nehta

e-Discharge Summary

Structured Document Template

Version 3.3 — 2 Dec 2011

Final

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Document Information

Document owner

Document Owner
The National Clinical Terminology and Information Service

Change history

Version	Date	Comments
1.0	21 Dec 2006	• Initial public release.
2.0	30 Jun 2009	• Re-release as "Core" Discharge Summary.
2.1	26 Aug 2009	• Revision of section 3; and • Other minor editing.
3.0	8 Mar 2010	• Upgrade to use version 2.0 of the Participation specification; • Include pathology archetypes; and • Incorporate IT14-06-06 feedback.
3.1	6 Sep 2010	• Upgrade to use version 3.0 of the Participation specification; and • Incorporate additional IT14-06-06 feedback.
3.2	2 Nov 2010	• DS-365: Incorporate IT14-06-06 feedback from Committee Meeting held on 25 Oct 2010; • DS-366: update acknowledgements list; • DS-367: rename to Discharge Summary Scope Exclusions and update exclusion statements; • DS-368: Include HL7 source link to statements about the use and registration of non-standard code sets in the structured document template; • DS-370: add missing hot links for NEHT2010i, NEHT2010q, and MOSB2008a; • DS-371: add new known issues; • DS-372: add statements that the Pathology and Data type and Participation specifications are non-normative; • DS-373: add reference set information for Problem/Diagnosis Description Values and Clinical Intervention Description Values.
3.3	2 Dec 2011	• Incorporate IT14-06-06 feedback from public comments collected between Nov 2010 and Feb 2011. • Include new version of LABORATORY REPORT and IMAGING TEST derived from NEHTA's published DCMs.

Version	Date	Comments
		Further information on these changes is detailed in Appendix D, *Log of Changes*.

Related documents

Name	Version/Release Date
National Discharge Summary Data Content Specification	Version 1.0, Issued 21 December 2006
Data Types in NEHTA Specifications: A Profile of the ISO 21090 Specification	Version 1.0, Issued September 2010
Data Specifications and Structured Document Templates - Guide for Use	Version 1.1, Issued September 2010
Participation Data Specification	Version 3.2, Issued 20 July 2011
Pathology Test Result Detailed Clinical Model Specification	Issued 01 September 2011, Version 2.0
Imaging Examination Result Detailed Clinical Model Specification	Issued 01 September 2011, Version 2.0

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- Members of the Australian DataTypes Project;
- Australian Institute of Health & Welfare;
- Medical Software Industry Association (MSIA) of Australia;
- Ocean Informatics; and
- Standards Australia Committee IT14-06-06.

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1 Introduction

1.1 Document Purpose

This document defines the Structured Document Template (SDT) for electronic discharge summaries in Australia. The SDT organises the data elements and data groups into a logical model for the clinical communication of discharge summaries.

The e-Discharge Summary SDT names the complete set of data elements that may be used interoperably in a valid discharge summary instance, and structures the content in a manner that delivers context and meaning. As such, it provides an information framework within which to achieve semantic interoperability, independent of any messaging format, sending/receiving application or data store.

This document is one component of the solution proposed by NEHTA for electronic discharge summaries. Other components include exchange format mappings, terminology reference sets and web service specifications.

This document draws on the significant work that resulted in the NEHTA National Discharge Summary Data Content Specification [NEHT2006a].

1.2 Document Scope

This specification document describes the logical information model proposed for use in communicating a discharge summary between a healthcare facility and the discharge summary recipients. The SDT defines the allowable set of data items, which may be used to facilitate interoperability, together with their structure, definition, datatype and constraints (including occurrence frequency, value domains and conditions of use).

The contents of this SDT release are restricted to those data items required to support the “Core Discharge Summary” specified in NEHTA e-Discharge Summary - Core Information Components [NEHT2010q]. The Core Discharge Summary defines the minimum set of data items that are recommended for implementation in any system that creates and transfers discharge summary information in Australia. This defines the core data components for exchange that are common to all clinical specialities/domains. It is anticipated that clinical domain specific discharge summaries will need additional data components to satisfy specialty specific requirements.

National extensions to the Core Discharge Summary will be considered to support particular specialty areas (e.g. Aged Care, Oncology, Obstetrics, Cardiology, Community Nursing). These extensions will be added to this SDT to form extended sets of nationally-agreed data items for discharge summary interoperable exchange. As such, the SDT will define the allowable set of data items, which may be used to facilitate interoperability at the national level.

Electronic discharge summary applications **SHALL** implement the core data components. It is anticipated that local extensions may be required to support specific local requirements. While it is possible for such local extensions to be achieved through negotiations and agreements between the information exchange partners, this is not a preferred option. It should be noted that data components used in local extensions should be sourced from standardised data groups and conformance rules that are developed and continue to be developed under the leadership of NEHTA. This approach is necessary to ensure interoperability and safe consumption of the interchanged information.

The specific content to be included in a discharge summary will depend upon the nature of the health problems/diagnoses, diagnostic tests performed, medications prescribed, and interventions performed etc. Some of this information is considered to be critical to include in every discharge summary for every subject of care, and as such is given an Obligation of ‘Essential’. For example:

- Subject of Care (Patient);
- Facility;
- Document Author;
- Encounter;
- Problems/Diagnoses;
- Clinical Synopsis;
- Current Medications on Discharge;
- Ceased Medications;
- Adverse Reactions; and
- Recommendations Provided.

Note that e-Discharge Summary - Core Information Components [NEHT2010q] specifies a number of data components required for document management and versioning. These items belong at a different architectural layer to that addressed by this SDT. Please refer to the relevant technical implementation specification, e.g. the CDA Implementation Guide, for information on how to implement these data components.

Other information components may be considered as not relevant to certain types of subject of care, and hence data may not always be collected for these information components during the encounter, and may not be populated in a discharge summary document instance for such subjects of care. These information components include:

- Nominated Primary Healthcare Provider;
- Diagnostic Investigations;
- Clinical Interventions;
- Alerts;
- Arranged Services; and
- Information Provided to Subject of Care and/or Relevant Parties.

1.3 Terminology

While NEHTA's delivery of a national standard clinical terminology is based on the Systematised Nomenclature of Medicine - Clinical Terms® (SNOMED CT® [1]) as the foundational resource, local variations and customisation of terms relevant to the Australian healthcare sector will be incorporated.

NEHTA, through the National Clinical Terminology and Information Service (NCTIS), is defining a national approach to clinical terminology. Consistent and accurate articulation and interpretation of clinical terms is critical to the process of safe information exchange.

SNOMED CT has been recommended by NEHTA and endorsed by the Australian federal, state and territory governments as the preferred clinical terminology for Australia, and is available for e-health software developers to use in their Australian products under International Health Terminology Standards Development Organisation (IHTSDO) licensing arrangements.

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

SNOMED CT Australian Release (SNOMED CT-AU) contains the Australian extension to SNOMED CT - the integrated national release of SNOMED CT for implementation in Australian deployed clinical IT systems.

