryRelationship inversionInd="true" typeCode="MFST">
         <observation classCode="OBS" moodCode="EVN">
          <id root="547FF5C0-7F8A-11E0-AE79-EE2B4924019B" />

          <!-- Manifestation -->
          <code code="39579001"
           codeSystem="2.16.840.1.113883.6.96"
           codeSystemName="SNOMED CT"
           displayName="Anaphylaxis" />

          <!-- Reaction Type -->
          <value code="419076005"
           codeSystem="2.16.840.1.113883.6.96"
           codeSystemName="SNOMED CT"
           displayName="Allergic reaction" xsi:type="CD" />
         </observation>
        </entryRelationship>

       </observation>
      </entryRelationship>
      <!-- End REACTION EVENT -->
     </act>
    </entry>
    <!-- End ADVERSE REACTION -->

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

       …

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

# 7.1.2 Medications (MEDICATION ORDERS)

## Identification

| | |
|---|---|
| **Name** | Medications (MEDICATION ORDERS) |
| **Metadata Type** | Section |
| **Identifier** | S-16146 |

## Relationships

### Parent

| Data Type | Name | Occurrences (child within parent) |
|---|---|---|
|  | Shared Health Summary | 1..1 |

### Children

| Data Type | Name | Occurrence |
|---|---|---|
|  | EXCLUSION STATEMENT - MEDICATIONS | 0..1 |
|  | Known Medication (MEDICATION INSTRUCTION) | 0..* |

# CDA® R-MIM Representation

Figure 7.5 Medications (MEDICATION ORDERS) shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

The Medications (MEDICATION ORDERS) section is composed of a Section class related to its context ClinicalDocument.structuredBody by a component.

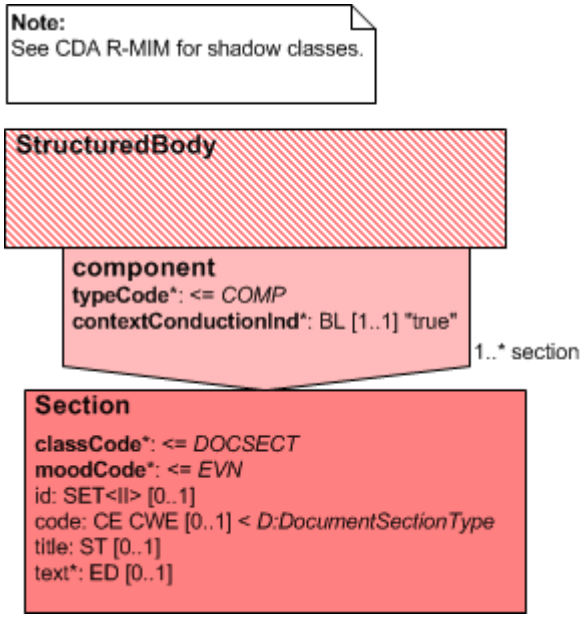


**Figure 7.5. Medications (MEDICATION ORDERS)**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 2 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/ | | |
| **Medications (MEDICATION ORDERS)** | Medicines that the subject of care is using. | 1..1 | component[meds]/**section** | | This component[meds] **SHALL NOT** contain both an instance of EXCLUSION STATEMENT - MEDICATIONS and an instance of Known Medication (MEDICATION INSTRUCTION). |
| | | | component[meds]/section/**title="Medications"** | | |
| | | | component[meds]/section/**text** | | Required CDA® element.<br><br>See Appendix A, *CDA® Narratives*. |
| Medications (MEDICATION ORDERS) > **Medication Orders Instance Identifier** | A globally unique identifier for each instance of a Medication Orders section. | 0..1 | component[meds]/section/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| Medications (MEDICATION ORDERS) > **Section Type** | Type of section. | 1..1 | component[meds]/section/**code** | | |
| | | | component[meds]/section/code/**@code="101.16146"** | | |
| | | | component[meds]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | component[meds]/section/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | component[meds]/section/code/**@displayName="Medication Orders"** | | |
| Medications (MEDICATION ORDERS) > **EXCLUSION STATEMENT - MEDICATIONS** | Statement to positively assert that the patient has not been prescribed or is not taking certain medication. | 0..1 | See: EXCLUSION STATEMENT - MEDICATIONS | | |
| Medications (MEDICATION ORDERS) > **Known Medication (MEDICATION INSTRUCTION)** | 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. | 0..* | See: Known Medication (MEDICATION INSTRUCTION) | | |

## Example 7.5. Medications (MEDICATION ORDERS) XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin CDA Header -->
   …
   <!-- End CDA Header -->

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

         <!-- Begin Medications (MEDICATION ORDERS) -->
         <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     <!-- Medication Orders Instance Identifier -->
     <id root="50846572-EFC7-11E0-8337-65094924219B" />
     <!-- Section Type -->
     <code code="101.16146"
      codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components"
      displayName="Medication Orders" />

     <title>Medications</title>
     <!-- Narrative text -->
     <text>Narrative.</text>

     <!-- NOTE: This Exclusion Statement is provided for illustrative purpose only. This section cannot contain both an entry for Exclusion Statement and any other entry. -->
     <!-- Begin EXCLUSION STATEMENT - MEDICATIONS -->
     <entry>
      <observation>
       …
      </observation>
     </entry>
     <!-- End EXCLUSION STATEMENT - MEDICATIONS -->

     <!-- Begin Known Medication (MEDICATION INSTRUCTION) -->
     <entry>
      <substanceAdministration>
       …
      </substanceAdministration>
     </entry>
     <!-- End Known Medication (MEDICATION INSTRUCTION) -->

    </section>
   </component>
         <!-- End Medications (MEDICATION ORDERS) -->

         …
```

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

# 7.1.2.1 EXCLUSION STATEMENT - MEDICATIONS

## Identification

| | |
|---|---|
| **Name** | EXCLUSION STATEMENT - MEDICATIONS |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16136 |

## Relationships

### Parent

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

## CDA® R-MIM Representation

Figure 7.6 Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

The Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) data group is represented by an Observation class that is related to its containing Section class by an entry.

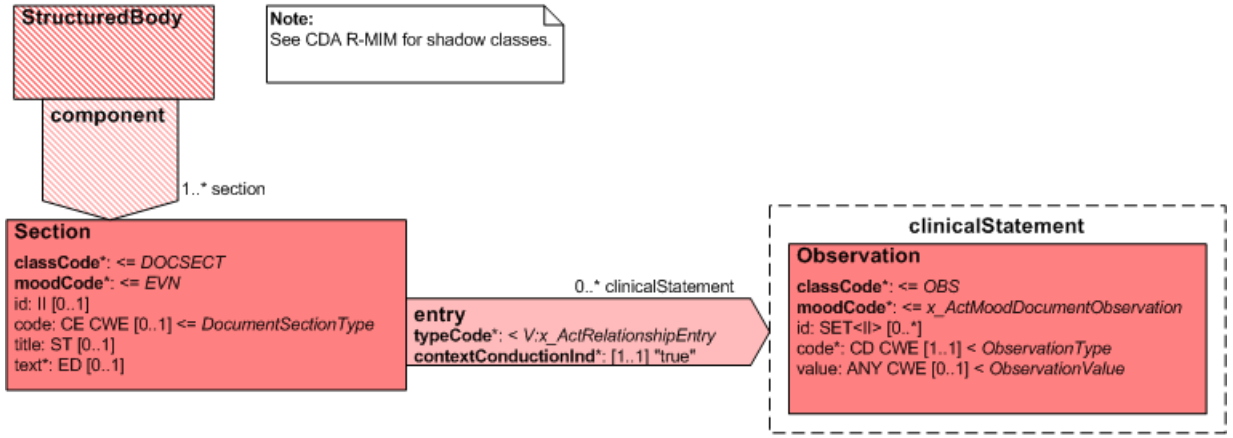


**Figure 7.6. Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS)**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 3 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/component[meds]/section/ | | |
| **EXCLUSION STATEMENT - MEDICATIONS** | Statement to positively assert that the patient has not been prescribed or is not taking certain medication. | 0..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>The cardinality of this component propagates to its children.<br><br>See Known Issues. |
| EXCLUSION STATEMENT - MEDICATIONS > **Global Statement** | The statement about the absence or exclusion of certain medication. | 1..1 | **entry[gbl_meds]** | | |
| | | | entry[gbl_meds]/**observation** | | |
| | | | entry[gbl_meds]/observation/**@classCode="OBS"** | | |
| | | | entry[gbl_meds]/observation/**@moodCode="EVN"** | | |
| | | | entry[gbl_meds]/observation/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | Optional CDA® element.<br><br>See <id> for available attributes. |
| | | | entry[gbl_meds]/observation/**code** | | |
| | | | entry[gbl_meds]/observation/code/**@code="103.16302.120.1.2"** | | |
| | | | entry[gbl_meds]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[gbl_meds]/observation/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[gbl_meds]/observation/code/**@displayName="Global Statement"** | | |
| | | | entry[gbl_meds]/observation/**value:CD** | NCTIS: Admin Codes - Global Statement Values<br><br>The value/@code **SHALL NOT** be "02". | See <code> for available attributes. |
| EXCLUSION STATEMENT - MEDICATIONS > **Detailed Clinical Model Identifier** | A globally unique identifier for this Detailed Clinical Model. | 1..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>See Known Issues. |

## Example 7.6. EXCLUSION STATEMENT - MEDICATIONS XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin CDA Header -->
   …
   <!-- End CDA Header -->

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

         <!-- Begin Medications (MEDICATION ORDERS) -->
         <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin EXCLUSION STATEMENT - MEDICATIONS -->
     <entry>
      <!-- Begin Global Statement -->
      <observation classCode="OBS" moodCode="EVN">
       <!-- ID is used for system purposes such as matching -->
       <id root="55d57cf0-2c70-11e2-81c1-0801600c9a66" />
       <code code="103.16302.120.1.2" codeSystem="1.2.36.1.2001.1001.101"
        codeSystemName="NCTIS Data Components"
        displayName="Global Statement" />
       <value code="01" codeSystem="1.2.36.1.2001.1001.101.104.16299"
        codeSystemName="NCTIS Global Statement Values"
        displayName="None known" xsi:type="CD" />
      </observation>
      <!-- End Global Statement -->
     </entry>
     <!-- End EXCLUSION STATEMENT - MEDICATIONS -->

    </section>
   </component>
         <!-- End Medications (MEDICATION ORDERS) -->

         …

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

# 7.1.2.2 Known Medication (MEDICATION INSTRUCTION)

## Identification

| | |
|---|---|
| **Name** | Known Medication (MEDICATION INSTRUCTION) |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16211 |

## Relationships

### Parent

| Data Type | Name | Occurrences (child within parent) |
|---|---|---|
|  | Medications (MEDICATION ORDERS) | 0..* |

## CDA® R-MIM Representation

Figure 7.7 Known Medication (MEDICATION INSTRUCTION) shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

The Known Medication (MEDICATION INSTRUCTION) data group is represented by a SubstanceAdministration class that is related to its containing Section class by an entry. The text attribute of that SubstanceAdministration class represents Directions.

Clinical Indication is represented by a reason Act class related to the containing SubstanceAdministration class by an entryRelationship. Medication Instruction Comment is represented by an Act class related the containing SubstanceAdministration class by an entryRelationship. Therapeutic Good Identification is represented by the code attribute of manufacturedMaterial.

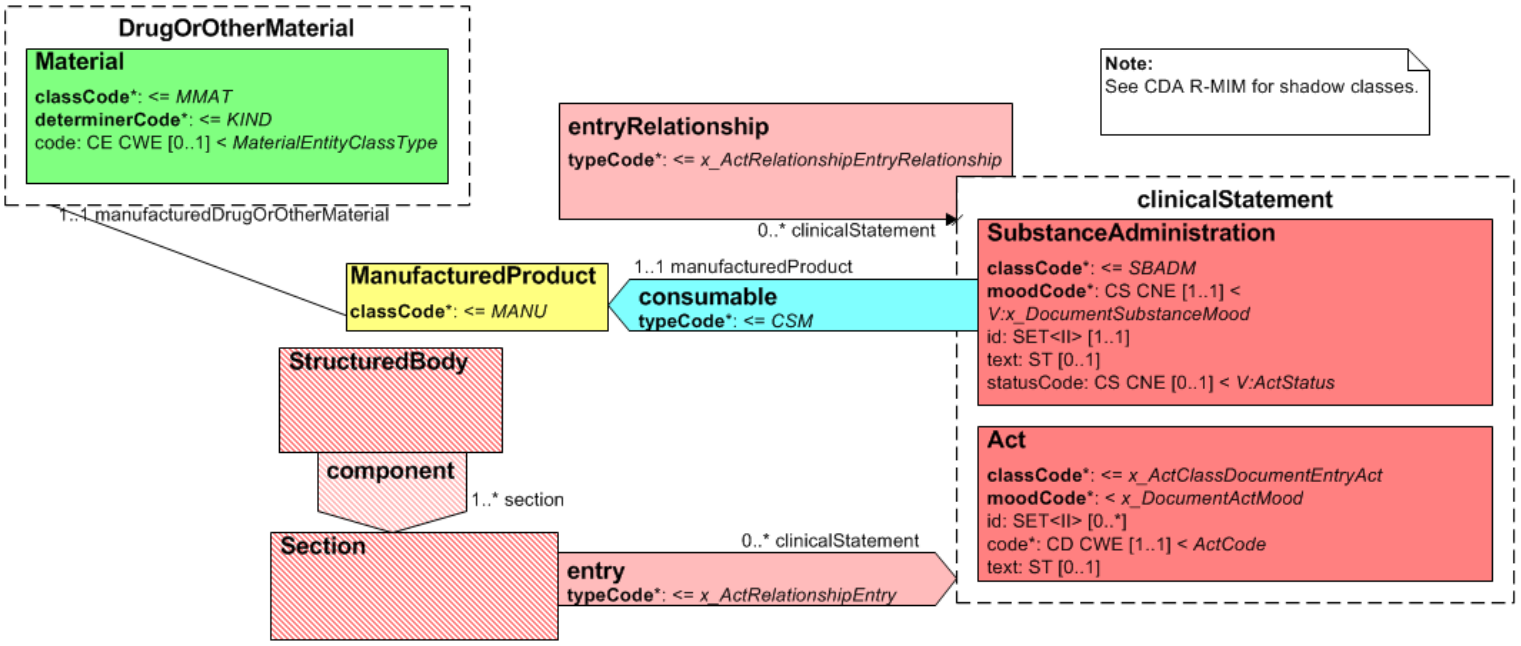


**Figure 7.7. Known Medication (MEDICATION INSTRUCTION)**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 3 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/component[meds]/section/ | | |
| **Known Medication (MEDICATION INSTRUCTION)** | 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. | 0..* | **entry[med_inst]** | | |
| | | | entry[med_inst]/**substanceAdministration** | | |
| | | | entry[med_inst]/substanceAdministration/**@moodCode="EVN"** | | |
| | | | entry[med_inst]/substanceAdministration/**@classCode="SBADM"** | | |
| Known Medication (MEDICATION INSTRUCTION) > **Medication Instruction Instance Identifier** | A globally unique object identifier for each instance of a Medication Instruction instruction. | 1..1 | entry[med_inst]/substanceAdministration/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| Known Medication (MEDICATION INSTRUCTION) > **Therapeutic Good Identification** | The medicine, vaccine or other therapeutic good being ordered for, administered to or used by the subject of care. | 1..1 | entry[med_inst]/substanceAdministration/**consumable/manufacturedProduct/manufacturedMaterial/code** | Australian Medicines Terminology (AMT):<br>• 929360061000036106 \|*Medicinal product reference set*\|<br>• 929360081000036101 \|*Medicinal product pack reference set*\|<br>• 929360071000036103 \|*Medicinal product unit of use reference set*\|<br>• 929360021000036102 \|*Trade product reference set*\|<br>• 929360041000036105 \|*Trade product pack reference set*\|<br>• 929360031000036100 \|*Trade product unit of use reference set*\|<br>• 929360051000036108 \|*Contained trade product pack reference set*\| | See <code> for available attributes. |
| Known Medication (MEDICATION INSTRUCTION) > **Directions** | A complete narrative description of how much, when and how to use the medicine, vaccine or other therapeutic good. | 1..1 | entry[med_inst]/substanceAdministration/**text:ST** | | |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| Known Medication (MEDICATION INSTRUCTION) > **Clinical Indication** | A reason for ordering the medicine, vaccine or other therapeutic good. | 0..1 | entry[med_inst]/substanceAdministration/**entryRelationship[cln_ind]/@typeCode="RSON"** | | |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/**act** | | |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/**@classCode="INFRM"** | | |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/**@moodCode="EVN"** | | |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/**code** | | |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/code/**@code="103.10141"** | | |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/code/**@displayName="Clinical Indication"** | | |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/**text:ST** | | |
| Known Medication (MEDICATION INSTRUCTION) > **Medication Instruction Comment** | Any additional information that may be needed to ensure the continuity of supply, rationale for current dose and timing, or safe and appropriate use. | 0..1 | entry[med_inst]/substanceAdministration/**entryRelationship[cmts]/@typeCode="COMP"** | | |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cmts]/**act** | | |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/**@classCode="INFRM"** | | |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/**@moodCode="EVN"** | | |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/**code** | | |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/code/**@code="103.16044"** | | |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/code/**@displayName="Additional Comments"** | | |
| | | | entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/**text:ST** | | |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| Known Medication (MEDICATION INSTRUCTION) > **Detailed Clinical Model Identifier** | A globally unique identifier for this Detailed Clinical Model. | 1..1 | n/a | | Not mapped directly, encompassed implicitly by CDA® in entry[med_inst]/substanceAdministration. |

## Example 7.7. Known Medication (MEDICATION INSTRUCTION) XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin CDA Header -->
   …
   <!-- End CDA Header -->

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

         <!-- Begin Medications (MEDICATION ORDERS) -->
         <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin Known Medication (MEDICATION INSTRUCTION) -->
     <entry>
      <substanceAdministration classCode="SBADM" moodCode="EVN">
       <!-- Medication Instruction Instance Identifier -->
       <id root="461B6EF6-754C-11E0-A3C3-D19F4824019B" />

       <!-- Directions -->
       <text xsi:type="ST">2 tablets daily after breakfast</text>

       <consumable>
        <manufacturedProduct>
         <manufacturedMaterial>
          <!-- Medicine (Therapeutic Good Identification) -->
          <code code="6647011000036101"
           codeSystem="2.16.840.1.113883.6.96"
           codeSystemName="SNOMED CT"
           displayName="Panadeine Forte tablet: uncoated" />
         </manufacturedMaterial>
        </manufacturedProduct>
       </consumable>

       <!-- Begin Clinical Indication -->
       <entryRelationship typeCode="RSON">
        <act classCode="INFRM" moodCode="EVN">
         <code code="103.10141"
          codeSystem="1.2.36.1.2001.1001.101"
          codeSystemName="NCTIS Data Components"
          displayName="Clinical Indication" />
         <text xsi:type="ST">Pain control.</text>
        </act>
       </entryRelationship>
       <!-- End Clinical Indication -->
```

```
      <!-- Begin Comment -->
      <entryRelationship typeCode="COMP">
       <act classCode="INFRM" moodCode="EVN">
        <code code="103.16044"
         codeSystem="1.2.36.1.2001.1001.101"
         codeSystemName="NCTIS Data Components"
         displayName="Additional Comments" />
        <text xsi:type="ST">Dosage to be reviewed in 10 days.</text>
       </act>
      </entryRelationship>
      <!-- End Comment -->
     </substanceAdministration>
    </entry>
    <!-- End Known Medication (MEDICATION INSTRUCTION) -->

   </section>
  </component>
       <!-- End Medications (MEDICATION ORDERS) -->

       …

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

# 7.1.3 Past and Current Medical History (MEDICAL HISTORY)

## Identification

| | |
|---|---|
| **Name** | Past and Current Medical History (MEDICAL HISTORY) |
| **Metadata Type** | Section |
| **Identifier** | S-16117 |

## Relationships

### Parent

| Data Type | Name | Occurrences (child within parent) |
|---|---|---|
|  | Shared Health Summary | 1..1 |

### Children

| Data Type | Name | Occurrence |
|---|---|---|
|  | PROBLEM/DIAGNOSIS | 0..* |
|  | EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES | 0..1 |
|  | PROCEDURE | 0..* |
|  | EXCLUSION STATEMENT - PROCEDURES | 0..1 |
|  | UNCATEGORISED MEDICAL HISTORY ITEM | 0..* |

# CDA® R-MIM Representation

Figure 7.8 Past and Current Medical History (MEDICAL HISTORY) shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

The Past and Current Medical History (MEDICAL HISTORY) section is composed of a Section class related to its context ClinicalDocument.structuredBody by a component.

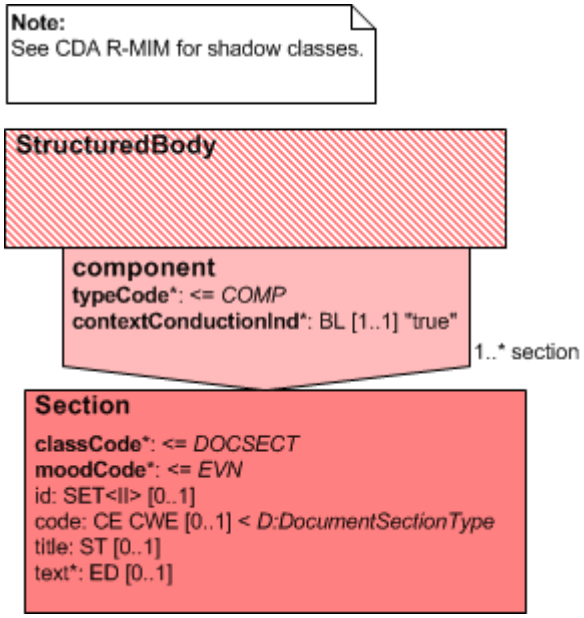


**Figure 7.8. Past and Current Medical History (MEDICAL HISTORY)**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 2 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/ | | |
| **Past and Current Medical History (MEDICAL HISTORY)** | The history of the subject of care's problems, diagnoses and medical or surgical procedures. | 1..1 | component[med_hist]/**section** | | Each instance of this component[med_hist] that contains an instance of UNCATEGORISED MEDICAL HISTORY ITEM **SHALL NOT** contain an instance of:<br>• EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES, or<br>• EXCLUSION STATEMENT - PROCEDURES.<br>Each instance of this component[med_hist] that does not contain an instance of UNCATEGORISED MEDICAL HISTORY ITEM **SHALL** contain:<br>• an instance of PROBLEM/DIAGNOSIS or EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES(but not both), and<br>• an instance of PROCEDURE or EXCLUSION STATEMENT - PROCEDURES (but not both). |
| | | | component[med_hist]/section/**title="Medical History"** | | |
| | | | component[med_hist]/section/**text** | | Required CDA® element.<br>See Appendix A, *CDA® Narratives*. |
| Past and Current Medical History (MEDICAL HISTORY) > **Medical History Instance Identifier** | A globally unique identifier for each instance of a Medical History section. | 0..1 | component[med_hist]/section/**id** | UUID<br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| Past and Current Medical History (MEDICAL HISTORY) > **Section Type** | Type of section. | 1..1 | component[med_hist]/section/**code** | | |
| | | | component[med_hist]/section/code/**@code="101.16117"** | | |
| | | | component[med_hist]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | component[med_hist]/section/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | component[med_hist]/section/code/**@displayName="Medical History"** | | |
| Past and Current Medical History (MEDICAL HISTORY) > **PROBLEM/DIAGNOSIS** | A health condition that, as determined by a clinician, may have impact on the physical, mental or social well-being of a person. A diagnosis is determined by scientific evaluation of pathological and pathophysiological findings identified from the patient's clinical history, family history, physical examination and diagnostic investigations. | 0..* | See: PROBLEM/DIAGNOSIS | | |
| Past and Current Medical History (MEDICAL HISTORY) > **EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES** | Statements which positively assert that the patient does not have the problem or diagnosis. | 0..1 | See: EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES | | |
| Past and Current Medical History (MEDICAL HISTORY) > **PROCEDURE** | A clinical activity carried out for therapeutic, evaluative, investigative, screening or diagnostic purposes. | 0..* | See: PROCEDURE | | |
| Past and Current Medical History (MEDICAL HISTORY) > **EXCLUSION STATEMENT - PROCEDURES** | Statements to positively assert that a certain procedure has not been performed on the patient. | 0..1 | See: EXCLUSION STATEMENT - PROCEDURES | | |
| Past and Current Medical History (MEDICAL HISTORY) > **UNCATEGORISED MEDICAL HISTORY ITEM** | A medical history entry that has not been categorised as either Procedure or Problem/Diagnosis. | 0..* | See: UNCATEGORISED MEDICAL HISTORY ITEM | | |

## Example 7.8. Past and Current Medical History (MEDICAL HISTORY) XML Fragment