NEHTA also releases the Australian Medicines Terminology (AMT) as the designated clinical terminology for medicines available in Australia. The AMT will provide a consistent approach to the identification and naming of medicines to support medicines management and related activity across the Australian healthcare domain.

NEHTA supports the use of the Logical Observation Identifiers Names and Codes (LOINC® [2]) for use with pathology information where appropriate.

For further information regarding terminology and the development of reference sets please visit *http://-www.nehta.gov.au/connecting-australia/terminology-and-information/clinical-terminology* and direct your questions to *terminologies@nehta.gov.au*.

1.4 Discharge Summary Definition

A discharge summary is defined in AS 4700.6 (2007) – Implementation of Health Level 7 (HL7) Version 2.5 – Part 6: Referral, discharge and health record messaging [SA2007a] specification as:

> *A collection of information about events during care by a provider or organisation.*

A *discharge summary* is a document produced during a subject of care's stay in hospital as an admitted or non-admitted patient and issued when or after a subject of care leaves the care of the hospital. Its primary function is to support the continuity of care as the subject of care returns to the care of their community healthcare providers.

The primary recipients of the discharge summary are healthcare providers who were providing care to the subject of care prior to the hospital stay, including:

- the subject of care's nominated primary healthcare provider, e.g. the usual General Practitioner or primary health service such as an Aboriginal Community Controlled Health Service;
- the referring clinician (e.g. private specialist);
- the residential aged care facility where the subject of care usually resides; and
- other health professionals who will be involved in the subject of care's post-discharge care.

Within this primary function the purpose of the NEHTA discharge summary package is to:

- assist and improve clinician-to-clinician communication; and
- enable system-to-system communication of semantically interoperable data.

The secondary functions of the discharge summary include:

- providing summary information regarding an earlier healthcare encounter on the re-presentation of the subject of care to acute care;
- use by clinical coders when coding relevant information pertinent to the healthcare encounter;
- providing the subject of care with a record of their hospital admission and care; and
- inclusion in an Individual Electronic Health Record (IEHR), which could include a national IEHR or a local repository, for example to support coordinated care.

[2] LOINC® is a registered trademark of the Regenstrief Institute, Inc.

1.5 Discharge Summary Scope Exclusions

The scope of this Discharge Summary specification excludes discharge summaries that:

- include an attached ‘Summary Health Profile’, or considers their future implementation;
- are functionally-specific to the transfer of care, as required by a ‘Referral’ including a "Discharge-Referral";
- are compiled upon the transfer of a subject of care between units within the acute care setting (i.e. Transfer Summary);
- are related to subject's of care being admitted for dialysis, same day radiotherapy and other procedures involving repetitive one day admissions; and
- are concerned with administrative notifications (e.g. admission and discharge notifications).

1.6 Intended Audience

This document is intended to be read and understood by:

1. Software development teams:
   a. To plan, architect or implement:
      - clinical applications, infrastructure components or messaging interfaces; and
      - systems that facilitate semantic interoperability.
   b. To support NEHTA-defined terminology in:
      - clinical and messaging interfaces;
      - generating value domains for data elements;
      - creating or receiving electronic information exchanges containing clinical content;
      - writing queries over clinical Electronic Health Record (EHR) data;
      - implementing data constraint checks; and
      - designing term mappings.
2. IT-aware clinicians who wish to evaluate the clinical suitability of NEHTA specifications.
3. Researchers who wish to explore certain aspects of NEHTA specifications.

The documents are technical in nature and expect the audience to be familiar with the language of health data specifications, and health information standards and their implementation.

1.7 Known Issues

There are known issues with this document in the following areas:

1. anatomical locations:
2. document purpose;

3. exclusion data groups;

4. health event; and

5. problem/diagnosis type.

Further information on these issues is detailed in Appendix A, *Known Issues*.

This structured document template relies on these specifications:

1. NEHTA Participation Data Specification [NEHT2011v]; and

2. NEHTA Data Types in NEHTA Specifications: A Profile of the ISO 21090 Specification [NEHT2010c].

At the time of authoring, these specifications have not received standards approval, are subject to change, and should not be considered normative.

2 Discharge Summary Structured Document

2.1 DISCHARGE SUMMARY

Identification

Name	DISCHARGE SUMMARY
Metadata Type	Structured Document
Identifier	SD-20000
OID	1.2.36.1.2001.1001.101.100.20000

Definition

Definition	A collection of information about events during care by a provider or organisation, which is released when the subject of care is discharged from the care of the provider organisation.
Definition Source	NEHTA
Synonymous Names	Separation Summary

Data Hierarchy

DISCHARGE SUMMARY			1..1
CONTEXT			
	DateTime Attested		1..1
	DOCUMENT AUTHOR		1..1
	SUBJECT OF CARE		1..1
	FACILITY		1..1
	Care Setting		0..1
	HEALTH EVENT IDENTIFICATION		0..1
		Health Event Identifier	0..1
		DateTime Health Event Started	1..1
		DateTime Health Event Ended	0..1

CONTENT	
EVENT	1..1
ENCOUNTER	1..1
Encounter Period	1..1
Separation Mode	1..1
Specialty	1..*
Location of Discharge	1..1
RESPONSIBLE HEALTH PROFESSIONAL AT TIME OF DISCHARGE	1..1
OTHER PARTICIPANT	0..*
PROBLEMS/DIAGNOSES THIS VISIT	1..1
EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	0..1
Global Statement	1..1
PROBLEM/DIAGNOSIS	0..*
Problem/Diagnosis Type	1..1
Problem/Diagnosis Description	1..1
CLINICAL INTERVENTIONS PERFORMED THIS VISIT	0..1
CLINICAL INTERVENTION	1..*
Clinical Intervention Description	1..1
CLINICAL SYNOPSIS	1..1
Clinical Synopsis Description	1..1
DIAGNOSTIC INVESTIGATIONS	0..1
PATHOLOGY TEST RESULT	0..*
Pathology Test Result Name	1..1
Diagnostic Service	0..1
TEST SPECIMEN DETAIL	0..*
Specimen Tissue Type	0..1
Collection Procedure	0..1
ANATOMICAL LOCATION	0..*
SPECIFIC LOCATION	0..1
Anatomical Location Name	0..1

											Side		0..1
										Anatomical Location Description			0..1
										Anatomical Location Image			0..*
									PHYSICAL PROPERTIES OF AN OBJECT				0..*
										Weight			0..1
										DIMENSIONS			0..1
											Volume		0..1
										Object Description			0..1
										Image			0..1
									COLLECTION AND HANDLING				0..1
										Sampling Preconditions			0..1
									HANDLING AND PROCESSING				0..1
										Collection DateTime			0..1
										Collection Setting			0..1
										DateTime Received			0..1
									IDENTIFIERS				0..1
										Specimen Identifier			0..1
										Parent Specimen Identifier			0..1
										Container Identifier			0..1
							Overall Pathology Test Result Status						1..1
							Clinical Information Provided						0..1
							PATHOLOGY TEST RESULT GROUP						0..*
								Pathology Test Result Group Name					1..1
								INDIVIDUAL PATHOLOGY TEST RESULT					1..*
									Individual Pathology Test Result Name				1..1
									Individual Pathology Test Result Value				0..1
										Individual Pathology Test Result Value Normal Status			0..1
										INDIVIDUAL PATHOLOGY TEST RESULT VALUE REFERENCE RANGE DETAILS			0..*