```
     <!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin CDA Header -->
   …
   <!-- End CDA Header -->

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

         <!-- Begin Past and Current Medical History (MEDICAL HISTORY) -->
         <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     <!-- Medical History Instance Identifier -->
     <id root="50846572-EFC7-11E0-8337-65094944019B" />
     <!-- Section Type -->
     <code code="101.16117"
      codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components"
      displayName="Medical History" />

     <title>Medical History</title>
     <!-- Narrative text -->
     <text>Narrative.</text>

     <!-- NOTE: All child component sections are shown for illustrative purpose only. Normative constraints on the contents of this component[med_hist]/section are specified in the mapping table. -->
     <!-- Begin PROBLEM/DIAGNOSIS -->
     <entry>
      <observation>
       …
      </observation>
     </entry>
     <!-- End PROBLEM/DIAGNOSIS -->

     <!-- Begin EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES -->
     <entry>
      <observation>
       …
      </observation>
     </entry>
     <!-- End EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES -->

     <!-- Begin PROCEDURE -->
     <entry>
      <procedure>
       …
      </procedure>
```

```
    </entry>
    <!-- End PROCEDURE -->

    <!-- Begin EXCLUSION STATEMENT - PROCEDURES -->
    <entry>
     <observation>
      …
     </observation>
    </entry>
    <!-- End EXCLUSION STATEMENT - PROCEDURES -->

    <!-- Begin UNCATEGORISED MEDICAL HISTORY ITEM -->
    <entry>
     <act>
      …
     </act>
    </entry>
    <!-- End UNCATEGORISED MEDICAL HISTORY ITEM -->
   </section>
  </component>
       <!-- End Past and Current Medical History (MEDICAL HISTORY) -->

       …

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

# 7.1.3.1 PROBLEM/DIAGNOSIS

## Identification

| | |
|---|---|
| **Name** | PROBLEM/DIAGNOSIS |
| **Metadata Type** | Data Group |
| **Identifier** | DG-15530 |

## Relationships

### Parent

| Data Type | Name | Occurrences (child within parent) |
|---|---|---|
|  | Past and Current Medical History (MEDICAL HISTORY) | 0..* |

## CDA® R-MIM Representation

Figure 7.9 PROBLEM/DIAGNOSIS shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

The PROBLEM/DIAGNOSIS data group is represented by an Observation class related to its containing Section class by an entry. The value attribute of that Observation class represents Problem/Diagnosis Identification, and the effectiveTime attribute represents Date of Onset.

Date of Resolution/Remission is mapped to an Observation class related to its containing Observation (PROBLEM/DIAGNOSIS) class by an entryRelationship. Problem/Diagnosis Comment is represented by an Act class related to its containing Observation (PROBLEM/DIAGNOSIS) class by an entryRelationship.

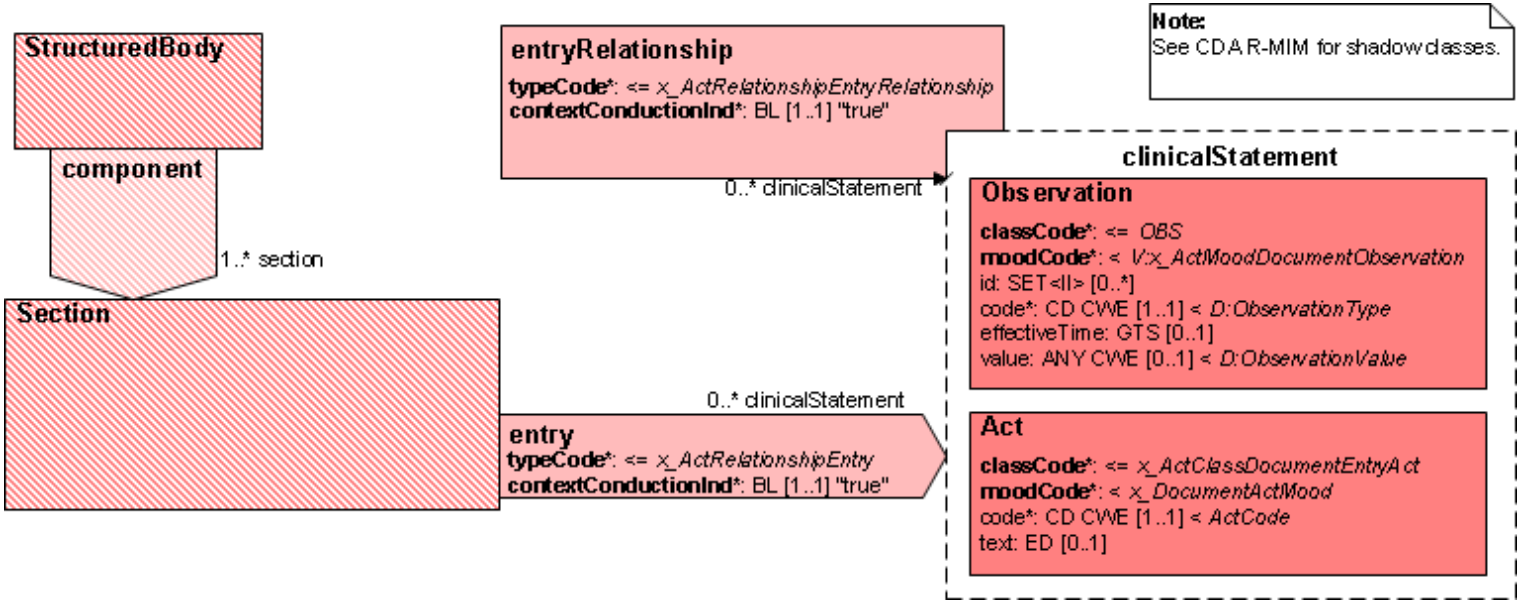


**Figure 7.9. PROBLEM/DIAGNOSIS**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 3 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/component[med_hist]/section/ | | |
| **PROBLEM/DIAGNOSIS** | A health condition that, as determined by a clinician, may have impact on the physical, mental or social well-being of a person. A diagnosis is determined by scientific evaluation of pathological and pathophysiological findings identified from the patient's clinical history, family history, physical examination and diagnostic investigations. | 0..* | **entry[prob]** | | |
| | | | entry[prob]/**observation** | | |
| | | | entry[prob]/observation/**@classCode="OBS"** | | |
| | | | entry[prob]/observation/**@moodCode="EVN"** | | |
| PROBLEM/DIAGNOSIS > **Problem/Diagnosis Instance Identifier** | A globally unique object identifier for each instance of a Problem/Diagnosis evaluation. | 1..1 | entry[prob]/observation/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| PROBLEM/DIAGNOSIS > **Detailed Clinical Model Identifier** | A globally unique identifier for this Detailed Clinical Model. | 1..1 | entry[prob]/observation/**code** | | |
| | | | entry[prob]/observation/code/**@code="282291009"** | | |
| | | | entry[prob]/observation/code/**@codeSystem="2.16.840.1.113883.6.96"** | | |
| | | | entry[prob]/observation/code/**@codeSystemName** | The value **SHOULD** be "SNOMED CT".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[prob]/observation/code/**@displayName="Diagnosis interpretation"** | | |
| PROBLEM/DIAGNOSIS > **Problem/Diagnosis Identification** | Identification of the problem or diagnosis. | 1..1 | entry[prob]/observation/**value:CD** | SNOMED CT-AU:<br>• 32570581000036105 \|*Problem/Diagnosis reference set*\| | See <code> for available attributes. |
| PROBLEM/DIAGNOSIS > **Date of Onset** | Estimated or actual date the problem or diagnosis began, as indicated or identified by the clinician. | 0..1 | entry[prob]/observation/**effectiveTime** | | The value **SHALL NOT** include a time.<br><br>See <time> for available attributes. |
| | | | entry[prob]/observation/effectiveTime/**low** | | |
| | | | entry[prob]/observation/effectiveTime/low/**@value** | | |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| PROBLEM/DIAGNOSIS > **Date of Resolution/Remission** | Estimated or actual date the problem or diagnosis resolved or went into remission, as indicated or identified by the clinician. | 0..1 | entry[prob]/observation/**entryRelationship[crt]/@typeCode="SUBJ"** | | |
| | | | entry[prob]/observation/entryRelationship[crt]/observation/**@classCode="OBS"** | | |
| | | | entry[prob]/observation/entryRelationship[crt]/observation/**@moodCode="EVN"** | | |
| | | | entry[prob]/observation/entryRelationship[crt]/observation/code/**@code="103.15510"** | | |
| | | | entry[prob]/observation/entryRelationship[crt]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[prob]/observation/entryRelationship[crt]/observation/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[prob]/observation/entryRelationship[crt]/observation/code/**@displayName="Date of Resolution/Remission"** | | |
| | | | entry[prob]/observation/entryRelationship[crt]/observation/**value:IVL_TS** | | The value **SHALL NOT** include a time.<br><br>See <time> for available attributes. |
| PROBLEM/DIAGNOSIS > **Problem/Diagnosis Comment** | Additional narrative about the problem or diagnosis not captured in other fields. | 0..1 | entry[prob]/observation/**entryRelationship[cmt]/@typeCode="COMP"** | | |
| | | | entry[prob]/observation/entryRelationship[cmt]/**act** | | |
| | | | entry[prob]/observation/entryRelationship[cmt]/act/**@classCode="INFRM"** | | |
| | | | entry[prob]/observation/entryRelationship[cmt]/act/**@moodCode="EVN"** | | |
| | | | entry[prob]/observation/entryRelationship[cmt]/act/**code** | | |
| | | | entry[prob]/observation/entryRelationship[cmt]/act/code/**@code="103.16545"** | | |
| | | | entry[prob]/observation/entryRelationship[cmt]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[prob]/observation/entryRelationship[cmt]/act/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[prob]/observation/entryRelationship[cmt]/act/code/**@displayName="Problem/Diagnosis Comment"** | | |
| | | | entry[prob]/observation/entryRelationship[cmt]/act/**text:ST** | | |

## Example 7.9. PROBLEM/DIAGNOSIS XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin CDA Header -->
   …
   <!-- End CDA Header -->

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

         <!-- Begin Past and Current Medical History (MEDICAL HISTORY) -->
         <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- NOTE: Though no other child component sections are shown the normative constraints on the contents of this component[med_hist]/section are specified in the mapping table. -->
     <!-- Begin PROBLEM/DIAGNOSIS -->
     <entry>
      <observation classCode="OBS" moodCode="EVN">
       <!-- Problem/Diagnosis Instance Identifier -->
       <id root="74D29C88-706E-11E0-9726-5ABE4824019B" />
       <!-- Detailed Clinical Model Identifier -->
       <code code="282291009"
        codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMED CT"
        displayName="Diagnosis interpretation" />

       <!-- Date of Onset -->
       <effectiveTime>
        <low value="20110410" />
       </effectiveTime>

       <!-- Problem/Diagnosis Identification -->
       <value code="85189001"
        codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMED CT"
        displayName="Acute appendicitis" xsi:type="CD" />

       <!-- Begin Date of Resolution/Remission -->
       <entryRelationship typeCode="SUBJ">
        <observation classCode="OBS" moodCode="EVN">
         <code code="103.15510"
          codeSystem="1.2.36.1.2001.1001.101"
          codeSystemName="NCTIS Data Components"
          displayName="Date of Resolution/Remission" />
         <value value="27042011" xsi:type="IVL_TS" />
        </observation>
```

```
      </entryRelationship>
      <!-- End Date of Resolution/Remission -->

      <!-- Begin Problem/Diagnosis Comment -->
      <entryRelationship typeCode="COMP">
       <act classCode="INFRM" moodCode="EVN">
        <code code="103.16545"
         codeSystem="1.2.36.1.2001.1001.101"
         codeSystemName="NCTIS Data Components"
         displayName="Problem/Diagnosis Comment" />
        <text xsi:type="ST">Problem/Diagnosis Comment goes here.</text>
       </act>
      </entryRelationship>
      <!-- End Problem/Diagnosis Comment -->

     </observation>
    </entry>
    <!-- End PROBLEM/DIAGNOSIS -->
    …

   </section>
  </component>
       <!-- End Past and Current Medical History (MEDICAL HISTORY) -->

       …

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

# 7.1.3.2 EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES

## Identification

| | |
|---|---|
| **Name** | EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16138 |

## Relationships

### Parent

| Data Type | Name | Occurrences (child within parent) |
|---|---|---|
|  | Past and Current Medical History (MEDICAL HISTORY) | 0..1 |

## CDA® R-MIM Representation

Figure 7.10 EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

The EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES data group is represented by an Observation class that is related to its containing Section class by an entry.

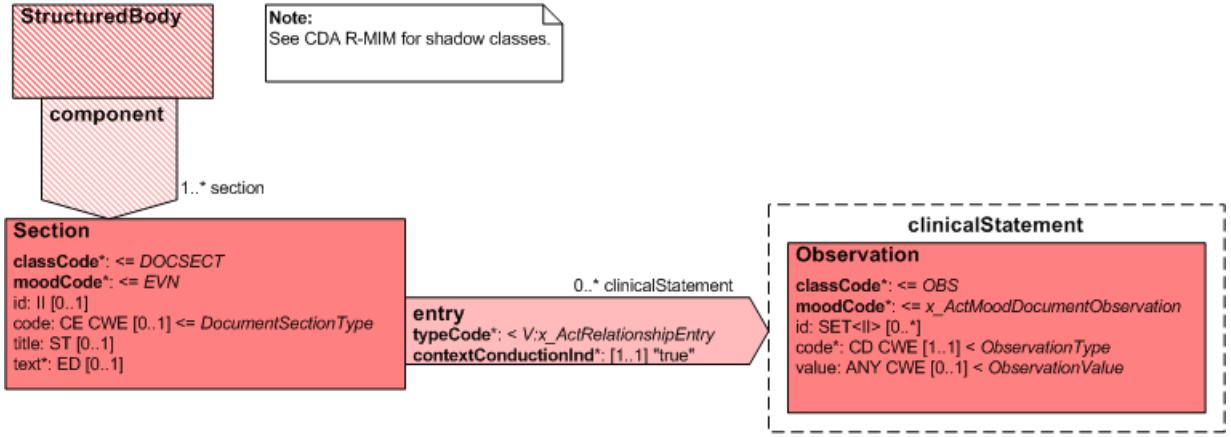


**Figure 7.10. EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 3 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/component[med_hist]/section/ | | |
| **EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES** | Statements which positively assert that the patient does not have the problem or diagnosis. | 0..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>The cardinality of this component propagates to its children.<br><br>See Known Issues. |
| EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES > **Global Statement** | The statement about the absence or exclusion. | 1..1 | **entry[gbl_prob]** | | |
| | | | entry[gbl_prob]/**observation** | | |
| | | | entry[gbl_prob]/observation/**@classCode="OBS"** | | |
| | | | entry[gbl_prob]/observation/**@moodCode="EVN"** | | |
| | | | entry[gbl_prob]/observation/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | Optional CDA® element.<br><br>See <id> for available attributes. |
| | | | entry[gbl_prob]/observation/**code** | | |
| | | | entry[gbl_prob]/observation/code/**@code="103.16302.120.1.3"** | | |
| | | | entry[gbl_prob]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[gbl_prob]/observation/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[gbl_prob]/observation/code/**@displayName="Global Statement"** | | |
| | | | entry[gbl_prob]/observation/**value:CD** | NCTIS: Admin Codes - Global Statement Values<br><br>The value/@code **SHALL NOT** be "02". | See <code> for available attributes. |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES > **Detailed Clinical Model Identifier** | A globally unique identifier for this Detailed Clinical Model. | 1..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>See Known Issues. |

## Example 7.10. EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin CDA Header -->
   …
   <!-- End CDA Header -->

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

         <!-- Begin Past and Current Medical History (MEDICAL HISTORY) -->
         <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- NOTE: Though no other child component sections are shown the normative constraints on the contents of this component[med_hist]/section are specified in the mapping table. -->
     <!-- Begin EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES -->
     <entry>
      <!-- Begin Global Statement -->
      <observation classCode="OBS" moodCode="EVN">
       <!-- ID is used for system purposes such as matching -->
       <id root="55d57cf0-2c70-11f2-81c1-0801600c9a66" />
       <code code="103.16302.120.1.3" codeSystem="1.2.36.1.2001.1001.101"
        codeSystemName="NCTIS Data Components"
        displayName="Global Statement" />
       <value code="01" codeSystem="1.2.36.1.2001.1001.101.104.16299"
        codeSystemName="NCTIS Global Statement Values"
        displayName="None known" xsi:type="CD" />
      </observation>
      <!-- End Global Statement -->
     </entry>
     <!-- End EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES -->
     …

    </section>
   </component>
         <!-- End Past and Current Medical History (MEDICAL HISTORY) -->

         …

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

# 7.1.3.3 PROCEDURE

## Identification

| | |
|---|---|
| **Name** | Procedure |
| **Metadata Type** | Data Group |
| **Identifier** | DG-15514 |

## Relationships

### Parent

| Data Type | Name | Occurrences (child within parent) |
|---|---|---|
|  | Past and Current Medical History (MEDICAL HISTORY) | 0..* |

## CDA® R-MIM Representation

Figure 7.11 PROCEDURE shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

The PROCEDURE data group is described by a Procedure class related to its containing Section class by an entry. The code attribute of that Procedure class represents Procedure Name, and the effectiveTime attribute represents Procedure DateTime. Procedure Comment is represented by an Act class related to its containing Procedure class by an entryRelationship.

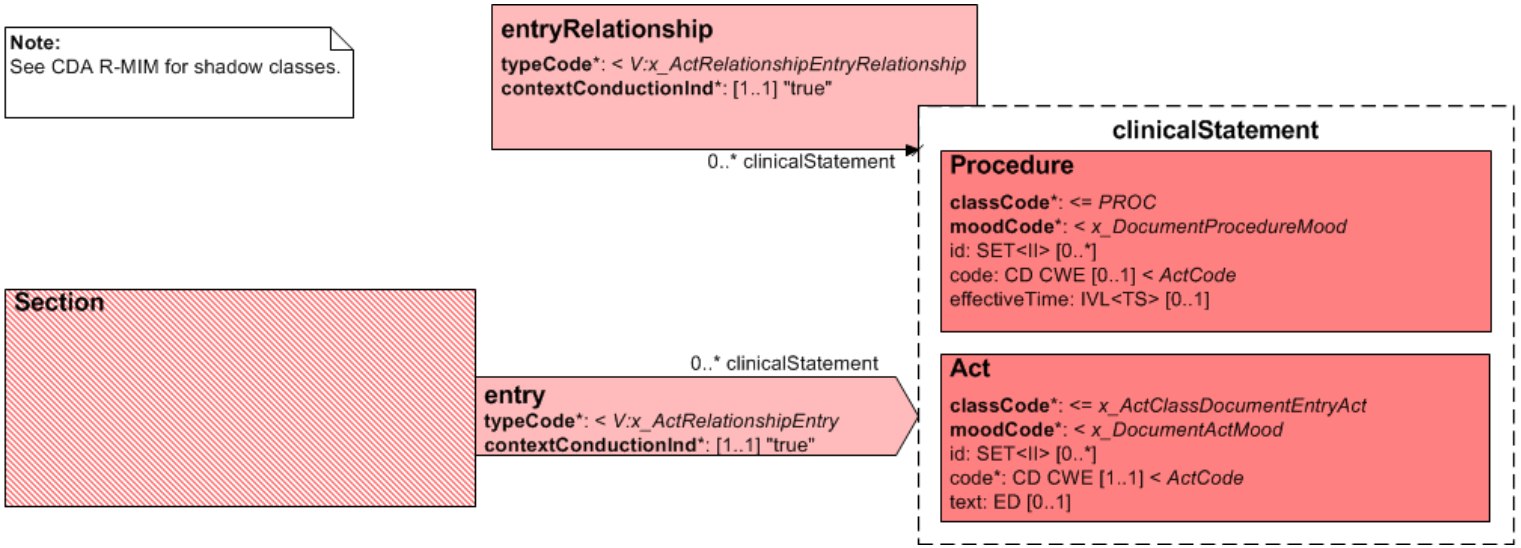


**Figure 7.11. PROCEDURE**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 3 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/component[med_hist]/section/ | | |
| **PROCEDURE** | A clinical activity carried out for therapeutic, evaluative, investigative, screening or diagnostic purposes. | 0..* | **entry[proc]** | | |
| | | | entry[proc]/procedure | | |
| | | | entry[proc]/procedure/**@classCode="PROC"** | | |
| | | | entry[proc]/procedure/**@moodCode="EVN"** | | |
| PROCEDURE > **Procedure Instance Identifier** | A globally unique identifier for each instance of a Procedure action. | 1..1 | entry[proc]/procedure/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| PROCEDURE > **Procedure Name** | The name of the procedure (to be) performed. | 1..1 | entry[proc]/procedure/**code** | SNOMED CT-AU:<br><br>• 32570141000036105 \|*Procedure foundation reference set*\| | See <code> for available attributes. |
| PROCEDURE > **Procedure Comment** | Additional narrative about the procedure not captured in other fields. | 0..1 | entry[proc]/procedure/entryRelationship[proc_cmt]/**@typeCode="COMP"** | | |
| | | | entry[proc]/procedure/entryRelationship[proc_cmt]/**act** | | |
| | | | entry[proc]/procedure/entryRelationship[proc_cmt]/act/**@classCode="INFRM"** | | |
| | | | entry[proc]/procedure/entryRelationship[proc_cmt]/act/**@moodCode="EVN"** | | |
| | | | entry[proc]/procedure/entryRelationship[proc_cmt]/act/**code** | | |
| | | | entry[proc]/procedure/entryRelationship[proc_cmt]/act/code/**@code="103.15595"** | | |
| | | | entry[proc]/procedure/entryRelationship[proc_cmt]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[proc]/procedure/entryRelationship[proc_cmt]/act/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[proc]/procedure/entryRelationship[proc_cmt]/act/code/**@displayName="Procedure Comment"** | | |
| | | | entry[proc]/procedure/entryRelationship[proc_cmt]/act/**text:ST** | | |
| PROCEDURE > **Procedure DateTime** | The date range during which the Procedure action occurred. | 1..1 | entry[proc]/procedure/**effectiveTime** | | See <time> for available attributes. |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| PROCEDURE > **Detailed Clinical Model Identifier** | A globally unique identifier for this Detailed Clinical Model. | 1..1 | n/a | | Not mapped directly, encompassed implicitly by CDA® in entry[proc]/procedure. |

## Example 7.11. PROCEDURE XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin CDA Header -->
   …
   <!-- End CDA Header -->

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

         <!-- Begin Past and Current Medical History (MEDICAL HISTORY) -->
         <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- NOTE: Though no other child component sections are shown the normative constraints on the contents of this component[med_hist]/section are specified in the mapping table. -->
     <!-- Begin PROCEDURE -->
     <entry>
      <procedure classCode="PROC" moodCode="EVN">
       <!-- Procedure Instance Identifier -->
       <id root="B96A38C6-706C-11E0-AD2E-42BC4824019B" />

       <!-- Procedure Name -->
       <code code="80146002"
        codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMED CT"
        displayName="Appendicectomy" />

       <!-- Begin Procedure DateTime -->
       <effectiveTime xsi:type="IVL_TS">
        <low value="20130101"/>
        <high value="20130201"/>
       </effectiveTime>
       <!-- End Procedure DateTime -->

       <!-- Begin Procedure Comment -->
       <entryRelationship typeCode="COMP">
        <act classCode="INFRM" moodCode="EVN">
         <code code="103.15595"
          codeSystem="1.2.36.1.2001.1001.101"
          codeSystemName="NCTIS Data Components"
          displayName="Procedure Comment" />
         <text xsi:type="ST">Procedure Comment goes here.</text>
        </act>
       </entryRelationship>
       <!-- End Procedure Comment -->
```

```
      </procedure>
     </entry>
     <!-- End PROCEDURE -->
     …

    </section>
   </component>
         <!-- End Past and Current Medical History (MEDICAL HISTORY) -->

         …

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

# 7.1.3.4 EXCLUSION STATEMENT - PROCEDURES

## Identification

| | |
|---|---|
| **Name** | EXCLUSION STATEMENT - PROCEDURES |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16603 |

## Relationships

### Parent

| Data Type | Name | Occurrences (child within parent) |
|---|---|---|
|  | Past and Current Medical History (MEDICAL HISTORY) | 0..1 |

## CDA® R-MIM Representation

Figure 7.12 EXCLUSION STATEMENT - PROCEDURES shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

The EXCLUSION STATEMENT - PROCEDURES data group is represented by an Observation class that is related to its containing Section class by an entry.

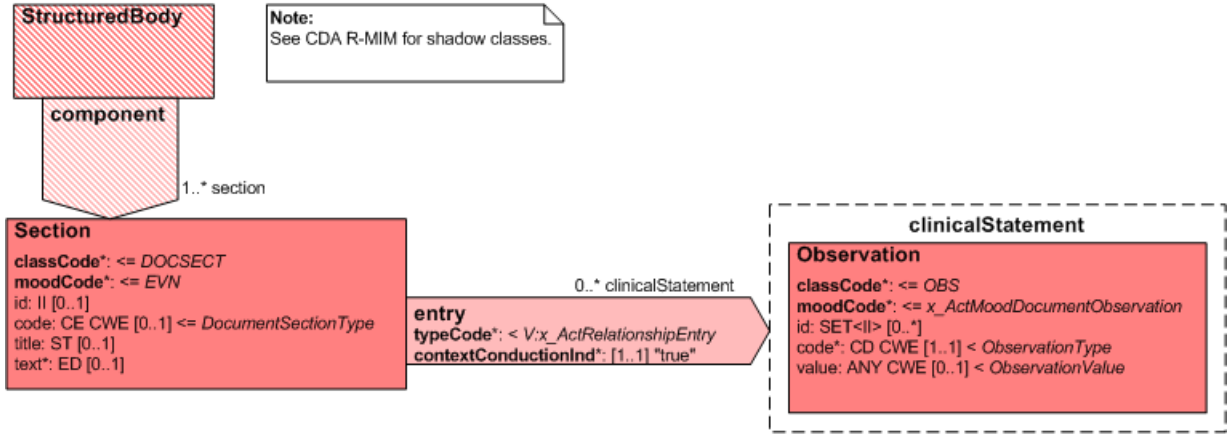


**Figure 7.12. EXCLUSION STATEMENT - PROCEDURES**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 3 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/component[med_hist]/section/ | | |
| **EXCLUSION STATEMENT - PROCEDURES** | Statements to positively assert that a certain procedure has not been performed on the patient. | 0..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>The cardinality of this component propagates to its children.<br><br>See Known Issues. |
| EXCLUSION STATEMENT - PROCEDURES > **Global Statement** | The statement about the absence or exclusion of procedure performed on the patient. | 1..1 | **entry[gbl_pro]** | | |
| | | | entry[gbl_pro]/**observation** | | |
| | | | entry[gbl_pro]/observation/**@classCode="OBS"** | | |
| | | | entry[gbl_pro]/observation/**@moodCode="EVN"** | | |
| | | | entry[gbl_pro]/observation/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | Optional CDA® element.<br><br>See <id> for available attributes. |
| | | | entry[gbl_pro]/observation/**code** | | |
| | | | entry[gbl_pro]/observation/code/**@code="103.16302.120.1.4"** | | |
| | | | entry[gbl_pro]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[gbl_pro]/observation/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[gbl_pro]/observation/code/**@displayName="Global Statement"** | | |
| | | | entry[gbl_pro]/observation/**value:CD** | NCTIS: Admin Codes - Global Statement Values<br><br>The value/@code **SHALL NOT** be "02". | See <code> for available attributes. |
| EXCLUSION STATEMENT - PROCEDURES > **Detailed Clinical Model Identifier** | A globally unique identifier for this Detailed Clinical Model. | 1..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>See Known Issues. |

## Example 7.12. EXCLUSION STATEMENT - PROCEDURES XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin CDA Header -->
   …
   <!-- End CDA Header -->

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

         <!-- Begin Past and Current Medical History (MEDICAL HISTORY) -->
         <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- NOTE: Though no other child component sections are shown the normative constraints on the contents of this component[med_hist]/section are specified in the mapping table. -->
     <!-- Begin EXCLUSION STATEMENT - PROCEDURES -->
     <entry>
      <!-- Begin Global Statement -->
      <observation classCode="OBS" moodCode="EVN">
       <!-- ID is used for system purposes such as matching -->
       <id root="55d57cf0-2d70-11f2-81c1-0801600c9a66" />
       <code code="103.16302.120.1.4" codeSystem="1.2.36.1.2001.1001.101"
        codeSystemName="NCTIS Data Components"
        displayName="Global Statement" />
       <value code="01" codeSystem="1.2.36.1.2001.1001.101.104.16299"
        codeSystemName="NCTIS Global Statement Values"
        displayName="None known" xsi:type="CD" />
      </observation>
      <!-- End Global Statement -->
     </entry>
     <!-- End EXCLUSION STATEMENT - PROCEDURES -->
     …

    </section>
   </component>
         <!-- End Past and Current Medical History (MEDICAL HISTORY) -->

         …

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

# 7.1.3.5 UNCATEGORISED MEDICAL HISTORY ITEM

## Identification

| | |
|---|---|
| **Name** | UNCATEGORISED MEDICAL HISTORY ITEM |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16627 |

## Relationships

### Parent

| Data Type | Name | Occurrences (child within parent) |
|---|---|---|
|  | Past and Current Medical History (MEDICAL HISTORY) | 0..* |

## CDA® R-MIM Representation

Figure 7.13 UNCATEGORISED MEDICAL HISTORY ITEM shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

The UNCATEGORISED MEDICAL HISTORY ITEM data group is represented by an Act class related to its containing Section class by an entry relationship. The text attribute of that Act class represents Medical History Item Description, and the effectiveTime attribute represents Medical History Item TimeInterval. Medical History Item Comment is represented by an Act class related to its containing Act (UNCATEGORISED MEDICAL HISTORY ITEM) class by an entryRelationship.