								Individual Pathology Test Result Value Reference Range Meaning	1..1
								Individual Pathology Test Result Value Reference Range	1..1
							Individual Pathology Test Result Comment		0..*
							Individual Pathology Test Reference Range Guidance		0..1
							Individual Pathology Test Result Status		1..1
						RESULT GROUP SPECIMEN DETAIL			0..1
							Specimen Tissue Type		0..1
							Collection Procedure		0..1
							ANATOMICAL LOCATION		0..*
								SPECIFIC LOCATION	0..1
								Anatomical Location Name	0..1
								Side	0..1
								Anatomical Location Description	0..1
								Anatomical Location Image	0..*
							PHYSICAL PROPERTIES OF AN OBJECT		0..*
								Weight	0..1
								DIMENSIONS	0..1
								Volume	0..1
								Object Description	0..1
								Image	0..1
							COLLECTION AND HANDLING		0..1
								Sampling Preconditions	0..1
							HANDLING AND PROCESSING		0..1
								Collection DateTime	0..1
								Collection Setting	0..1
								DateTime Received	0..1
							IDENTIFIERS		0..1
								Specimen Identifier	0..1
								Parent Specimen Identifier	0..1

								Container Identifier	0..1
					Pathological Diagnosis				0..*
					Pathology Test Conclusion				0..1
					Test Result Representation				0..1
					Test Comment				0..1
					TEST REQUEST DETAILS				0..*
						Test Requested Name			0..*
						Laboratory Test Result Identifier			0..1
					Pathology Test Result DateTime				1..1
				IMAGING EXAMINATION RESULT					0..*
					Imaging Examination Result Name				1..1
					Imaging Modality				0..1
					ANATOMICAL LOCATION				0..*
						SPECIFIC LOCATION			0..1
							Anatomical Location Name		0..1
							Side		0..1
						Anatomical Location Description			0..1
						Anatomical Location Image			0..*
					Imaging Examination Result Status				1..1
					Clinical Information Provided				0..1
					Findings				0..1
					IMAGING EXAMINATION RESULT GROUP				0..*
						Imaging Examination Result Group Name			1..1
						INDIVIDUAL IMAGING EXAMINATION RESULT			1..*
							Individual Imaging Examination Result Name		1..1
							Imaging Examination Result Value		0..1
							Imaging Examination Result Value Normal Status		0..1
							IMAGING EXAMINATION RESULT VALUE REFERENCE RANGE DETAILS		0..*

| | | |

						Dose Instruction	1..1
					Unit of Use Quantity Dispensed		0..1
					Reason for Therapeutic Good		0..1
					Additional Comments		0..1
					MEDICATION HISTORY		1..1
						Item Status	1..1
						CHANGE DETAIL	0..1
							Changes Made	1..1
							Reason for Change	0..1
						Medication Duration	0..1
				CEASED MEDICATIONS			1..1
					EXCLUSION STATEMENT - MEDICATIONS		0..1
					Global Statement		1..1
					THERAPEUTIC GOOD		0..*
					Therapeutic Good Identification		1..1
					MEDICATION HISTORY		1..1
						Item Status	1..1
						CHANGE DETAIL	1..1
							Changes Made	1..1
							Reason for Change	1..1
		HEALTH PROFILE					1..1
			HEALTHCARE PROVIDERS				0..1
				NOMINATED PRIMARY HEALTHCARE PROVIDER			1..*
			ADVERSE REACTIONS				1..1
				EXCLUSION STATEMENT - ADVERSE REACTION			0..1
					Global Statement		1..1
					ADVERSE REACTION		0..*
					Agent Description		1..1

					Adverse Reaction Type	1..1
					REACTION DETAIL	0..*
					Reaction Description	1..1
			ALERTS			0..1
				ALERT		1..*
					Alert Type	1..1
					Alert Description	1..1
		PLAN				1..1
			ARRANGED SERVICES			0..1
				ARRANGED SERVICE		1..*
					Arranged Service Description	1..1
					Service Commencement Window	0..1
					Service Booking Status	1..1
					PROTOCOL	0..1
					SERVICE PROVIDER	0..1
			RECORD OF RECOMMENDATIONS AND INFORMATION PROVIDED			1..1
				RECOMMENDATIONS PROVIDED		1..*
					RECOMMENDATION RECIPIENT	1..1
					Recommendation Note	1..1
				INFORMATION PROVIDED		0..1
					Information Provided to Subject of Care and/or Relevant Parties	1..1

3 Discharge Summary Context

3.1 DateTime Attested

Identification

Name	DateTime Attested
Metadata Type	Data Element
Identifier	DE-20106
OID	1.2.36.1.2001.1001.101.103.20106

Definition

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

Usage

Conditions of Use	Where possible, exact dates should be used. Incomplete dates should generally only be used for retrospective data collection.
Conditions of Use Source	NEHTA
Examples	See: Appendix B: *Specification Guide for Use* />
Misuse	Entering approximate dates when an exact date is available.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY	Essential		Single

3.2 DOCUMENT AUTHOR

Identification

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

Definition

Definition	The healthcare provider who is the main author of the document.
Definition Source	NEHTA
Synonymous Names	Author

Usage

Conditions of Use	This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v]. The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B: *Specification Guide for Use*. Additional obligation and occurrence constraints: • LOCATION OF PARTICIPATION is **PROHIBITED**. • Entity Identifier is **ESSENTIAL**. • Relationship to Subject of Care is **PROHIBITED**. • DEMOGRAPHIC DATA is **PROHIBITED**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**. Other additional constraints: • Participation Type **SHALL** have an implementation-specific fixed value equivalent to “Document Author”. • Role **SHOULD** have a value chosen from 1220.0 - ANZSCO - Australia and New Zealand Standard Classification of Occupations, First Edition, 2006 - METeOR 350899. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used. • The value of one Entity Identifier **SHALL** be an Australian HPI-I.

	• AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY	Essential		Single

3.3 SUBJECT OF CARE

Identification

Name	SUBJECT OF CARE
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296
External Identifier	AS 5017-2006

Definition

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

Usage

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

	• Qualifications is **PROHIBITED**. Other additional constraints: • Participation Type **SHALL** have an implementation-specific fixed value equivalent to “Subject of Care”. • Role **SHALL** have an implementation-specific fixed value equivalent to “Patient”. • The value of Entity Identifier **SHALL** be an Australian IHI. • ADDRESS **SHALL** have an Address Purpose value of “Residential” or “Temporary Accommodation”. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY	Essential		Single

3.4 FACILITY

Identification

Name	FACILITY
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	Details pertaining to the identification of a Healthcare Organisation/Facility which is involved in or associated with the delivery of the healthcare services to the subject of care, or caring for his/her wellbeing.
Definition Source	NEHTA
Synonymous Names	Healthcare Organisation Identification Healthcare Facility Facility Details.