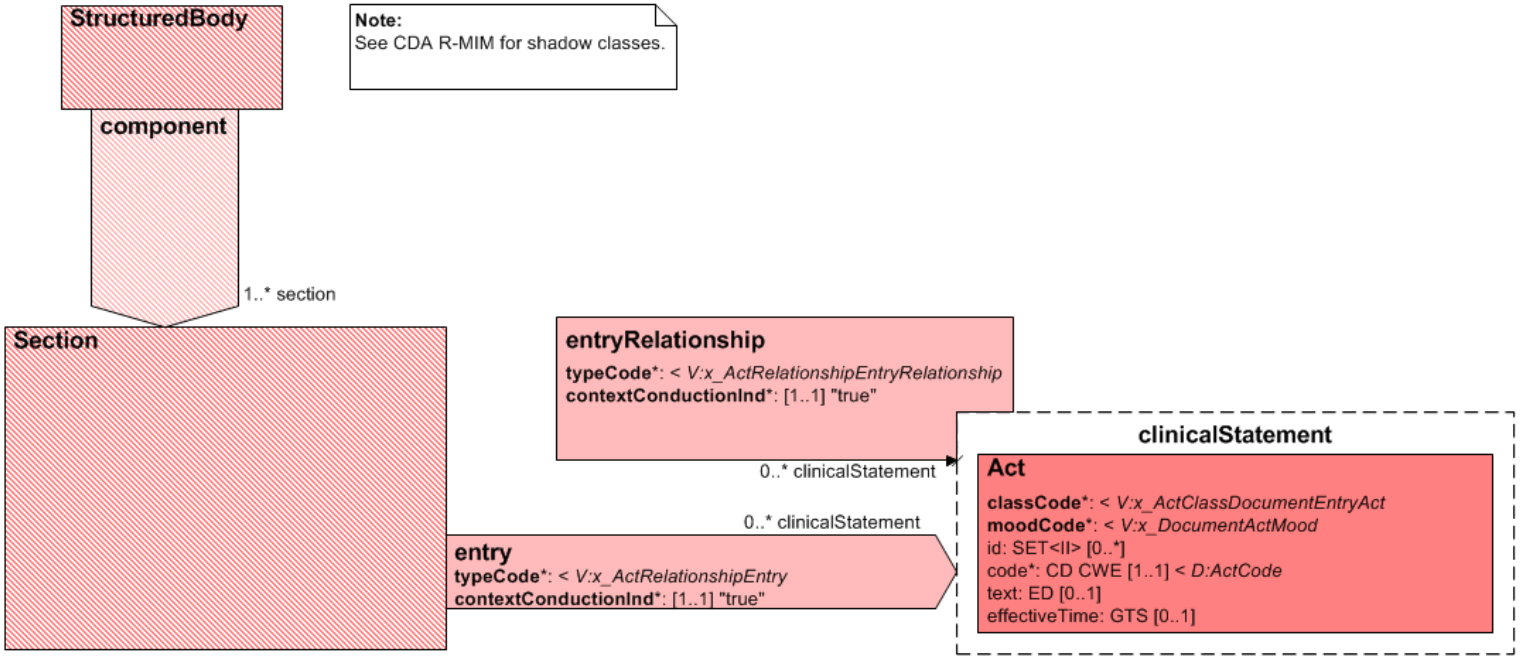


**Figure 7.13. UNCATEGORISED MEDICAL HISTORY ITEM**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 3 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/component[med_hist]/section/ | | |
| **UNCATEGORISED MEDICAL HISTORY ITEM** | A medical history entry that has not been categorised as either Procedure or Problem/Diagnosis. | 0..* | **entry[med_hist_item]** | | |
| | | | entry[med_hist_item]/**act** | | |
| | | | entry[med_hist_item]/act/**@classCode="ACT"** | | |
| | | | entry[med_hist_item]/act/**@moodCode="EVN"** | | |
| UNCATEGORISED MEDICAL HISTORY ITEM > **Uncategorised Medical History Item Instance Identifier** | A globally unique identifier for each instance of an Uncategorised Medical History Item evaluation. | 1..1 | entry[med_hist_item]/act/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| UNCATEGORISED MEDICAL HISTORY ITEM > **Detailed Clinical Model Identifier** | A globally unique identifier for this Detailed Clinical Model. | 1..1 | entry[med_hist_item]/act/**code** | | |
| | | | entry[med_hist_item]/act/code/**@code="102.16627"** | | |
| | | | entry[med_hist_item]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[med_hist_item]/act/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[med_hist_item]/act/code/**@displayName="Uncategorised Medical History Item"** | | |
| UNCATEGORISED MEDICAL HISTORY ITEM> **Medical History Item Description** | A description of the problem, diagnosis or procedure as a medical history item. | 1..1 | entry[med_hist_item]/act/**text:ST** | | |
| UNCATEGORISED MEDICAL HISTORY ITEM > **Medical History Item TimeInterval** | The date range during which the problem or diagnosis is applied or the procedure occurred. | 0..1 | entry[med_hist_item]/act/**effectiveTime** | | See <time> for available attributes. |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| UNCATEGORISED MEDICAL HISTORY ITEM > **Medical History Item Comment** | Additional narrative about the problem, diagnosis or procedure. | 0..1 | entry[med_hist_item]/act/entryRelationship[cmt]/**@typeCode="COMP"** | | |
| | | | entry[med_hist_item]/act/entryRelationship[cmt]/**act** | | |
| | | | entry[med_hist_item]/act/entryRelationship[cmt]/act/**@classCode="INFRM"** | | |
| | | | entry[med_hist_item]/act/entryRelationship[cmt]/act/**@moodCode="EVN"** | | |
| | | | entry[med_hist_item]/act/entryRelationship[cmt]/act/**code** | | |
| | | | entry[med_hist_item]/act/entryRelationship[cmt]/act/code/**@code="103.16630"** | | |
| | | | entry[med_hist_item]/act/entryRelationship[cmt]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[med_hist_item]/act/entryRelationship[cmt]/act/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[med_hist_item]/act/entryRelationship[cmt]/act/code/**@displayName="Medical History Item Comment"** | | |
| | | | entry[med_hist_item]/act/entryRelationship[cmt]/act/**text:ST** | | |

## Example 7.13. UNCATEGORISED MEDICAL HISTORY ITEM XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin CDA Header -->
   …
   <!-- End CDA Header -->

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

         <!-- Begin Past and Current Medical History (MEDICAL HISTORY) -->
         <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- NOTE: Though no other child component sections are shown the normative constraints on the contents of this component[med_hist]/section are specified in the mapping table. -->
     <!-- Begin UNCATEGORISED MEDICAL HISTORY ITEM -->
     <entry>
      <act classCode="ACT" moodCode="EVN">
       <!-- Uncategorised Medical History Item Instance Identifier -->
       <id root="0CBE0B42-7072-11E0-94B1-26C24824019B" />
       <!-- Detailed Clinical Model Identifier -->
       <code code="102.16627"
        codeSystem="1.2.36.1.2001.1001.101"
        codeSystemName="NCTIS Data Components"
        displayName="Uncategorised Medical History Item" />

       <!-- Medical History Item Description -->
       <text xsi:type="ST">Other Medical History Item Description goes here.</text>

       <!-- Begin Medical History Item Time Interval -->
       <effectiveTime>
        <low value="201010131000+1000" />
        <high value="201010131030+1000" />
       </effectiveTime>
       <!-- End Medical History Item Time Interval -->

       <!-- Begin Medical History Item Comment -->
       <entryRelationship typeCode="COMP">
        <act classCode="INFRM" moodCode="EVN">
         <code code="103.16630"
          codeSystem="1.2.36.1.2001.1001.101"
          codeSystemName="NCTIS Data Components"
          displayName="Medical History Item Comment" />
         <text xsi:type="ST">Medical History Item Comment goes here.</text>
        </act>
       </entryRelationship>
```

```
      <!-- End Medical History Item Comment -->

     </act>
    </entry>
    <!-- End UNCATEGORISED MEDICAL HISTORY ITEM -->
    …

   </section>
  </component>
       <!-- End Past and Current Medical History (MEDICAL HISTORY) -->

       …

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

# 7.1.4 IMMUNISATIONS

## Identification

| | |
|---|---|
| **Name** | IMMUNISATIONS |
| **Metadata Type** | Section |
| **Identifier** | S-16638 |

## Relationships

### Parent

| Data Type | Name | Occurrences (child within parent) |
|---|---|---|
|  | Shared Health Summary | 1..1 |

### Children

| Data Type | Name | Occurrence |
|---|---|---|
|  | Administered Immunisation (MEDICATION ACTION) | 0..* |
|  | Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) | 0..1 |

# CDA® R-MIM Representation

Figure 7.14 IMMUNISATIONS shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

The IMMUNISATIONS section is composed of a Section class related to its context ClinicalDocument.structuredBody by a component.

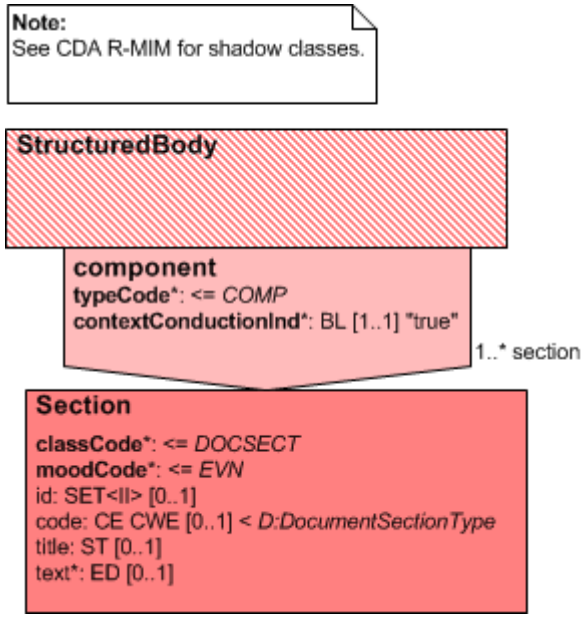


**Figure 7.14. IMMUNISATIONS**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 2 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/ | | |
| **IMMUNISATIONS** | Information about vaccines given to the subject of care. | 1..1 | component[imms]/**section** | | This component[imms] **SHALL NOT** contain both an instance of Administered Immunisation (MEDICATION ACTION) and an instance of Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS). |
| | | | component[imms]/section/**title="Immunisations"** | | |
| | | | component[imms]/section/**text** | | Required CDA® element.<br><br>See Appendix A, *CDA® Narratives*. |
| IMMUNISATIONS > **Immunisations Instance Identifier** | A globally unique identifier for each instance of an Immunisations section. | 0..1 | component[imms]/section/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| IMMUNISATIONS > **Section Type** | Type of section. | 1..1 | component[imms]/section/**code** | | |
| | | | component[imms]/section/code/**@code="101.16638"** | | |
| | | | component[imms]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | component[imms]/section/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | component[imms]/section/code/**@displayName="Immunisations"** | | |
| IMMUNISATIONS > **Administered Immunisation (MEDICATION ACTION)** | The act of administering a dose of a vaccine to a person for the purpose of preventing or minimising the effects of a disease by producing immunity or to counter the effects of an infectious organism. | 0..* | See: Administered Immunisation (MEDICATION ACTION) | | |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| IMMUNISATIONS > **Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS)** | Statements that positively assert that the patient has not received immunisations. | 0..1 | See: Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) | | |

## Example 7.14. IMMUNISATIONS XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin CDA Header -->
   …
   <!-- End CDA Header -->

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

         <!-- Begin IMMUNISATIONS -->
         <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     <!-- Immunisations Identifier -->
     <id root="9416d68a-2254-4e15-ad2f-4bda26ae652f" />
     <!-- Section Type -->
     <code code="101.16638" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Immunisations" />
     <title>Immunisations</title>
     <!-- Narrative text -->
     <text>Narrative.</text>

     <!-- Begin Administered Immunisation (MEDICATION ACTION) -->
     <entry>
      <substanceAdministration classCode="SBADM" moodCode="EVN">
       …
      </substanceAdministration>
     </entry>
     <!-- End Administered Immunisation (MEDICATION ACTION) -->

     <!-- NOTE: This Exclusion Statement is provided for illustrative purpose only. This section cannot contain both an entry for Exclusion Statement and any other entry. -->
     <!-- Begin Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) -->
     <entry>
      <observation>
       …
      </observation>
     </entry>
     <!-- End Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) -->
    </section>
   </component>
         <!-- End IMMUNISATIONS -->

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

# 7.1.4.1 Administered Immunisation (MEDICATION ACTION)

## Identification

| | |
|---|---|
| **Name** | Administered Immunisation (MEDICATION ACTION) |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16210 |

## Relationships

### Parent

| Data Type | Name | Occurrences (child within parent) |
|---|---|---|
|  | IMMUNISATIONS | 0..* |

## CDA® R-MIM Representation

Figure 7.15 Administered Immunisation (MEDICATION ACTION) shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

The Administered Immunisation (MEDICATION ACTION) data group is represented by a SubstanceAdministration class that is related to its containing Section class by an entry. The effectiveTime attribute of that SubstanceAdministration class represents Medication Action DateTime.

Therapeutic Good Identification is represented by the code attribute of manufacturedMaterial. Sequence Number is represented by the sequenceNumber attribute of an entryRelationship relating a Supply class to the containing SubstanceAdministration class.