Usage

Conditions of Use	This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v]. The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B: *Specification Guide for Use*. Additional obligation and occurrence constraints: • Participation Period is **PROHIBITED**. • LOCATION OF PARTICIPATION is **PROHIBITED**. • Entity Identifier is **ESSENTIAL**. • ADDRESS is **ESSENTIAL**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**. Other additional constraints: • Participation Type **SHALL** have an implementation-specific fixed value equivalent to “Facility”. • Role **SHALL** have a value representing the type of Facility e.g. Hospital, Clinic. • The value of at least one Entity Identifier **SHALL** be an Australian HPI-O.

	• AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • The value of at least one Electronic Communication Medium **SHALL** be “Telephone” or “Mobile telephone”. • The value of at least one Electronic Communication Medium **SHALL** be “Facsimile machine”. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a ORGANISATION.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY	Essential		Single

3.5 Care Setting

Identification

Name	Care Setting
Metadata Type	Data Element
Identifier	DE-20111
OID	1.2.36.1.2001.1001.101.103.20111

Definition

Definition	A description of the type of care setting within which healthcare services have been provided to the subject of care.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[1] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Accident and Emergency. 2. Acute Care.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY	Optional		Single

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

3.6 HEALTH EVENT IDENTIFICATION

Identification

Name	HEALTH EVENT IDENTIFICATION
Metadata Type	Data Group
Identifier	DG-10331
OID	1.2.36.1.2001.1001.101.102.10331

Definition

Definition	Identifies or labels a health story or focus against which one or more related healthcare events can be grouped.
Definition Source	NEHTA
Synonymous Names	Episode
Notes	Conceptually, a health event is a happening or situation e.g. post-Discharge care/rehabilitation, (named) Disease Management program, for which healthcare services (events) are provided to the subject of care to which the health event relates. The health event identification: • is determined by a healthcare provider/healthcare organisation • is initiated to manage/track address certain health problem(s)/issue(s) • can cover one or more illnesses • can involve one or more provider(s) • can be ongoing A document may be attributed with more than one Health Event Identification; i.e. a healthcare record may be included in more than one 'healthcare story or focus'. When the same Health Event Identification is applied to other documents, all of the values (identifier and DateTimes) of the data group are duplicated in those other documents.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Health Event Identifier	Optional		Single
	DateTime Health Event Started	Essential		Single
	DateTime Health Event Ended	Optional		Single

3.7 Health Event Identifier

Identification

Name	Health Event Identifier
Metadata Type	Data Element
Identifier	DE-10333
OID	1.2.36.1.2001.1001.101.103.10333

Definition

Definition	The unique label/identifier for a specific health story or focus to which the clinical document is linked or with which it is associated.
Definition Source	NEHTA
Synonymous Names	
Assumptions	The same label/identifier can be recorded in more that one clinical document of the same or different types. Recording the same label/identifier serves to link a series of healthcare events/encounters/clinical interactions to the same health event. The Health Event Identifier is intended for system/computer consumption and does not need to be seen/consumed by a human user, e.g. the discharge summary recipient. Health Event is used synonymously with Episode and Encounter. A visit to the emergency department is considered an encounter. A second visit to the emergency department, although for the same (unresolved) problem is considered another encounter. An admission to the hospital (from admission to discharge) is considered an encounter. A re-admission to the hospital for the unresolved problem(s) from the previous admission should be considered as another encounter. This is especially important for management of subjects of care with chronic illness such as hypertension, chronic respiratory diseases, etc. where multiple emergency department visits, admission or GP visits can occur. Information from jurisdiction consultation also indicates that about 5% of admitted subjects of care may experience "administrative discharge", e.g. a surgical patient may be "administratively discharged" to the care of the palliative care team but stays in the hospital, and is likely to stay in the same ward and same bed. Such subjects of care will have two episode IDs assigned for the single admission, but only one discharge summary will be generated for the subject of care, being at the time of physical discharge from the hospital. Jurisdiction advisor recommends that the 2nd episode ID should be used in such cases where the subject of care is assigned two episode IDs during a single encounter.
Assumptions Source	NEHTA
Notes	This is used for local definition and local use cases and is not used by a national IHI Service.
Data Type	UniqueIdentifier

Usage

Examples	See: Appendix B: *Specification Guide for Use*

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	HEALTH EVENT IDENTIFICATION	Optional		Single

3.8 DateTime Health Event Started

Identification

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

Definition

Definition	The date and time of the start of the healthcare event/encounter/clinical interaction that the document or document set relates to.
Definition Source	NEHTA
Synonymous Names	
Notes	The meaning of 'DateTime Health Event Started' is defined within each Structured Document Template in terms of needing an anchoring point for the document or document set.
Data Type	DateTime

Usage

Conditions of Use	Where possible, exact dates should be used. Incomplete dates should generally only be used for retrospective data collection.
Conditions of Use Source	NEHTA
Examples	See: Appendix B: *Specification Guide for Use*
Misuse	Entering approximate dates when an exact date is available.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	HEALTH EVENT IDENTIFICATION	Essential		Single

3.9 DateTime Health Event Ended

Identification

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

Definition

Definition	The date and time of the end of the health event that the document or document set relates to.
Definition Source	NEHTA
Synonymous Names	
Notes	The meaning of 'DateTime Health Event Ended' is defined within each Structured Document Template in terms of needing an anchoring point for the document or document set.
Data Type	DateTime

Usage

Conditions of Use	Where possible, exact dates should be used. Incomplete dates should generally only be used for retrospective data collection.
Conditions of Use Source	NEHTA
Examples	See: Appendix B: *Specification Guide for Use*
Misuse	Entering approximate dates when an exact date is available.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	HEALTH EVENT IDENTIFICATION	Optional		Single

4 Event Section

4.1 EVENT

Identification

Name	EVENT
Metadata Type	Section
Identifier	S-16006
OID	1.2.36.1.2001.1001.101.101.16006

Definition

Definition	Details of the subject of care's stay in a healthcare facility which instigated the creation of the discharge summary.
Definition Source	NEHTA
Synonymous Names	
Scope	This includes clinical observations, assessments and interventions.
Scope Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY	Essential		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	ENCOUNTER	Essential		Single
	PROBLEMS/DIAGNOSES THIS VISIT	Essential		Single
	CLINICAL INTERVENTIONS PERFORMED THIS VISIT	Optional		Single
	CLINICAL SYNOPSIS	Essential		Single
	DIAGNOSTIC INVESTIGATIONS	Optional		Single