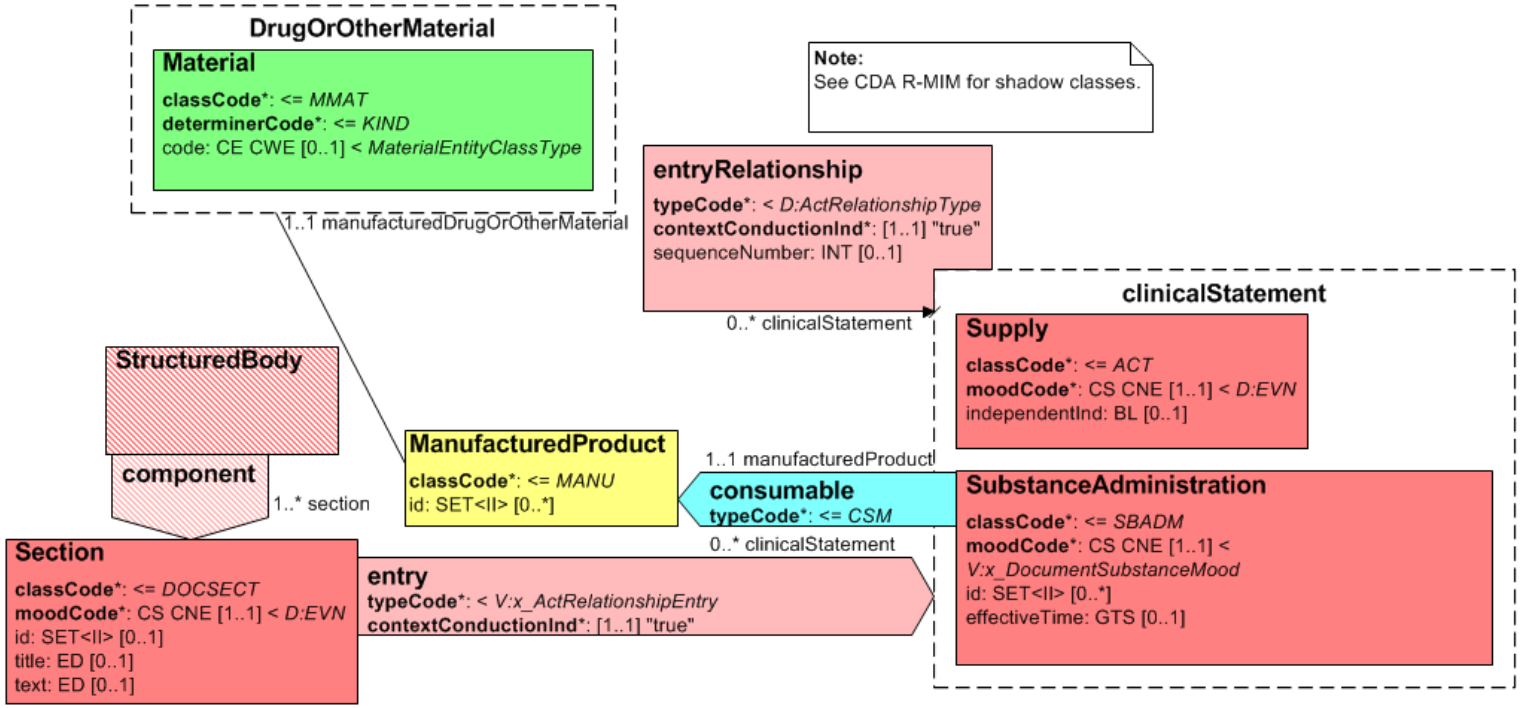


**Figure 7.15. Administered Immunisation (MEDICATION ACTION)**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 3 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/component[imms]/section/ | | |
| **Administered Immunisation (MEDICATION ACTION)** | The act of administering a dose of a vaccine to a person for the purpose of preventing or minimising the effects of a disease by producing immunity or to counter the effects of an infectious organism. | 0..* | entry[med_act] | | |
| | | | entry[med_act]/**substanceAdministration** | | |
| | | | entry[med_act]/substanceAdministration/**@classCode="SBADM"** | | |
| | | | entry[med_act]/substanceAdministration/**@moodCode="EVN"** | | |
| Administered Immunisation (MEDICATION ACTION) > **Medication Action Instance Identifier** | A globally unique identifier for each instance of Medication Action action. | 1..1 | entry[med_act]/substanceAdministration/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | See <id> for available attributes. |
| Administered Immunisation (MEDICATION ACTION) > **Therapeutic Good Identification** | The vaccine that was administered to or used by the subject of care. | 1..1 | entry[med_act]/substanceAdministration/**consumable/manufacturedProduct/manufacturedMaterial/code** | Australian Medicines Terminology (AMT):<br>• 929360061000036106 \|*Medicinal product reference set*\|<br>• 929360081000036101 \|*Medicinal product pack reference set*\|<br>• 929360071000036103 \|*Medicinal product unit of use reference set*\|<br>• 929360021000036102 \|*Trade product reference set*\|<br>• 929360041000036105 \|*Trade product pack reference set*\|<br>• 929360031000036100 \|*Trade product unit of use reference set*\|<br>• 929360051000036108 \|*Containered trade product pack reference set*\| | See <code> for available attributes. |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| Administered Immunisation (MEDICATION ACTION) > **Vaccine Sequence Number (Sequence Number)** | The sequence number specific to the action being recorded. | 0..1 | entry[med_act]/substanceAdministration/**entryRelationship[sply]/@typeCode="COMP"** | | |
| | | | entry[med_act]/substanceAdministration/entryRelationship[sply]/**sequenceNumber/@value** | | |
| | | | entry[med_act]/substanceAdministration/entryRelationship[sply]/**supply** | | |
| | | | entry[med_act]/substanceAdministration/entryRelationship[sply]/supply/**@classCode="SPLY"** | | |
| | | | entry[med_act]/substanceAdministration/entryRelationship[sply]/supply/**@moodCode="EVN"** | | |
| | | | entry[med_act]/substanceAdministration/entryRelationship[sply]/supply/**independentInd/@value="false"** | | |
| Administered Immunisation (MEDICATION ACTION) > **Medication Action DateTime** | Date, and optionally time, that the medication action is completed. | 1..1 | entry[med_act]/substanceAdministration/**effectiveTime** | | See <time> for available attributes. |
| Administered Immunisation (MEDICATION ACTION) > **Detailed Clinical Model Identifier** | A globally unique identifier for this Detailed Clinical Model. | 1..1 | n/a | | Not mapped directly, encompassed implicitly by CDA® in entry[med_act]/substanceAdministration. |

## Example 7.15. Administered Immunisation (MEDICATION ACTION) XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin CDA Header -->
   …
   <!-- End CDA Header -->

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

         <!-- Begin IMMUNISATIONS -->
         <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin Administered Immunisation (MEDICATION ACTION) -->
     <entry>
      <substanceAdministration classCode="SBADM" moodCode="EVN">
       <!-- Medication Action Instance Identifier -->
       <id root="C5F9D7BA-A2B3-11E0-9C5E-5D194924019B" />

       <!-- Medication Action DateTime -->
       <effectiveTime value="20110427" />
       <consumable>
        <manufacturedProduct>
         <manufacturedMaterial>
          <!-- Medicine (Therapeutic Good Identification) -->
          <code code="1625510000036100"
           codeSystem="2.16.840.1.113883.6.96"
           codeSystemName="SNOMED CT"
           displayName="Fluvax 2014 injection: suspension, 0.5 mL syringe" />
         </manufacturedMaterial>
        </manufacturedProduct>
       </consumable>

       <!-- Begin Vaccine Sequence Number (Sequence Number) -->
       <entryRelationship typeCode="COMP">
        <sequenceNumber value="123456" />
        <supply classCode="SPLY" moodCode="EVN">
         <independentInd value="false" />
        </supply>
       </entryRelationship>
       <!-- End Vaccine Sequence Number (Sequence Number) -->

      </substanceAdministration>
     </entry>
     <!-- End Administered Immunisation (MEDICATION ACTION) -->
```

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

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

# 7.1.4.2 Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS)

## Identification

| | |
|---|---|
| **Name** | Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) |
| **Metadata Type** | Data Group |
| **Identifier** | DG-16136 |

## Relationships

### Parent

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

## CDA® R-MIM Representation

Figure 7.6 Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) shows a subset of the CDA® R-MIM containing those classes being referred to in the CDA® Mapping. This data component maps to CDA® Body elements.

The Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) data group is represented by an Observation class that is related to its containing Section class by an entry.

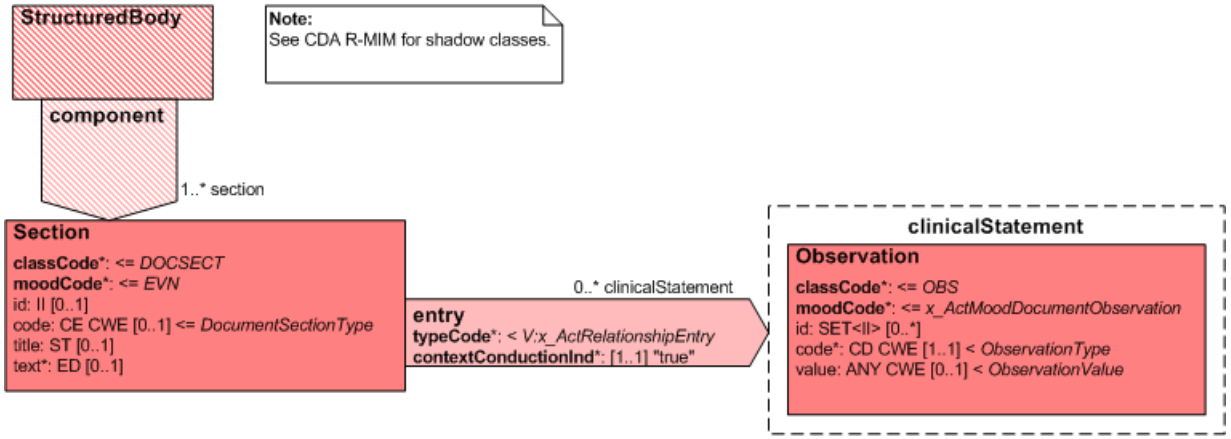


**Figure 7.16. Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS)**

# CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Body Level 3 Data Elements** | | | Context: ClinicalDocument/component/structuredBody/component[imms]/section/ | | |
| **Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS)** | Statements that positively assert that the patient has not received immunisations. | 0..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>The cardinality of this component propagates to its children.<br><br>See Known Issues. |
| Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) > **Global Statement** | The statement about the absence or exclusion of certain medication. | 1..1 | **entry[gbl_meds]** | | |
| | | | entry[gbl_meds]/**observation** | | |
| | | | entry[gbl_meds]/observation/**@classCode="OBS"** | | |
| | | | entry[gbl_meds]/observation/**@moodCode="EVN"** | | |
| | | | entry[gbl_meds]/observation/**id** | UUID<br><br>This is a technical identifier that is used for system purposes such as matching. If a suitable internal key is not available, a UUID **MAY** be used. | Optional CDA® element.<br><br>See <id> for available attributes. |
| | | | entry[gbl_meds]/observation/**code** | | |
| | | | entry[gbl_meds]/observation/code/**@code="103.16302.120.1.5"** | | |
| | | | entry[gbl_meds]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"** | | |
| | | | entry[gbl_meds]/observation/code/**@codeSystemName** | The value **SHOULD** be "NCTIS Data Components".<br><br>See CodeSystem OIDs. | Optional CDA® element. |
| | | | entry[gbl_meds]/observation/code/**@displayName="Global Statement"** | | |
| | | | entry[gbl_meds]/observation/**value:CD** | NCTIS: Admin Codes - Global Statement Values<br><br>The value/@code **SHALL NOT** be "02". | See <code> for available attributes. |
| Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) > **Detailed Clinical Model Identifier** | A globally unique identifier for this Detailed Clinical Model. | 1..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>See Known Issues. |

## Example 7.16. Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) XML Fragment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

   <!-- Begin CDA Header -->
   …
   <!-- End CDA Header -->

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

         <!-- Begin IMMUNISATIONS -->
         <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) -->
     <entry>
      <!-- Begin Global Statement -->
      <observation classCode="OBS" moodCode="EVN">
       <!-- ID is used for system purposes such as matching -->
       <id root="55d57cf0-2c70-11e2-81c1-0801600c9a66" />
       <code code="103.16302.120.1.5" codeSystem="1.2.36.1.2001.1001.101"
        codeSystemName="NCTIS Data Components"
        displayName="Global Statement" />
       <value code="01" codeSystem="1.2.36.1.2001.1001.101.104.16299"
        codeSystemName="NCTIS Global Statement Values"
        displayName="None known" xsi:type="CD" />
      </observation>
      <!-- End Global Statement -->
     </entry>
     <!-- End Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) -->

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

         …

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

# 8 Common Patterns

## 8.1 code

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

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

A *displayName* is highly recommended.

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

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

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

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

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

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

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

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

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

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

### Example 8.1. code

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


<!-- Alternate code system in use and a translation into the specified code system is available -->
<code
   code="J45.9"
   codeSystem="2.16.840.1.113883.6.135"
   codeSystemName="icd10am"
   displayName="Asthma, unspecified">
   <originalText>Asthma</originalText>
   <translation
      code="195967001"
      codeSystem="2.16.840.1.113883.19.6.96"
      codeSystemName="SNOMED CT"
      displayName="Asthma"/>
</code>


<!-- Alternate code system in use and no translation into the specified code system is available -->
<code
   code="J45.9"
   codeSystem="2.16.840.1.113883.6.135"
   codeSystemName="icd10am"
   displayName="Asthma, unspecified">
   <originalText>Asthma</originalText>
</code>



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

# 8.2 id

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

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

The root attribute is **REQUIRED** and is a unique identifier that guarantees the global uniqueness of the instance identifier. The root alone **MAY** be the entire instance identifier. The root attribute **SHALL** be a UUID or OID.

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

In the case of Entity Identifier, assigningAuthorityName is **RECOMMENDED**.

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

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

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

### Example 8.2. id

```
<id root="2.16.840.1.113883.19" extension="123A45" />
```

```
<ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />
```

# 8.3 time

When a time value is supplied it **SHALL** include hours and minutes.

When a time value is supplied it **MAY** include seconds and fractions of seconds.

When a time value is supplied it **SHALL** include a time zone.

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

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

### Example 8.3. Simple timestamp

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

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

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

### Example 8.4. Low time

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

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

### Example 8.5. Interval timestamp 1

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

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

### Example 8.6. Interval timestamp 2

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

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

### Example 8.7. Width time

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

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

# 8.4 Entity Identifier

## CDA® Mapping

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

## Example 8.8. Entity Identifier

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

<xs:asEntityIdentifier classCode="IDENT">
 <xs:id root="1.2.36.1.2001.1005.29.8003621566684455" extension="542181" assigningAuthorityName="Croydon GP Centre" />
   <xs:code code="MR" codeSystem="2.16.840.1.113883.12.203" codeSystemName="Identifier Type (HL7)" />
</xs:asEntityIdentifier>

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

# 8.5 Person Name

## CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Data Elements** | | | | | |
| **Person Name** | The appellation by which an individual may be identified separately from any other within a social context. | Cardinality comes from linking parent. | **name** | | |
| Person Name > **Name Title** | An honorific form of address commencing a name. | 0..* | name/**prefix** | | |
| Person Name > **Family Name** | That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names. | 1..1 | name/**family** | | |
| Person Name > **Given Name** | The person's identifying names within the family group or by which the person is uniquely socially identified. | 0..* | name/**given** | | |
| Person Name > **Name Suffix** | The additional term used following a person's name to identify that person. | 0..* | name/**suffix** | | |
| Person Name > **Preferred Name Indicator** | A flag to indicate that this is the name a person has selected for use. | 0..1 | name/**@use** | A code for representing “preferred name” has been requested from HL7® International but is not currently available. | If both Preferred Name Indicator and Person Name Usage have been provided, the use attribute **SHALL** include them as space separated list of codes. |
| Person Name > **Person Name Usage** | The classification that enables differentiation between recorded names for a person. | 0..1 | name/**@use** | AS 5017-2006: Health Care Client Name Usage | If both Preferred Name Indicator and Person Name Usage have been provided, the use attribute **SHALL** include them as space separated list of codes. |

## Example 8.9. Person Name

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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

# 8.6 Address

## CDA® Mapping

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Data Elements** | | | | | |
| **Address** | The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity. | Cardinality comes from linking parent. | **addr** | | In an event where the Address of the Subject of Care is 'Unknown' or 'Masked / Not to be disclosed for privacy reason', the following conditions **SHOULD** be applied.<br><br>The nullFlavor = "UNK" **SHOULD** be permitted if the value of address is not known and the value of 'No Fixed Address Indicator' is false.<br><br>The nullFlavor = "MSK" **SHOULD** be permitted if the value of address is masked and the value of 'No Fixed Address Indicator' is false.<br><br>The nullFlavor = "NA" **SHOULD** be permitted if value of 'No Fixed Address Indicator' is true. (This is the same as the current CDA® IG constraint).<br><br>The value of the <addr> data group **SHALL** be populated in all other circumstances. |
| Address > **No Fixed Address Indicator** | A flag to indicate whether or not the participant has no fixed address. | 1..1 | addr/**@nullFlavor** | If true, nullFlavor="NA". If false omit nullFlavor and fill in address. | |

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| Address > **Australian or International Address** | Represents a choice to be made at run-time between an AUSTRALIAN ADDRESS and an INTERNATIONAL ADDRESS. | 1..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>The cardinality of this component propagates to its children. |
| Address > Australian or International Address > **International Address** | The description of a non-Australian location where an entity is located or can be otherwise reached or found. | 0..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>The cardinality of this component propagates to its children. |
| Address > Australian or International Address > International Address > **International Address Line** | A composite of address details comprising a low level geographical/physical description of a location that, used in conjunction with the other high level address components, i.e. international state/province, international postcode and country, forms a complete geographic/physical address. | 0..* | addr/**streetAddressLine** | | |
| Address > Australian or International Address > International Address > **International State/Province** | The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country. | 0..1 | addr/**state** | | |
| Address > Australian or International Address > International Address > **International Postcode** | The alphanumeric descriptor for a postal delivery area (as defined by the postal service of a country other than Australia) aligned with locality, suburb or place for an address. | 0..1 | addr/**postalCode** | | |
| Address > Australian or International Address > International Address > **Country** | The country component of the address. | 0..1 | addr/**country** | Australia Bureau of Statistics, Standard Australian Classification of Countries (SACC) Cat. No. 1269 [ABS2008] | Use the name, not the numbered code. |
| Address > Australian or International Address > **Australian Address** | The description of an Australian location where an entity is located or can be otherwise reached or found. | 0..1 | n/a | | This logical NEHTA data component has no mapping to CDA®.<br><br>The cardinality of this component propagates to its children. |
| Address > Australian or International Address > Australian Address > **Unstructured Australian Address Line** | A composite of one or more low level standard address components describing a geographical/physical location that, used in conjunction with the other high level address components, e.g. Australian suburb/town/locality name, Australian postcode and Australian State/Territory, forms a complete geographical/physical address. | 0..* | addr/**streetAddressLine** | | |

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

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

## Example 8.10. Address

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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


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

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

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

# 8.7 Electronic Communication Detail

## CDA® Mapping

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

## Example 8.11. Electronic Communication Detail

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

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


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


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

# 8.8 Employment

## CDA® Mapping

### Note

NS = In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the HL7® code set registration procedure[2] with an appropriate object identifier (OID), and **SHALL** be publicly available.

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

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| **CDA® Data Elements** | | | | | |
| **Employment Detail** | A person's occupation and employer. | Cardinality comes from linking parent. | n/a | | This logical NEHTA data component has no mapping to CDA®. |
| Employment Detail > **Employer Organisation** | The organisation that the individual is working for in respect to the role they are playing in the nominated participation. | 1..* | **ext:asEmployment/ext:employerOrganization** | | There is a known issue in the NEHTA Participation Data Specification [NEHT2011v] for this logical data component's cardinality.<br><br>Furthermore the corresponding CDA® elements ext:asEmployment and ext:employerOrganization do not allow the cardinality to be '0..*'/multiple. The cardinality **SHALL** be interpreted as '0..1' instead of '0..*'. |
| | | | ext:asEmployment/**@classCode="EMP"** | | |

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

| NEHTA SCS Data Component | Data Component Definition | Card | CDA® Schema Data Element | Vocab | Comments |
|---|---|---|---|---|---|
| Employment Detail > Employer Organisation > **Entity Identifier** | A number or code issued for the purpose of identifying a participant within a healthcare context. | 1..* | ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Entity Identifier>** | The value of one Entity Identifier **SHALL** be an Australian HPI-O. | See common pattern: Entity Identifier. |
| Employment Detail > Employer Organisation > **Address** | The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity. | 1..* | ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Address>** | AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. | See common pattern: Address. |
| Employment Detail > Employer Organisation > **Electronic Communication Detail** | The electronic communication details of entities. | 1..* | ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Electronic Communication Detail>** | | See common pattern: Electronic Communication Detail. |
| Employment Detail > Employer Organisation > **Organisation** | Any organisation of interest to, or involved in, the business of healthcare service provision. | 1..1 | n/a | | Not mapped directly, encompassed implicitly in assignedAuthor/ext:asEmployment/employerOrganization. |
| Employment Detail > Employer Organisation > Organisation > **Organisation Name** | The name by which an organisation is known or called. | 1..1 | ext:asEmployment/ext:employerOrganization/**asOrganizationPartOf/wholeOrganization/name** | | |
| Employment Detail > Employer Organisation > Organisation > **Department/Unit** | The name by which a department or unit within a larger organisation is known or called. | 0..1 | ext:asEmployment/ext:employerOrganization/**name** | | |
| Employment Detail > Employer Organisation > Organisation > **Organisation Name Usage** | The classification that enables differentiation between recorded names for an organisation or service location. | 0..1 | ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/name/**@use** | AS 4846-2006: Health Care Provider Organisation Name Usage | |
| Employment Detail > **Employment Type** | The basis on which the person is employed by the employer organisation. | 0..1 | ext:asEmployment/**ext:jobClassCode** | NS | |
| Employment Detail > **Occupation** | A descriptor of the class of job based on similarities in the tasks undertaken. | 0..* | ext:asEmployment/**ext:jobCode** | *1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 [ABS2009]* | The corresponding CDA® element ext:jobCode does not allow the cardinality to be '0..*'/multiple. The cardinality **SHALL** be interpreted as '0..1' instead of '0..*'. |
| Employment Detail > **Position In Organisation** | A descriptor of the job or the job role based on the management hierarchy of the organisation. | 0..1 | ext:asEmployment/**ext:code** | NS | |

## Example 8.12. Employment

```
<!-- This xml fragment is provided to demonstrate an example instance of each structured element in the CDA® Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA® Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<!-- Employment Details -->
<ext:asEmployment classCode="EMP">

    <!-- Position In Organisation -->
    <ext:code>
        <originalText>Chief Oncologist</originalText>
    </ext:code>

    <!-- Occupation -->
    <ext:jobCode code="253314" codeSystem="2.16.840.1.113883.13.62"
        codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
        displayName="Medical Oncologist"/>"/>

    <!-- Employment Type -->
    <ext:jobClassCode code="FT" codeSystem="2.16.840.1.113883.5.1059" codeSystemName="HL7:EmployeeJobClass" displayName="full-time"/>

    <!-- Employer Organisation -->
    <ext:employerOrganization>
        <!-- Department/Unit -->
        <name>Oncology Ward</name>
        <asOrganizationPartOf>
            <wholeOrganization>

                <!-- Organisation Name -->
                <name use="ORGB">Acme Hospital</name>

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

                <!-- Address -->
                <addr use="WP">
                    <houseNumber>1</houseNumber>
                    <streetName>Clinician</streetName>
                    <streetNameType>St</streetNameType>
                    <city>Nehtaville</city>
                    <state>QLD</state>
                    <postalCode>5555</postalCode>
                    <additionalLocator>32568931</additionalLocator>
                </addr>