4.2 ENCOUNTER

Identification

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

Definition

Definition	Administrative details of the subject of care's stay in a healthcare facility.
Definition Source	NEHTA
Synonymous Names	Admission
Scope	This data group includes stays as an admitted subject of care as well as stays managed in an Emergency Department without leading to admission.
Scope Source	NEHTA
Assumptions	A discharge summary will not be generated for subjects of care attending a healthcare facility for day care/services, e.g. haemodialysis.
Assumptions Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	EVENT	Essential		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Encounter Period	Essential		Single
	Separation Mode	Essential		Single
	Specialty	Essential		Multiple
	Location of Discharge	Essential		Single
	RESPONSIBLE HEALTH PROFESSIONAL AT TIME OF DISCHARGE	Essential		Single

Data Type	Name	Obligation	Condition	Occurrence
	OTHER PARTICIPANT	Optional		Multiple

4.3 Encounter Period

Identification

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

Definition

Definition	The date (and optionally time) of the start and end of the encounter that this discharge summary refers to.
Definition Source	NEHTA
Synonymous Names	
Notes	In the case of admitted subjects of care: • the start of the encounter period is the date/time of their admission to the healthcare facility; • the end of the encounter period is the date/time of their discharge from the healthcare facility;
Data Type	TimeInterval

Usage

Examples	See: Appendix B: *Specification Guide for Use*

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ENCOUNTER	Essential		Single

4.4 Separation Mode

Identification

Name	Separation Mode
Metadata Type	Data Element
Identifier	DE-20121
OID	1.2.36.1.2001.1001.101.103.20121

Definition

Definition	Status at separation of the subject of care and place to which the person is released.
Definition Source	NEHTA
Synonymous Names	Separation Reason Discharge Reason Discharge To
Notes	Based on METeOR Data Element Concept 270094
Data Type	CodedText
Value Domain	Separation Mode Values

Usage

Examples	1. Discharge/transfer to (an)other acute hospital

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ENCOUNTER	Essential		Single

4.5 Separation Mode Values

Identification

Name	Separation Mode Values
Metadata Type	Value Domain
Identifier	VD-20121
OID	1.2.36.1.2001.1001.101.104.20121
External Identifier	METeOR id: 270688

Definition

Definition	A code set representing the status and destination of a patient at separation.
Definition Source	AIHW National Health Data Dictionary

Value Domain

Source	*METeOR: AIHW Mode of Separation*[1]
Permissible Values	1 Discharge/transfer to (an)other acute hospital. 2 Discharge/transfer to a residential aged care service, unless this is the usual place of residence. 3 Discharge/transfer to (an)other psychiatric hospital. 4 Discharge/transfer to other health care accommodation (includes mothercraft hospitals). 5 Statistical discharge - type change. 6 Left against medical advice/discharge at own risk. 7 Statistical discharge from leave. 8 Died. 9 Other (includes discharge to usual residence, own accommodation/welfare institution (includes prisons, hostels and group homes providing primarily welfare services)).

[1] http://meteor.aihw.gov.au/content/index.phtml/itemId/270094

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Separation Mode	Essential		Single

4.6 Specialty

Identification

Name	Specialty
Metadata Type	Data Element
Identifier	DE-16028
OID	1.2.36.1.2001.1001.101.103.16028

Definition

Definition	The clinical specialty under which the subject of care was treated during the encounter.
Definition Source	NEHTA
Synonymous Names	
Notes	When the subject of care has been managed by multiple clinical specialities during the encounter/event, each specialty should only appear once. The specialties are in reverse chronological order (i.e. the last specialty appears first) so that the subject of care's journey during the healthcare event can be readily discerned.
Data Type	CodeableText
Value Domain	Specialty Values

Usage

Examples	1. Specialist urogynaecologist 2. Specialist paediatric gastroenterologist and hepatologist 3. Specialist otolaryngologist - head and neck surgeon

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ENCOUNTER	Essential		Multiple

4.7 Specialty Values

Identification

Name	Specialty Values
Metadata Type	Value Domain
Identifier	VD-16028
OID	1.2.36.1.2001.1001.101.104.16028

Definition

Definition	The set of values for the clinical specialty under which the subject of care was treated during the encounter.
Definition Source	NEHTA

Value Domain

Source	Medical Board of Australia: Medical Specialties and Specialty Fields [MBA2010a]

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Specialty	Essential		Single

4.8 Location of Discharge

Identification

Name	Location of Discharge
Metadata Type	Data Element
Identifier	DE-16040
OID	1.2.36.1.2001.1001.101.103.16040

Definition

Definition	The physical location *from* which the subject of care was discharged. In the case of admitted subjects of care, this should be the ward in which they were located at the time of discharge. For non-admitted subjects of care, this may be the department in which the encounter occurred.
Definition Source	NEHTA
Synonymous Names	
Notes	For non-admitted subjects of care the value of this data element would typically be the Emergency Department or equivalent.
Data Type	Text

Usage

Examples	1. Emergency Department 2. Cardiac Ward 3. Oncology Ward

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ENCOUNTER	Essential		Single

4.9 RESPONSIBLE HEALTH PROFESSIONAL AT TIME OF DISCHARGE

Identification

Name	RESPONSIBLE HEALTH PROFESSIONAL AT TIME OF DISCHARGE
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	The healthcare provider who has the overall responsibility for the care given to the subject of care at the time of discharge.
Definition Source	NEHTA
Synonymous Names	

Usage

Conditions of Use	This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v]. The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B: *Specification Guide for Use*. Additional obligation and occurrence constraints: • LOCATION OF PARTICIPATION is **PROHIBITED**. • Entity Identifier is **ESSENTIAL**. • Relationship to Subject of Care is **PROHIBITED**. • DEMOGRAPHIC DATA is **PROHIBITED**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**. Other additional constraints: • Participation Type **SHALL** have an implementation-specific value equivalent to “Responsible Health Professional at Time of Discharge”. • Role **SHOULD** have a value chosen from 1220.0 - ANZSCO - Australia and New Zealand Standard Classification of Occupations, First Edition, 2006 - METeOR 350899. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used.

	• The value of Entity Identifier **SHALL** be an Australian HPI-I. • AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ENCOUNTER	Essential		Single

4.10 OTHER PARTICIPANT

Identification

Name	OTHER PARTICIPANT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	Other healthcare providers who were involved in the encounter, or individuals associated with the subject of care at the time of the encounter, and the role that they played – e.g. registrar, referred specialist, referring clinician, emergency contact.
Definition Source	NEHTA
Synonymous Names	
Notes	The value of Participation Type will depend upon the nature of the participant's involvement in the healthcare event.