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

            </wholeOrganization>
        </asOrganizationPartOf>

    </ext:employerOrganization>
```

```
</ext:asEmployment>
```

# 9 NEHTA CDA® Extensions

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

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

This section contains extensions that have been defined for Australian concepts not represented in CDA®.

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

# 9.1 ClinicalDocument.completionCode

Figure 9.1 CDA® R-MIM Representation shows a subset of the CDA® R-MIM containing those classes with the relevant NEHTA CDA® extension represented.

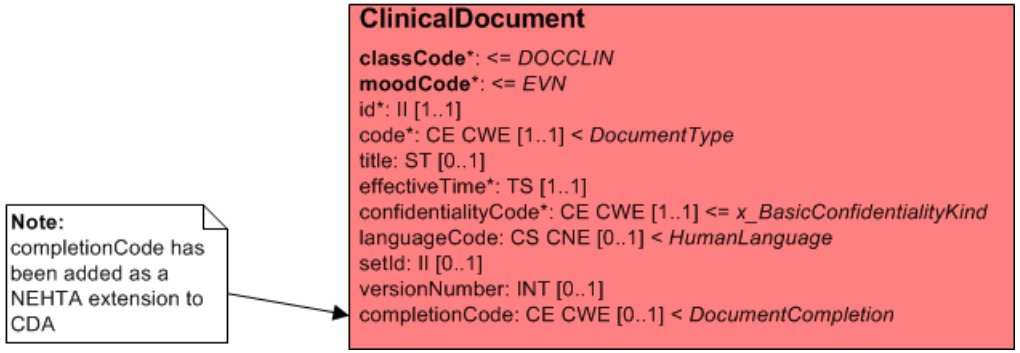


**Figure 9.1. CDA® R-MIM Representation**

# 9.2 EntityIdentifier

Figure 9.2 CDA® R-MIM Representation shows a subset of the CDA® R-MIM containing those classes with the relevant NEHTA CDA® extension represented.

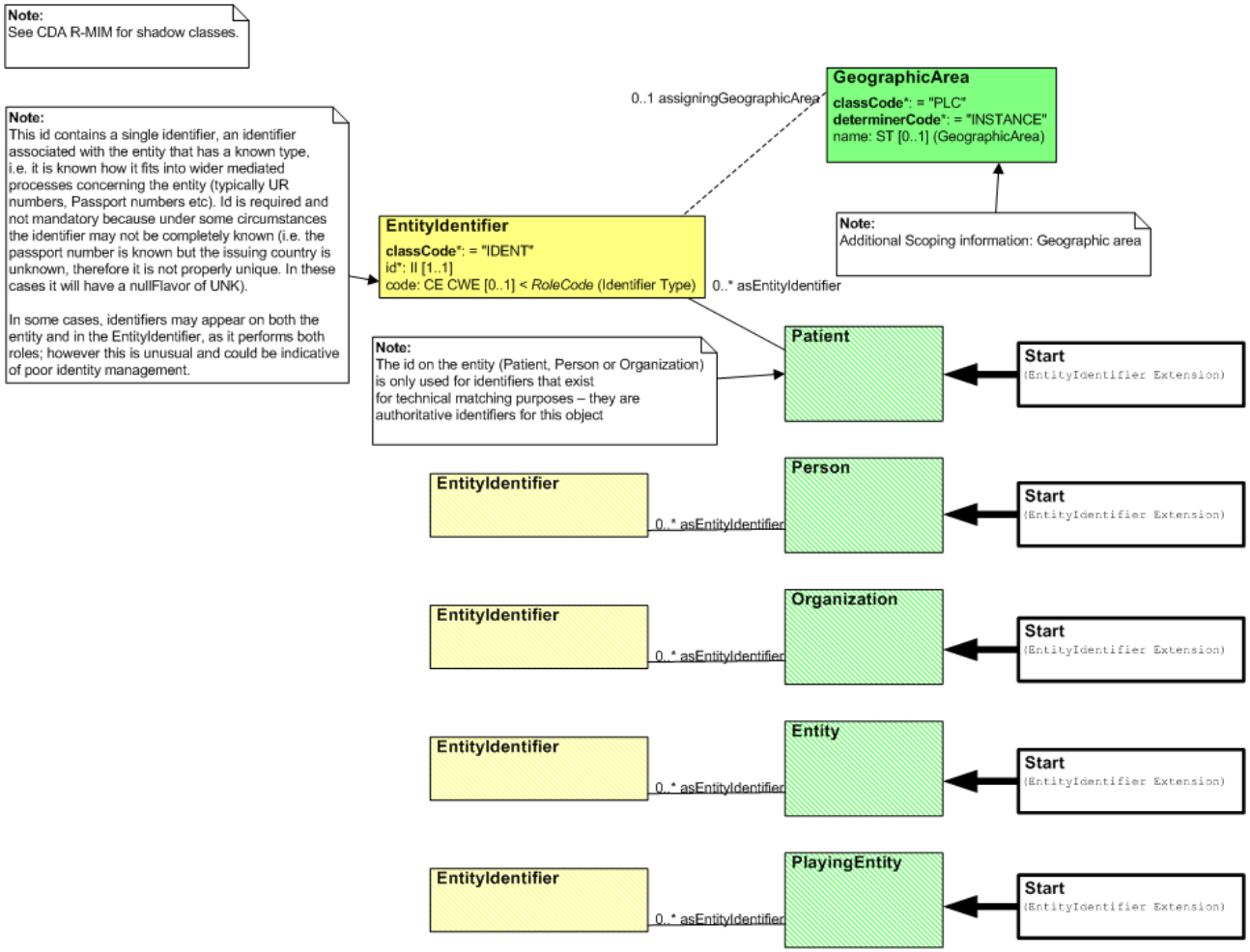


**Figure 9.2. CDA® R-MIM Representation**

# 9.3 Entitlement

Figure 9.3 CDA® R-MIM Representation shows a subset of the CDA® R-MIM containing those classes with the relevant NEHTA CDA® extension represented.

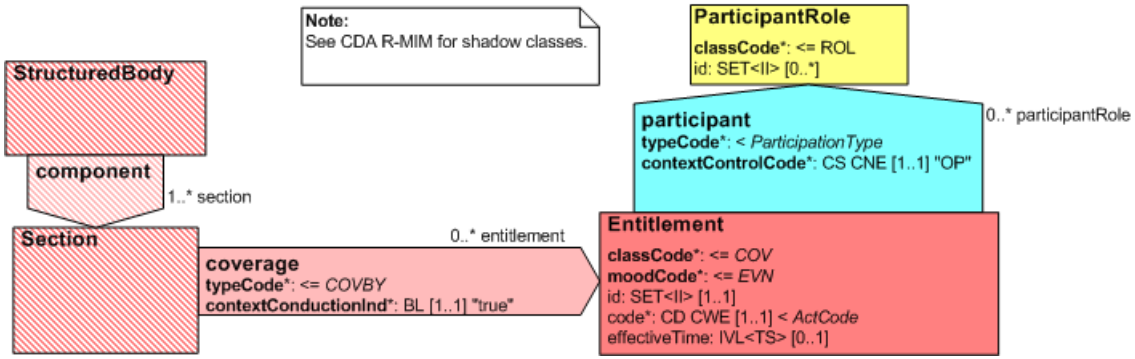


**Figure 9.3. CDA® R-MIM Representation**

# 9.4 Multiple Birth

Figure 9.4 CDA® R-MIM Representation shows a subset of the CDA® R-MIM containing those classes with the relevant NEHTA CDA® extension represented.

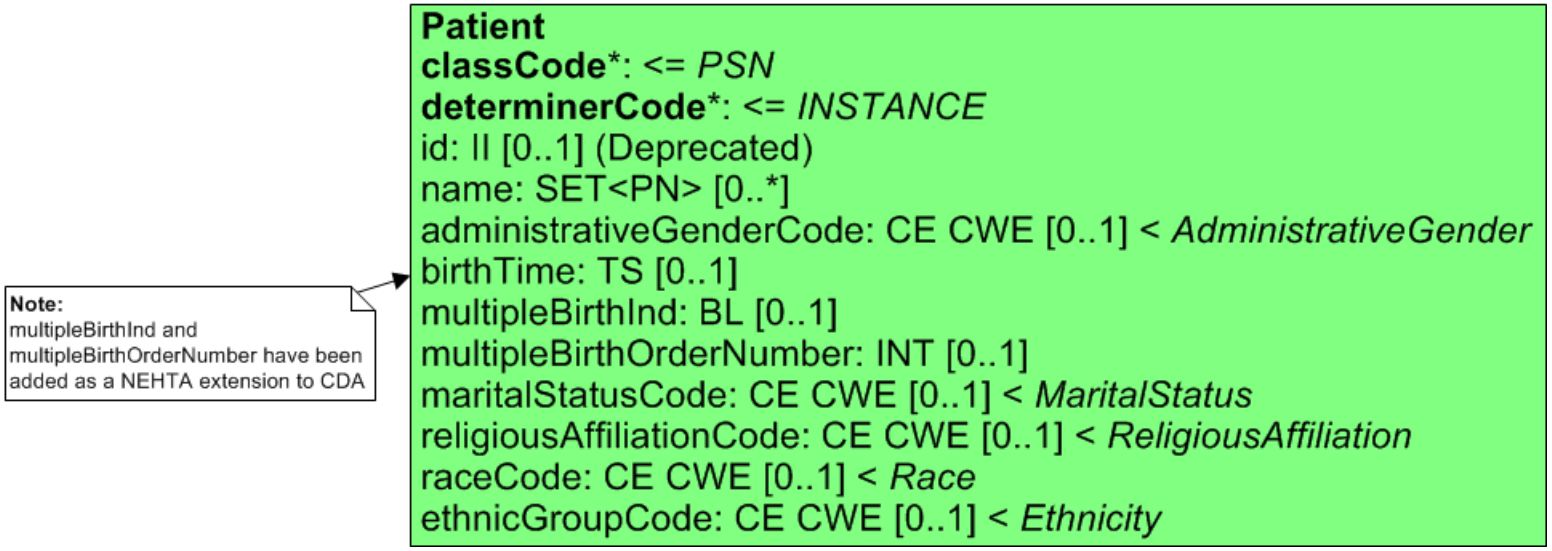


**Figure 9.4. CDA® R-MIM Representation**

# 9.5 Administrative Gender Code

Figure 9.5 CDA® R-MIM Representation shows a subset of the CDA® R-MIM containing those classes with the relevant NEHTA CDA® extension represented.

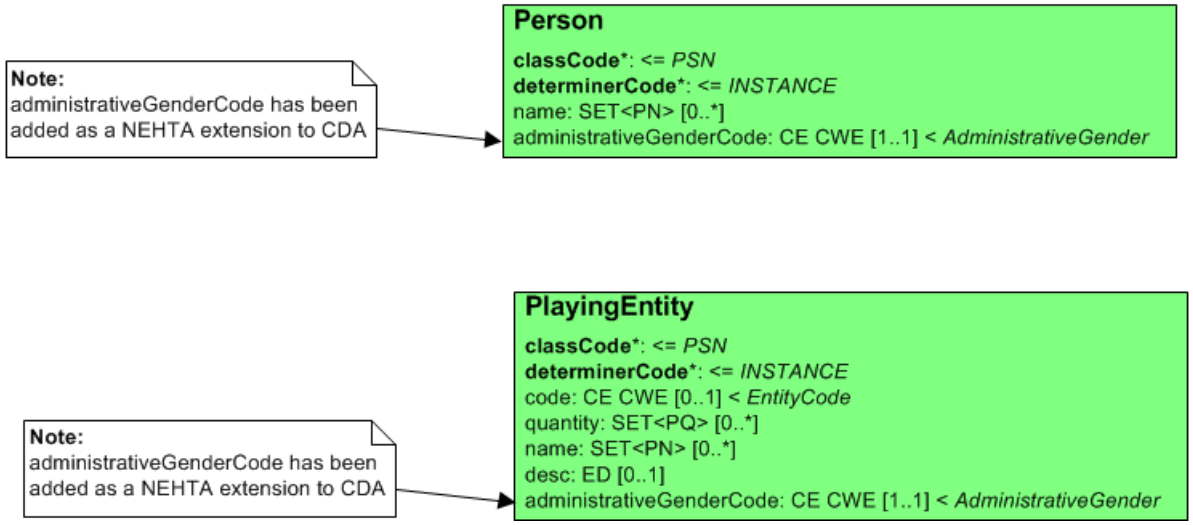


**Figure 9.5. CDA® R-MIM Representation**

# 9.6 Birth Time

Figure 9.6 CDA® R-MIM Representation shows a subset of the CDA® R-MIM containing those classes with the relevant NEHTA CDA® extension represented.

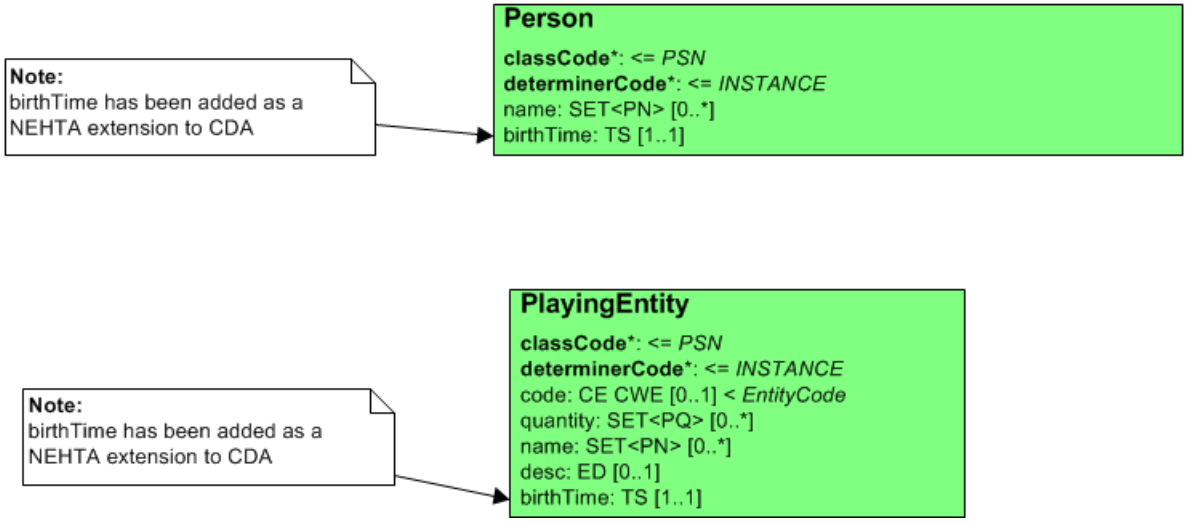


**Figure 9.6. CDA® R-MIM Representation**

# 9.7 Deceased Time

Figure 9.7 CDA® R-MIM Representation shows a subset of the CDA® R-MIM containing those classes with the relevant NEHTA CDA® extension represented.

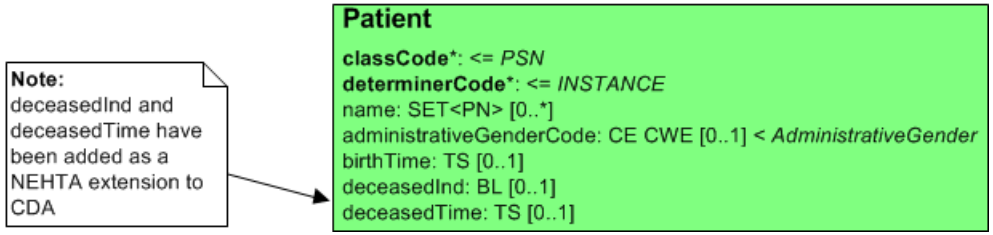


**Figure 9.7. CDA® R-MIM Representation**

# 9.8 Employment

Figure 9.8 CDA® R-MIM Representation shows a subset of the CDA® R-MIM containing those classes with the relevant NEHTA CDA® extension represented.

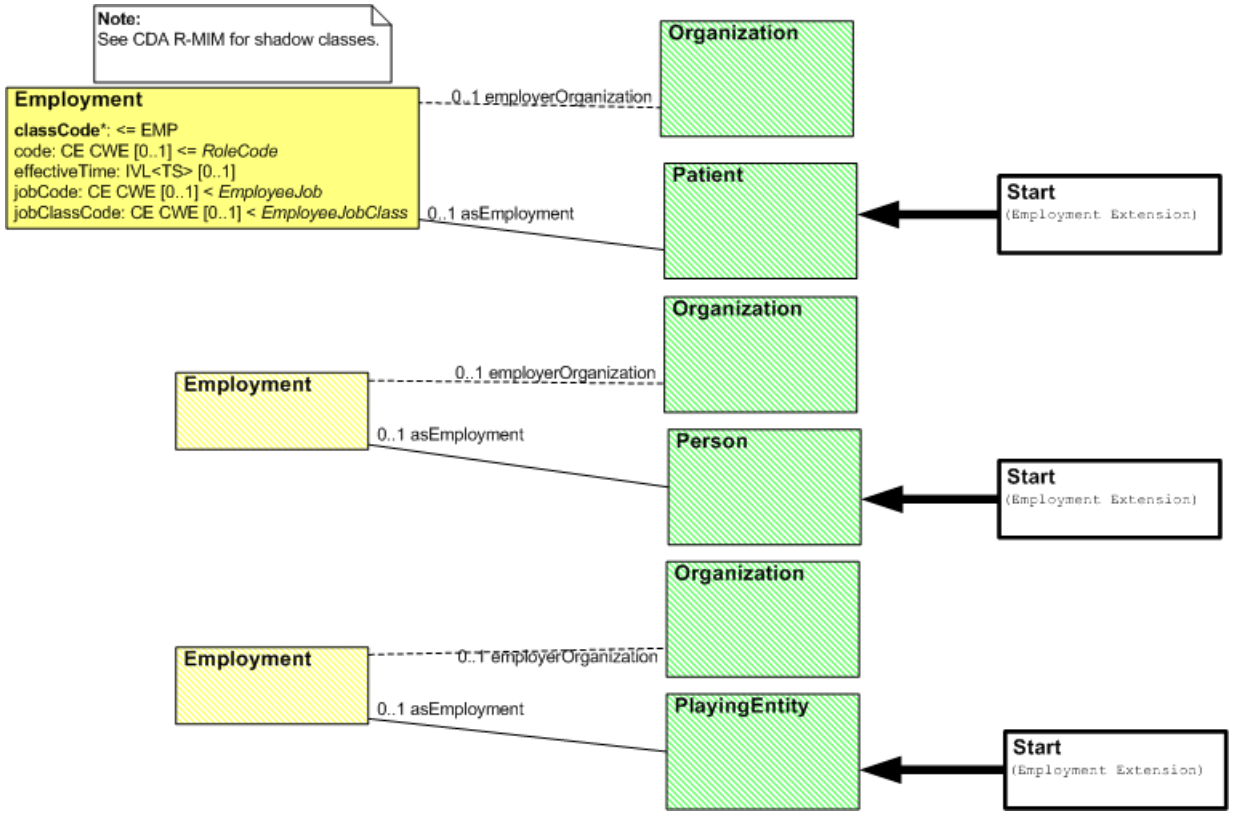


**Figure 9.8. CDA® R-MIM Representation**

# 9.9 Qualifications

Figure 9.9 CDA® R-MIM Representation shows a subset of the CDA® R-MIM containing those classes with the relevant NEHTA CDA® extension represented.

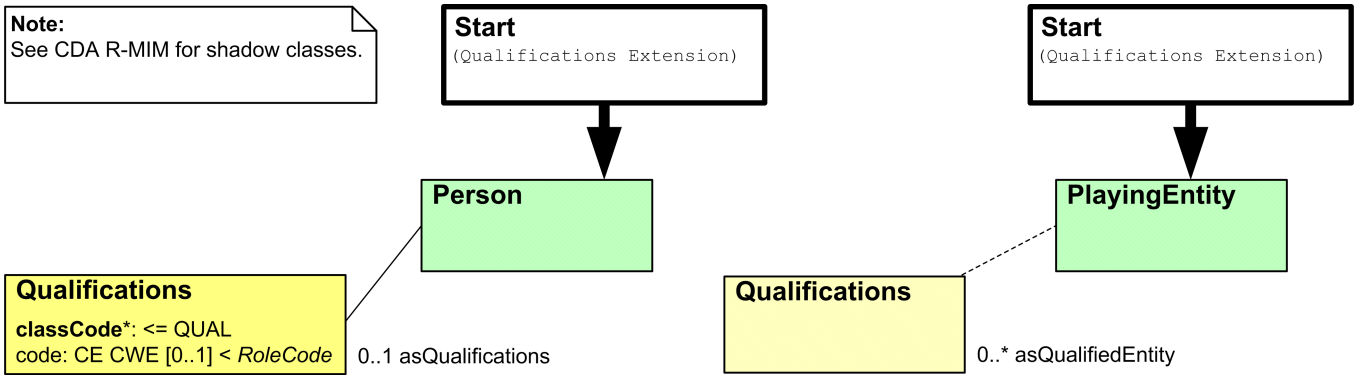


**Figure 9.9. CDA® R-MIM Representation**

# 10 Vocabularies and Code Sets



**Example 10.1. All values**

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

**Example 10.2. One value**

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

# 10.1 HL7®: TelecommunicationAddressUse

| Code | Value |
|---|---|
| **H** | Home |
| **HP** | Primary Home |
| **HV** | Vacation Home |
| **WP** | Workplace |
| **AS** | Answering Service |
| **EC** | Emergency Contact |
| **MC** | Mobile Contact |

| Code | Value |
|---|---|
| **PG** | Pager |

# 10.2 AS 5017-2006 Health Care Client Identifier Sex

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

# 10.3 AS 5017-2006: Health Care Client Name Usage

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

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

## Note

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

## Note

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

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

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

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

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

**Note**
There are no suitable HL7® codes, so extension codes have been created.

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

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

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

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

AS 5017-2006 mapped to HL7® AddressUse Code

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A – The referred date component is accurately known.

E – The referred date component is an estimate.

U – The referred date component is unknown.

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

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

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

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

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

The possible combinations are as follows:

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

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

# 10.12 NCTIS: Admin Codes - Document Status

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

# 10.13 NCTIS: Admin Codes - Global Statement Values

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

# 10.14 NCTIS: Admin Codes - Entitlement Type

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

# 10.15 HL7® v3 CDA®: Act.moodCode

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

# 10.16 METeOR 291036: Indigenous Status

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

# 10.17 CodeSystem OIDs

## Note

The entries in the codeSystem (Name) column enable identification of the codeSystem OID to be used, but may not be the proper name of that codeSystem, i.e. the value of the codeSystemName attribute. The value of codeSystemName **SHOULD** be the name associated with the OID in the HL7® OID Registry[1].

| codeSystem (OID) | codeSystem (Name) |
|---|---|
| 1.2.36.1.2001.1001.101 | NCTIS Data Components |
| 2.16.840.1.113883.13.62 | 1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 |
| 2.16.840.1.113883.13.65 | AIHW Mode of Separation |
| 2.16.840.1.113883.6.96 | SNOMED CT |
| 2.16.840.1.113883.6.96 | SNOMED CT-AU |
| 1.2.36.1.2001.1004.100 | Australian Medicines Terminology (AMT) v2 |
| 2.16.840.1.113883.6.96 | Australian Medicines Terminology (AMT) v3 |
| 2.16.840.1.113883.6.1 | LOINC |

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

# Appendix A. CDA® Narratives

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

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

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

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

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# Appendix B. Log of Changes

This appendix lists the major changes and normative changes applied to this CDA® Implementation Guide resulting from validation and feedback. A single change is likely to be listed multiple times, as changes are listed in order of appearance and categorised by location in the document. For example, a cardinality change may appear in both the Data Hierarchy and CDA® Mapping table.

## Note

This specification includes typographical, stylistic, and editorial corrections.

All XML fragments have been reviewed and updated to align with the semantic changes defined in the CDA® Mapping tables.

All CDA® R-MIM representations have been reviewed and updated to align with the semantic changes defined in the CDA® Mapping tables.

A number of technical identifiers have been included in the Data Hierarchy; many of these were already present in the mappings but not explicitly identified as logical data elements.

Changes from Version 1.3 12 Mar 2012 to Version 1.4 10 Apr 2015

| ID | Document Ref | | Change Type | Change Detail | Change Initiated By | Rationale For Change | Date Changed |
|---|---|---|---|---|---|---|---|
| | Section | Section Name | | | | | |
| 1 | 3 | Shared Health Summary Data Hierarchy | Normative Impact to Mappings | Added new logical data element Reaction Type 0..1. | NEHTA | Requirements Change.<br>Alignment with updates to the logical model (SCS). | 04 Dec 2014 |
| | | | | Renamed OTHER MEDICAL HISTORY ITEM to UNCATEGORISED MEDICAL HISTORY ITEM. | | | |
| | | | | Added new technical identifier Adverse Reactions Instance Identifier 0..1. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |
| | | | | Added new technical identifier Medication Orders Instance Identifier 0..1. | | | |
| | | | | Added new technical identifier Medical History Instance Identifier 0..1. | | | |
| | | | | Added new technical identifier Immunisations Instance Identifier 0..1. | | | |
| 2 | 3 | Shared Health Summary Data Hierarchy | No Normative Impact to Mappings | Replaced logical data element Start Date/Time (DateTime Started) with logical data element Procedure DateTime in data group PROCEDURE - already present in the mapping table. | NEHTA | Alignment with updates to the logical model (SCS). | 04 Dec 2014 |

| ID | Document Ref | | Change Type | Change Detail | Change Initiated By | Rationale For Change | Date Changed |
|---|---|---|---|---|---|---|---|
| | Section | Section Name | | | | | |
| 3 | 3 | Shared Health Summary Data Hierarchy | No Normative Impact to Mappings | Added technical identifier Document Instance Identifier 1..1 - already present in the mapping table. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |
| | | | | Added technical identifier Document Type 1..1 - already present in the mapping table. | | | |
| | | | | Added new technical identifier Section Type 1..1 in section ADVERSE REACTIONS - already present in the mapping table. | | | |
| | | | | Added new technical identifier Section Type 1..1 in section Medications (MEDICATION ORDERS) - already present in the mapping table. | | | |
| | | | | Added new technical identifier Section Type 1..1 in section Past and Current Medical History (MEDICAL HISTORY) - already present in the mapping table. | | | |
| | | | | Added new technical identifier Section Type 1..1 in section IMMUNISATIONS - already present in the mapping table. | | | |
| | | | | Added new technical identifier Detailed Clinical Model Identifier 1..1 in data group EXCLUSION STATEMENT - ADVERSE REACTIONS - not mapped. | | | |
| | | | | Added technical identifier Adverse Reaction Instance Identifier 1..1 - already present in the mapping table. | | | |
| | | | | Added technical identifier Detailed Clinical Model Identifier 1..1 in data group ADVERSE REACTION - already present in the mapping table. | | | |
| | | | | Added new technical identifier Detailed Clinical Model Identifier 1..1 in data group EXCLUSION STATEMENT - MEDICATIONS - not mapped. | | | |
| | | | | Added technical identifier Medication Instruction Instance Identifier 1..1 - already present in the mapping table. | | | |
| | | | | Added new technical identifier Detailed Clinical Model Identifier 1..1 in data group Known Medication (MEDICATION INSTRUCTION) - not mapped. | | | |
| | | | | Added technical identifier Problem/Diagnosis Instance Identifier 1..1 - already present in the mapping table. | | | |
| | | | | Added technical identifier Detailed Clinical Model Identifier 1..1 in data group PROBLEM/DIAGNOSIS - already present in the mapping table. | | | |
| | | | | Added new technical identifier Detailed Clinical Model Identifier 1..1 in data group EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES - not mapped. | | | |
| | | | | Added technical identifier Procedure Instance Identifier 1..1 - already present in the mapping table. | | | |
| | | | | Added new technical identifier Detailed Clinical Model Identifier 1..1 in data group PROCEDURE - not mapped. | | | |
| | | | | Added new technical identifier Detailed Clinical Model Identifier 1..1 in data group EXCLUSION STATEMENT - PROCEDURES - not mapped. | | | |
| | | | | Added technical identifier Uncategorised Medical History Item Instance Identifier 1..1 - already present in the mapping table. | | | |

| ID | Document Ref | | Change Type | Change Detail | Change Initiated By | Rationale For Change | Date Changed |
|---|---|---|---|---|---|---|---|
| | Section | Section Name | | | | | |
| | | | | Added technical identifier Detailed Clinical Model Identifier 1..1 in data group UNCATEGORISED MEDICAL HISTORY ITEM - already present in the mapping table. | | | |
| | | | | Added technical identifier Medication Action Instance Identifier 1..1 - already present in the mapping table. | | | |
| | | | | Added new technical identifier Detailed Clinical Model Identifier 1..1 in data group Administered Immunisation (MEDICATION ACTION) - not mapped. | | | |
| | | | | Added new technical identifier Detailed Clinical Model Identifier 1..1 in data group Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) - not mapped. | | | |
| 4 | 4 | Administrative Observations | Normative Impact to Mappings | Cardinality of component/section[admin_obs]/text changed to 0..1 | NEHTA | Change Request | 09 Jan 2015 |
| | | | | Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | | | |
| 5 | 5 | CDA® Header | Normative Impact to Mappings | LegalAuthenticator cardinality corrected to 1..1 | NEHTA | Defect Correction<br>Improved Guidance | 23 Dec 2014 |
| | | | | ClinicalDocument/templateId/@extension updated to "1.4" | | | |
| | | | | ClinicalDocument/languageCode constraints applied to require the format of the value to be <Language Code> – <DIALECT> with Language set to "en" and the Dialect should be "AU". | | | |
| | | | | Added row for ClinicalDocument/versionNumber/@value 0..1. | | | |
| | | | | Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | | | |
| 6 | 5 | CDA® Header | No Normative Impact to Mappings | Added row for ClinicalDocument/setId 0..1. | NEHTA | Improved Guidance | 04 Dec 2014 |
| 7 | 5.1.1 | LegalAuthenticator | Normative Impact to Mappings | LegalAuthenticator cardinality corrected to 1..1 | NEHTA | Defect Correction | 04 Dec 2014 |
| | | | | Added a constraint to legalAuthenticator/time/@value to require the value include both a time and a date. | | | |
| 8 | 6.1 | SHARED HEALTH SUMMARY | Normative Impact to Mappings | DateTime Attested: Added a constraint to require the value include both a time and a date. | NEHTA | Alignment with updates to the logical model (SCS). | 04 Dec 2014 |
| | | | | Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | | | |
| 9 | 6.1 | SHARED HEALTH SUMMARY | No Normative Impact to Mappings | Added technical identifier Document Instance Identifier 1..1 - already present in the mapping table as ClinicalDocument/id. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |
| | | | | Added technical identifier Document Type 1..1 - already present in the mapping table as ClinicalDocument/code. | | | |

| ID | Document Ref | | Change Type | Change Detail | Change Initiated By | Rationale For Change | Date Changed |
|---|---|---|---|---|---|---|---|
| | Section | Section Name | | | | | |
| 10 | 6.1.1 | DOCUMENT AUTHOR | Normative Impact to Mappings | Participation Period: Added constraint defining the allowed attributes and elements of author/time. | NEHTA | Requirements Change. | 24 Feb 2015 |
| | | | | Address: Changed cardinality from 1..* to 0..*. | | | |
| | | | | Address: Added constraint, addr/@use SHALL be set to "WP". | | | |
| | | | | Electronic Communication Detail: Changed cardinality from 1..* to 0..*. | | | |
| | | | | Electronic Communication Detail: Added constraint, telecom/@use SHALL be set to "WP". | | | |
| | | | | Added Entitlement as 0..*. | | | |
| | | | | Added Qualifications as 0..1. | | | |
| 11 | 6.1.1 | DOCUMENT AUTHOR | No Normative Impact to Mappings | Participation Period: Reworded the constraint requiring author/time to hold the same value as Date Time Attested. | NEHTA | Improved guidance. | 24 Feb 2015 |
| 12 | 6.1.2 | SUBJECT OF CARE | Normative Impact to Mappings | Added Source of Death Notification as 0..1. | NEHTA | Requirements Change. | 22 Dec 2014 |
| | | | | Added Mother's Original Family as 0..1. | | | |
| | | | | Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | | | |
| 13 | 7.1.1 | ADVERSE REACTIONS | Normative Impact to Mappings | Added constraint on allowed child components; ADVERSE REACTION and EXCLUSION STATEMENT - ADVERSE REACTIONS are mutually exclusive. | NEHTA | Alignment to logical model. | 04 Dec 2014 |