Usage

Conditions of Use	This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v]. The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B: *Specification Guide for Use*. Additional obligation and occurrence constraints: • LOCATION OF PARTICIPATION is **PROHIBITED**. • If the OTHER PARTICIPANT has an Australian HPI-I, then Entity Identifier is **ESSENTIAL**, otherwise it is **OPTIONAL**. • If the OTHER PARTICIPANT has an Australian HPI-I, then DEMOGRAPHIC DATA is **PROHIBITED**, otherwise it is **OPTIONAL**. • Date of Birth is Calculated From Age is **PROHIBITED**. • DATE OF BIRTH ACCURACY INDICATOR is **PROHIBITED**. • AGE DETAIL is **PROHIBITED**. • Birth Plurality is **PROHIBITED**. • Birth Order is **PROHIBITED**. • DATE OF DEATH DETAIL is **PROHIBITED**.

	• Source of Death Notification is **PROHIBITED**. • Mothers Original Family Name is **PROHIBITED**. • Country of Birth is **PROHIBITED**. • State/Territory of Birth is **PROHIBITED**. • Indigenous Status is **PROHIBITED**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**. Other additional constraints: • Role **SHOULD** have a value chosen from 1220.0 - ANZSCO - Australia and New Zealand Standard Classification of Occupations, First Edition, 2006 - METeOR 350899. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON. • If the OTHER PARTICIPANT has an Australian HPI-I, then one value of Entity Identifier **SHALL** be an Australian HPI-I.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ENCOUNTER	Optional		Multiple

4.11 PROBLEMS/DIAGNOSES THIS VISIT

Identification

Name	PROBLEMS/DIAGNOSES THIS VISIT
Metadata Type	Section
Identifier	S-16142
OID	1.2.36.1.2001.1001.101.101.16142

Definition

Definition	Describes the diagnostic labels or problem statements assigned by the healthcare provider to describe the diagnoses or health/medical problems relevant to the subject of care during the encounter.
Definition Source	NEHTA
Synonymous Names	Problems/Diagnoses This Admission Problems/Diagnoses During This Visit Problems/Diagnosis This Encounter
Scope	Used to describe the subject of care's diagnoses or health/problem problems that were identified and managed during a specific health event/encounter. NOTE: This section label uses a generic term 'This Visit' as the section label is intended for use in discharge summary for either admitted subjects of care or Emergency Department visits (for which the encounter is not considered as admission). For admitted subjects of care this section label can be replaced with a more specific label, e.g. 'PROBLEMS/DIAGNOSES: This Admission'.
Scope Source	NEHTA
Notes	Types of problems/diagnoses may include: 1. Principal Problem/Diagnosis 2. Co-morbidities 3. Complications

Usage

Conditions of Use	This **SHALL** include at least one problem/diagnosis whose type is “Principal”.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	EVENT	Essential		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	Optional		Single
	PROBLEM/DIAGNOSIS	Optional		Multiple

4.12 EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES

Identification

Name	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES
Metadata Type	Data Group
Identifier	DG-16138
OID	1.2.36.1.2001.1001.101.102.16138

Definition

Definition	Assertion that no problem or diagnosis information is included in this section of the document.
Definition Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PROBLEMS/DIAGNOSES THIS VISIT	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Global Statement	Essential		Single

4.13 Global Statement

Identification

Name	Global Statement
Metadata Type	Data Element
Identifier	DE-16302
OID	1.2.36.1.2001.1001.101.103.16302

Definition

Definition	Global statements about the exclusion.
Definition Source	openEHR Foundation
Synonymous Names	
Context	This can be used to capture any information that is needed to be explicitly recorded as being absent or excluded within the record.
Context Source	openEHR Foundation
Data Type	CodedText
Value Domain	Global Statement Values

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	Optional		Multiple

4.14 Global Statement Values

Identification

Name	Global Statement Values
Metadata Type	Value Domain
Identifier	VD-16299
OID	1.2.36.1.2001.1001.101.104.16299

Definition

Definition	The set of values for the global statements about the exclusion of problems or diagnoses.
Definition Source	openEHR Foundation

Value Domain

Source	NEHTA	
Permissible Values	*Not asked*	No information about problems/diagnoses is available because the patient was not asked or not able to be asked
	None known	No information about problems/diagnoses is known
	None supplied	No information about problems/diagnoses is supplied

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Global Statement	Essential		Single

4.15 PROBLEM/DIAGNOSIS

Identification

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

Definition

Definition	Describes a diagnostic label or problem statement assigned by the healthcare provider to describe the diagnoses or health/medical problems affecting the subject of care.
Definition Source	NEHTA
Synonymous Names	
Notes	An account of relevant identified health related problems as reported by a healthcare provider. This can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status as assessed by a healthcare provider. This data group should only include problems/diagnoses related to the healthcare encounter that the discharge summary is created for.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PROBLEMS/DIAGNOSES THIS VISIT	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Problem/Diagnosis Type	Essential		Single
	Problem/Diagnosis Description	Essential		Single

4.16 Problem/Diagnosis Type

Identification

Name	Problem/Diagnosis Type
Metadata Type	Data Element
Identifier	DE-15547
OID	1.2.36.1.2001.1001.101.103.15547

Definition

Definition	The type used to categorise the problem/diagnosis.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodedText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[2] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Principal 2. Complication 3. Co-morbidity

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS	Essential		Single

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

4.17 Problem/Diagnosis Description

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS	Essential		Single

4.18 Problem/Diagnosis Reference Set

Identification

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Problem/Diagnosis Description	Essential		Single

4.19 CLINICAL INTERVENTIONS PERFORMED THIS VISIT

Identification

Name	CLINICAL INTERVENTIONS PERFORMED THIS VISIT
Metadata Type	Section
Identifier	S-20109
OID	1.2.36.1.2001.1001.101.101.20109

Definition

Definition	Describes the clinical interventions (including operations, procedures and relevant nursing and allied health interventions) performed on the subject of care during the healthcare encounter.
Definition Source	NEHTA
Synonymous Names	Procedures Performed This Visit
Scope	Used to describe surgical, medical, nursing and/or allied health interventional procedures performed on the subject of care during a health care encounter, and excludes diagnostic procedures. NOTE: This section label uses a generic term 'This Visit' as the section label is intended for use in discharge summary for either admitted subjects of care or Emergency Department Visits (for which the encounter is not considered as admission). For admitted subjects of care this section label can be replaced with a more specific label, e.g. 'PROCEDURES PERFORMED: This Admission'.
Scope Source	NEHTA

Usage

Misuse	Used to describe diagnostic procedures performed during visit/encounter.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	EVENT	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	CLINICAL INTERVENTION	Essential		Multiple

4.20 CLINICAL INTERVENTION

Identification

Name	CLINICAL INTERVENTION
Metadata Type	Data Group
Identifier	DG-15514
OID	1.2.36.1.2001.1001.101.102.15514

Definition

Definition	Describes an intervention carried out by a healthcare provider to improve, maintain or assess the health of a subject of care, in a clinical situation that may require clinical judgement to produce a subjective finding (i.e. an 'action' that may include an 'evaluation').
Definition Source	NEHTA
Synonymous Names	Therapeutic Intervention Therapeutic Procedure Treatment Procedure Counselling/Advising
Scope	Describes the clinical interventions or procedures performed on the subject of care by a healthcare provider. The information is relevant and/or important for the ongoing management of the subject of care, as in the cases of referral or post discharge care. These interventions can be invasive or non-invasive in nature, and may include cognitive intervention procedures, but exclude diagnostic procedures.
Scope Source	NEHTA
Notes	Captures detailed information on relevant clinical interventions, as performed by a healthcare provider. Includes information on therapeutic/treatment procedures during the healthcare visit/encounter and can include diagnostic procedures.