| | | | | Added new technical identifier Adverse Reactions Instance Identifier 0..1 as component[adv_reacts]/section/id. | | | |
| | | | | Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | | | |
| 14 | 7.1.1 | ADVERSE REACTIONS | No Normative Impact to Mappings | Added new technical identifier Section Type 1..1 - already present in the mapping table as component[adv_reacts]/section/code. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |
| 15 | 7.1.1.1 | EXCLUSION STATEMENT - ADVERSE REACTIONS | Normative Impact to Mappings | Added a comment for row entry[gbl_adv]/observation/id that this element is an optional CDA® element. | NEHTA | Requirements Change.<br>Alignment to logical model. | 04 Dec 2014 |
| | | | | Added a constraint on entry[gbl_adv]/observation/value:CD that the value **SHALL NOT** be "02". | | | |
| | | | | Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | | | |
| 16 | 7.1.1.1 | EXCLUSION STATEMENT - ADVERSE REACTIONS | No Normative Impact to Mappings | Added new technical identifier Detailed Clinical Model Identifier 1..1 - not mapped to CDA®. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |

| ID | Document Ref | | Change Type | Change Detail | Change Initiated By | Rationale For Change | Date Changed |
|---|---|---|---|---|---|---|---|
| | Section | Section Name | | | | | |
| 17 | 7.1.1.2 | ADVERSE REACTION | Normative Impact to Mappings | Substance/Agent: Added SNOMED CT-AU reference set 142321000036106 \|*Adverse reaction agent reference set*\| to the permissible values. | NEHTA | Change Request<br>Requirements Change<br>Alignment to logical model. | 04 Dec 2014 |
| | | | | Manifestation: Added SNOMED CT-AU reference set 142341000036103 \|*Clinical manifestation reference set*\| to the permissible values. | | | |
| | | | | Manifestation: Added a row for entryRelationship[mfst]/observation/id. | | | |
| | | | | Added new logical data element Reaction Type 0..1 as entryRelationship[rct_evnt]/observation/value. | | | |
| | | | | Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | | | |
| 18 | 7.1.1.2 | ADVERSE REACTION | No Normative Impact to Mappings | Added technical identifier Adverse Reaction Instance Identifier 1..1 - already present in the mapping table as component[adv_react]/section/id. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |
| | | | | Added technical identifier Detailed Clinical Model Identifier 1..1 - already present in the mapping table as component[adv_react]/section/code. | | | |
| 19 | 7.1.2 | Medications (MEDICATION ORDERS) | Normative Impact to Mappings | Added constraint on allowed child components; Known Medication (MEDICATION INSTRUCTION) and EXCLUSION STATEMENT - MEDICATIONS are mutually exclusive. | NEHTA | Alignment to logical model. | 04 Dec 2014 |
| | | | | Added new technical identifier Medication Orders Instance Identifier 0..1 as component[meds]/section/id. | | | |
| | | | | Corrected component[meds]/section/code/@displayName from "Medications" to "Medication Orders". | | | |
| | | | | Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | | | |
| 20 | 7.1.2 | Medications (MEDICATION ORDERS) | No Normative Impact to Mappings | Added new technical identifier Section Type 1..1 - already present in the mapping table as component[meds]/section/code. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |
| 21 | 7.1.2.1 | EXCLUSION STATEMENT - MEDICATIONS | Normative Impact to Mappings | Added a comment for row entry[gbl_meds]/observation/id that this element is an optional CDA® element. | NEHTA | Requirements Change.<br>Alignment to logical model. | 04 Dec 2014 |
| | | | | Added a constraint on entry[gbl_meds]/observation/value:CD that the value **SHALL NOT** be "02". | | | |
| | | | | Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | | | |
| 22 | 7.1.2.1 | EXCLUSION STATEMENT - MEDICATIONS | No Normative Impact to Mappings | Added new technical identifier Detailed Clinical Model Identifier 1..1 - not mapped to CDA®. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |
| 23 | 7.1.2.2 | Known Medication (MEDICATION INSTRUCTION) | Normative Impact to Mappings | Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | NEHTA | Improved guidance. | 04 Dec 2014 |
| 24 | 7.1.2.2 | Known Medication (MEDICATION INSTRUCTION) | No Normative Impact to Mappings | Added technical identifier Medication Instruction Instance Identifier 1..1 - already present in the mapping table as entry[med_inst]/substanceAdministration/id. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |
| | | | | Added new technical identifier Detailed Clinical Model Identifier 1..1 - not mapped to CDA®. | | | |

| ID | Document Ref | | Change Type | Change Detail | Change Initiated By | Rationale For Change | Date Changed |
|---|---|---|---|---|---|---|---|
| | Section | Section Name | | | | | |
| 25 | 7.1.3 | Past and Current Medical History (MEDICAL HISTORY) | Normative Impact to Mappings | Added constraints on allowed combinations of child components: If there is an instance of UNCATEGORISED MEDICAL HISTORY ITEM there cannot be any EXCLUSION STATEMENTs; If there is no instance of UNCATEGORISED MEDICAL HISTORY ITEM then there must be an instance of PROCEDURE (or its exclusion statement) and an instance of PROBLEM/DIAGNOSIS ( or its exclusion statement).<br>Added new technical identifier Medical History Instance Identifier 0..1 as component[med_hist]/section/id.<br>Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | NEHTA | Alignment to logical model. | 04 Dec 2014 |
| 26 | 7.1.3 | Past and Current Medical History (MEDICAL HISTORY) | No Normative Impact to Mappings | Added new technical identifier Section Type 1..1 - already present in the mapping table as component[med_hist]/section/code. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |
| 27 | 7.1.3.1 | PROBLEM/DIAGNOSIS | Normative Impact to Mappings | Date of Onset: Added a constraint that the value **SHALL NOT** include a time.<br>Date of Onset: Changed mapping to be more specific; from (entry[prob]/observation/effectiveTime) to (entry[prob]/observation/effectiveTime/low/@value).<br>Date of Remission: Added a constraint that the value **SHALL NOT** include a time.<br>Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | NEHTA | Requirements Change. | 24 Feb 2015 |
| 28 | 7.1.3.1 | PROBLEM/DIAGNOSIS | No Normative Impact to Mappings | Added technical identifier Problem/Diagnosis Instance Identifier 1..1 - already present in the mapping table as entry[prob]/observation/id.<br>Added technical identifier Detailed Clinical Model Identifier 1..1 - already present in the mapping table as entry[prob]/observation/code. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |
| 29 | 7.1.3.2 | EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES | Normative Impact to Mappings | Added a comment for row entry[gbl_prob]/observation/id that this element is an optional CDA® element.<br>Added a constraint on entry[gbl_prob]/observation/value:CD that the value **SHALL NOT** be "02".<br>Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | NEHTA | Requirements Change.<br>Alignment to logical model. | 04 Dec 2014 |
| 30 | 7.1.3.2 | EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES | No Normative Impact to Mappings | Added new technical identifier Detailed Clinical Model Identifier 1..1 - not mapped to CDA®. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |
| 31 | 7.1.3.3 | PROCEDURE | Normative Impact to Mappings | Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | NEHTA | Inclusion of technical identifiers from the logical model (SCS).<br>Alignment with updates to the logical model (SCS). | 04 Dec 2014 |

| ID | Document Ref | | Change Type | Change Detail | Change Initiated By | Rationale For Change | Date Changed |
|---|---|---|---|---|---|---|---|
| | Section | Section Name | | | | | |
| 32 | 7.1.3.3 | PROCEDURE | No Normative Impact to Mappings | Added technical identifier Procedure Instance Identifier 1..1 - already present in the mapping table as entry[pro]/procedure/id. | NEHTA | Inclusion of technical identifiers from the logical model (SCS).<br>Alignment with updates to the logical model (SCS). | 04 Dec 2014 |
| | | | | Added technical identifier Detailed Clinical Model Identifier 1..1 - not mapped to CDA®. | | | |
| | | | | Replaced logical data element Start Date/Time (DateTime Started) with logical data element Procedure DateTime in data group PROCEDURE - already present in the mapping table as entry[proc]/procedure/effectiveTime. | | | |
| 33 | 7.1.3.2 | EXCLUSION STATEMENT - PROCEDURES | Normative Impact to Mappings | Added a comment for row entry[gbl_pro]/observation/id that this element is an optional CDA® element. | NEHTA | Requirements Change.<br>Alignment to logical model. | 04 Dec 2014 |
| | | | | Added a constraint on entry[gbl_pro]/observation/value:CD that the value **SHALL NOT** be "02". | | | |
| | | | | Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | | | |
| 34 | 7.1.3.2 | EXCLUSION STATEMENT - PROCEDURES | No Normative Impact to Mappings | Added new technical identifier Detailed Clinical Model Identifier 1..1 - not mapped to CDA®. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |
| 35 | 7.1.3.5 | UNCATEGORISED MEDICAL HISTORY ITEM | Normative Impact to Mappings | Renamed OTHER MEDICAL HISTORY ITEM to UNCATEGORISED MEDICAL HISTORY ITEM, the value for @displayName changed from "Other Medical History Item" to "Uncategorised Medical History Item".. | NEHTA | Change Request<br>Alignment to logical model. | 04 Dec 2014 |
| | | | | Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | | | |
| 36 | 7.1.3.5 | UNCATEGORISED MEDICAL HISTORY ITEM | No Normative Impact to Mappings | Added technical identifier Uncategorised Medical History Item Instance Identifier 1..1 - already present in the mapping table as entry[med_hist_item]/act/id. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |
| | | | | Added technical identifier Detailed Clinical Model Identifier 1..1 - already present in the mapping table as entry[med_hist_item]/act/code. | | | |
| 37 | 7.1.4 | IMMUNISATIONS | Normative Impact to Mappings | Added constraint on allowed child components; Administered Immunisation (MEDICATION ACTION) and Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) are mutually exclusive. | NEHTA | Alignment to logical model. | 04 Dec 2014 |
| | | | | Added new technical identifier Immunisations Instance Identifier 0..1 as component[imms]/section/id. | | | |
| | | | | Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | | | |
| 38 | 7.1.4 | IMMUNISATIONS | No Normative Impact to Mappings | Added new technical identifier Section Type 1..1 - already present in the mapping table as component[imms]/section/code. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |

| ID | Document Ref | | Change Type | Change Detail | Change Initiated By | Rationale For Change | Date Changed |
|---|---|---|---|---|---|---|---|
| | Section | Section Name | | | | | |
| 39 | 7.1.4.1 | Administered Immunisation (MEDICATION ACTION) | Normative Impact to Mappings | Therapeutic Good Identification: Added AMT reference set 929360071000036103 \|*Medicinal product unit of use reference set*\| to the permissible values. | NEHTA | Change Request<br>Alignment to logical model. | 04 Dec 2014 |
| | | | | Therapeutic Good Identification: Added AMT reference set 929360031000036100 \|*Trade product unit of use reference set*\| to the permissible values. | | | |
| | | | | Therapeutic Good Identification: Added AMT reference set 929360051000036108 \|*Contained trade product pack reference set*\| to the permissible values. | | | |
| | | | | Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | | | |
| 40 | 7.1.4.1 | Administered Immunisation (MEDICATION ACTION) | No Normative Impact to Mappings | Added technical identifier Medication Action Instance Identifier 1..1 - already present in the mapping table as entry[med_act]/substanceAdministration/id. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |
| | | | | Added new technical identifier Detailed Clinical Model Identifier 1..1 - not mapped to CDA®. | | | |
| 41 | 7.1.4.2 | EXCLUSION STATEMENT - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) | Normative Impact to Mappings | Added a comment for row entry[gbl_meds]/observation/id that this element is an optional CDA® element. | NEHTA | Requirements Change.<br>Alignment to logical model. | 04 Dec 2014 |
| | | | | Added a constraint on entry[gbl_meds]/observation/value:CD that the value **SHALL NOT** be "02". | | | |
| | | | | Identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided. | | | |
| 42 | 7.1.4.2 | EXCLUSION STATEMENT - Immunisations (EXCLUSION STATEMENT - MEDICATIONS) | No Normative Impact to Mappings | Added new technical identifier Detailed Clinical Model Identifier 1..1 - not mapped to CDA®. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |
| 43 | 8.4 | Entity Identifier | No Normative Impact to Mappings | ext:asEntityIdentifier/ext:id/@assigningAuthorityName: Changed from "**MAY** be used" to "**SHOULD** be used". | NEHTA | Improved Guidance | 04 Dec 2014 |
| 44 | 8.5 | Person Name | Normative Impact to Mappings | Preferred Name Indicator: Removed the statement that this is represented by "L" and replaced with a known issue that a code for this has been requested from HL®7 international but is not currently available. | NEHTA | Defect Correction | 04 Dec 2014 |
| 45 | 8.5 | Person Name | No Normative Impact to Mappings | Preferred Name Indicator: Reworded constraint on representation to unambiguously require a space separated list of codes. | NEHTA | Inclusion of technical identifiers from the logical model (SCS). | 04 Dec 2014 |
| | | | | Person Name Usage: Reworded constraint on representation to unambiguously require a space separated list of codes. | | | |
| 46 | 8.6 | Address | No Normative Impact to Mappings | Address: Added information on the use of nullFlavors for Address. | NEHTA | Improved Guidance | 04 Dec 2014 |
| 47 | 8.7 | Electronic Communication Detail | No Normative Impact to Mappings | Electronic Communication Medium: Removed duplicate inapplicable row for telecom/@use. | NEHTA | Defect Correction | 04 Dec 2014 |

| ID | Document Ref | | Change Type | Change Detail | Change Initiated By | Rationale For Change | Date Changed |
|---|---|---|---|---|---|---|---|
| | Section | Section Name | | | | | |
| 48 | 8.8 | Employment | Normative Impact to Mappings | Employer Organisation: Changed cardinality from 0..* to 1..*. | NEHTA | Defect Correction<br>Requirements Change | 04 Dec 2014 |
| | | | | Added row for Address 1..*. | | | |
| | | | | Address: Added constraint, addr/@use should be set to "WP". | | | |
| | | | | Added row for Electronic Communication Detail 1..*. | | | |
| | | | | Electronic Communication Detail: Added constraint, telecom/@use should be set to "WP". | | | |
| 49 | 10 | Vocabularies and Code Sets | No Normative Impact to Mappings | Removed unused vocabulary: section 10.18 NCTIS: Admin Codes - Result Status. | NEHTA | Defect Correction | 18 Dec 2014 |
| | | | | Removed unused vocabulary: section 10.16 HL7 v3 CDA®: RelatedDocument.typeCode. | | | |
| 50 | 10.17 | CodeSystem OIDs | No Normative Impact to Mappings | Corrected the name displayed in the table for code system 2.16.840.1.113883.13.62 to the registered name "1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1". | NEHTA | Defect Correction<br>Updates to terminology over time. | 04 Dec 2014 |
| | | | | Added the registered name of code system 2.16.840.1.113883.6.96 to the list "SNOMED CT". | | | |
| | | | | Added "Australian Medicines Terminology (AMT) v3" to the list of code system names. | | | |
| | | | | Corrected the name displayed in the table for code system 1.2.36.1.2001.1004.100 to the registered name "Australian Medicines Terminology (AMT) v2". | | | |
| | | | | Added the code system 1.2.36.1.2001.1001.101 NCTIS Data Components to the list. | | | |

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