Usage

Misuse	Recording Medications prescribed; or Reporting Pathology or Diagnostic Imaging results.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	CLINICAL INTERVENTIONS PERFORMED THIS VISIT	Essential		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Clinical Intervention Description	Essential		Single

4.21 Clinical Intervention Description

Identification

Name	Clinical Intervention Description
Metadata Type	Data Element
Identifier	DE-15579
OID	1.2.36.1.2001.1001.101.103.15579

Definition

Definition	Describes the clinical intervention undertaken on or provided to the subject of care.
Definition Source	NEHTA
Synonymous Names	
Notes	A separate description should be included for each Clinical Intervention performed.
Data Type	CodeableText
Value Domain	Clinical Intervention Description Values

Usage

Examples	1. Creation of Arterio-venous shunt for haemodialysis 2. Peritoneal Dialysis

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	CLINICAL INTERVENTION	Essential		Single

4.22 Clinical Intervention Description Values

Identification

Name	Clinical Intervention Description Values
Metadata Type	Value Domain
Identifier	VD-15579
OID	1.2.36.1.2001.1001.101.104.15579
External Identifier	SNOMED CT-AU Concept Id: 32570141000036105

Definition

Definition	This is the Procedure foundation reference set from SNOMED CT-AU. It is the broadest possible terminology to support the recording of clinical interventions in Australian e-health implementations.
Definition Source	NEHTA

Value Domain

Source	SNOMED CT-AU Procedure foundation reference set

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Clinical Intervention Description	Essential		Single

4.23 CLINICAL SYNOPSIS

Identification

Name	CLINICAL SYNOPSIS
Metadata Type	Data Group
Identifier	DG-15513
OID	1.2.36.1.2001.1001.101.102.15513

Definition

Definition	Summary information or comments about the clinical management of the subject of care, and the prognosis of diagnoses/problems identified during the healthcare encounter. It may also include health-related information pertinent to the subject of care, and a clinical interpretation of relevant investigations and observations performed on the subject of care (including pathology and diagnostic imaging).
Definition Source	NEHTA
Synonymous Names	Clinical Comment Clinical Note Clinical Summary Clinical Management Summary
Scope	Narrative information is captured or entered here by a healthcare provider from the focus of a healthcare provider, carer, subject of care and/or others unrelated to the subject of care.
Scope Source	NEHTA

Usage

Conditions of Use	Used by the healthcare provider to describe additional information such as interpretation and the subject of care's understanding of the health care event that are not captured by other structured or unstructured information components pertinent to that health care event.
Conditions of Use Source	NEHTA
Misuse	Used in place of other individual data items. Used to list discharge medications.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	EVENT	Essential		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
T	Clinical Synopsis Description	Essential		Single

4.24 Clinical Synopsis Description

Identification

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

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	CLINICAL SYNOPSIS	Essential		Single

4.25 DIAGNOSTIC INVESTIGATIONS

Identification

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

Definition

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

Usage

Misuse	Including diagnostic test results which are NOT considered to be relevant to the subject of care's ongoing care.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	EVENT	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	PATHOLOGY TEST RESULT	Optional		Multiple
	IMAGING EXAMINATION RESULT	Optional		Multiple

4.26 PATHOLOGY TEST RESULT

Identification

Name	PATHOLOGY TEST RESULT
Metadata Type	Data Group
Identifier	DG-16144
OID	1.2.36.1.2001.1001.101.102.16144

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	DIAGNOSTIC INVESTIGATIONS	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Pathology Test Result Name	Essential		Single
	Diagnostic Service	Optional		Single

Data Type	Name	Obligation	Condition	Occurrence
	TEST SPECIMEN DETAIL	Optional		Multiple
	Overall Pathology Test Result Status	Essential		Single
	Clinical Information Provided	Optional		Single
	PATHOLOGY TEST RESULT GROUP	Optional		Multiple
	Pathological Diagnosis	Optional		Multiple
	Pathology Test Conclusion	Optional		Single
	Test Result Representation	Optional		Single
	Test Comment	Optional		Single
	TEST REQUEST DETAILS	Optional		Multiple
	Pathology Test Result DateTime	Essential		Single

4.27 Pathology Test Result Name

Identification

Name	Pathology Test Result Name
Metadata Type	Data Element
Identifier	DE-11017
OID	1.2.36.1.2001.1001.101.103.11017

Definition

Definition	Identification of the pathology test performed, sometimes including specimen type.
Definition Source	NEHTA
Notes	The test name can refer to a single test (e.g. HbA1c) or to a test group such as electrolytes, FBC or coagulation tests.
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[3] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PATHOLOGY TEST RESULT	Essential		Single

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

4.28 Diagnostic Service

Identification

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

Definition

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

Usage

Examples	1. Biochemistry. 2. Haematology.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PATHOLOGY TEST RESULT	Optional		Single

4.29 Diagnostic Service Values

Identification

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

Definition

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

Value Domain

Source	HL7

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Diagnostic Service	Essential		Single

4.30 TEST SPECIMEN DETAIL

Identification

Name	TEST SPECIMEN DETAIL
Metadata Type	Data Group
Identifier	DG-16156
OID	1.2.36.1.2001.1001.101.102.16156

Definition

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

Usage

Conditions of Use	This **SHOULD** be used where there is a single specimen for the entire pathology test.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PATHOLOGY TEST RESULT	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Specimen Tissue Type	Optional		Single
	Collection Procedure	Optional		Single
	ANATOMICAL LOCATION	Optional		Multiple
	PHYSICAL PROPERTIES OF AN OBJECT	Optional		Multiple
	COLLECTION AND HANDLING	Optional		Single

Data Type	Name	Obligation	Condition	Occurrence
	HANDLING AND PROCESSING	Optional		Single
	IDENTIFIERS	Optional		Single

4.31 Specimen Tissue Type

Identification

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

Definition

Definition	The type of specimen to be collected.
Definition Source	NEHTA
Synonymous Names	
Notes	The categorisation of the sample taken from an individual and submitted for pathology investigation.
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[4] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

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

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	TEST SPECIMEN DETAIL	Optional		Single

4.32 Collection Procedure

Identification

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

Definition

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

Usage

Examples	1. Venepuncture 2. Biopsy 3. Resection

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	TEST SPECIMEN DETAIL	Optional		Single

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

4.33 ANATOMICAL LOCATION

Identification

Name	ANATOMICAL LOCATION
Metadata Type	Data Group
Identifier	DG-16150
OID	1.2.36.1.2001.1001.101.102.16150

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	TEST SPECIMEN DETAIL	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	SPECIFIC LOCATION	Optional		Single
	Anatomical Location Description	Optional		Single
	Anatomical Location Image	Optional		Multiple

4.34 SPECIFIC LOCATION

Identification

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

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ANATOMICAL LOCATION	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Anatomical Location Name	Optional		Single
	Side	Optional		Single

4.35 Anatomical Location Name

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	SPECIFIC LOCATION	Optional		Single

4.36 Body Structure Foundation Reference Set

Identification

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Anatomical Location Name	Essential		Single

4.37 Side

Identification

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

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	SPECIFIC LOCATION	Optional		Single

4.38 Laterality Reference Set

Identification

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Side	Essential		Single

4.39 Anatomical Location Description

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ANATOMICAL LOCATION	Optional		Single

4.40 Anatomical Location Image

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ANATOMICAL LOCATION	Optional		Multiple

4.41 PHYSICAL PROPERTIES OF AN OBJECT

Identification

Name	PHYSICAL PROPERTIES OF AN OBJECT
Metadata Type	Data Group
Identifier	DG-16166
OID	1.2.36.1.2001.1001.101.102.16166

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	TEST SPECIMEN DETAIL	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Weight	Optional		Single
	DIMENSIONS	Optional		Single
	Object Description	Optional		Single
	Image	Optional		Single

4.42 Weight

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PHYSICAL PROPERTIES OF AN OBJECT	Optional		Single

4.43 DIMENSIONS

Identification

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

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PHYSICAL PROPERTIES OF AN OBJECT	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Volume	Optional		Single

4.44 Volume

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	DIMENSIONS	Optional		Single

4.45 Object Description

Identification

Name	Object Description
Metadata Type	Data Element
Identifier	DE-16621
OID	1.2.36.1.2001.1001.101.103.16621

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PHYSICAL PROPERTIES OF AN OBJECT	Optional		Single

4.46 Image

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PHYSICAL PROPERTIES OF AN OBJECT	Optional		Single

4.47 COLLECTION AND HANDLING

Identification

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

Definition

Definition	Collection and handling requirements.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	TEST SPECIMEN DETAIL	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Sampling Preconditions	Optional		Single

4.48 Sampling Preconditions

Identification

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

Definition

Definition	Any conditions to be met before the sample should be taken.
Definition Source	NEHTA
Synonymous Names	
Notes	Can also be used to document any known deviations from collection or handling instructions, e.g. patient was not fasted. Examples include fasting, 'full bladder', 'sterile field' or any special instructions on the handling or immediate processing of the sample e.g. centrifuge on receipt.
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[6] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	COLLECTION AND HANDLING	Optional		Single

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

4.49 HANDLING AND PROCESSING

Identification

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

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	TEST SPECIMEN DETAIL	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Collection DateTime	Optional		Single
	Collection Setting	Optional		Single
	DateTime Received	Optional		Single

4.50 Collection DateTime

Identification

Name	Collection DateTime
Metadata Type	Data Element
Identifier	DE-11013
OID	1.2.36.1.2001.1001.101.103.11013

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	HANDLING AND PROCESSING	Optional		Single

4.51 Collection Setting

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	HANDLING AND PROCESSING	Optional		Single

4.52 DateTime Received

Identification

Name	DateTime Received
Metadata Type	Data Element
Identifier	DE-11014
OID	1.2.36.1.2001.1001.101.103.11014

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	HANDLING AND PROCESSING	Optional		Single

4.53 IDENTIFIERS

Identification

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

Definition

Definition	Sample identifications.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	TEST SPECIMEN DETAIL	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Specimen Identifier	Optional		Single
	Parent Specimen Identifier	Optional		Single
	Container Identifier	Optional		Single

4.54 Specimen Identifier

Identification

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

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IDENTIFIERS	Optional		Single

4.55 Parent Specimen Identifier

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IDENTIFIERS	Optional		Single

4.56 Container Identifier

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IDENTIFIERS	Optional		Single

4.57 Overall Pathology Test Result Status

Identification

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

Definition

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

Usage

Examples	1. Interim 2. Final

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PATHOLOGY TEST RESULT	Essential		Single

4.58 Pathology Test Result Status Values

Identification

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

Definition

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

Value Domain

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Overall Pathology Test Result Status	Essential		Single

4.59 Clinical Information Provided

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PATHOLOGY TEST RESULT	Optional		Single

4.60 PATHOLOGY TEST RESULT GROUP

Identification

Name	PATHOLOGY TEST RESULT GROUP
Metadata Type	Data Group
Identifier	DG-16469
OID	1.2.36.1.2001.1001.101.102.16469

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PATHOLOGY TEST RESULT	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Pathology Test Result Group Name	Essential		Single
	INDIVIDUAL PATHOLOGY TEST RESULT	Essential		Multiple
	RESULT GROUP SPECIMEN DETAIL	Optional		Single

4.61 Pathology Test Result Group Name

Identification

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

Definition

Definition	The name of a group of pathology test results.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[7] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PATHOLOGY TEST RESULT GROUP	Essential		Single

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

4.62 INDIVIDUAL PATHOLOGY TEST RESULT

Identification

Name	INDIVIDUAL PATHOLOGY TEST RESULT
Metadata Type	Data Group
Identifier	DG-16489
OID	1.2.36.1.2001.1001.101.102.16489

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PATHOLOGY TEST RESULT GROUP	Essential		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Individual Pathology Test Result Name	Essential		Single
	Individual Pathology Test Result Value	Optional		Single
	Individual Pathology Test Result Value Normal Status	Optional		Single
	INDIVIDUAL PATHOLOGY TEST RESULT VALUE REFERENCE RANGE DETAILS	Optional		Multiple
	Individual Pathology Test Result Comment	Optional		Multiple

Data Type	Name	Obligation	Condition	Occurrence
	Individual Pathology Test Reference Range Guidance	Optional		Single
	Individual Pathology Test Result Status	Essential		Single

4.63 Individual Pathology Test Result Name

Identification

Name	Individual Pathology Test Result Name
Metadata Type	Data Element
Identifier	DE-16571
OID	1.2.36.1.2001.1001.101.103.16571

Definition

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

Usage

Examples	1. Glucose. 2. Haemoglobin. 3. Phenotype. 4. Titre. 5. Scatterplot image.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	INDIVIDUAL PATHOLOGY TEST RESULT	Essential		Single

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

4.64 Individual Pathology Test Result Value

Identification

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

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	INDIVIDUAL PATHOLOGY TEST RESULT	Optional		Single

4.65 Result Value Values

Identification

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

Definition

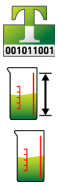
Definition	The set of values for the measured level/magnitude of the test result component.
Definition Source	NEHTA

Value Domain

Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Individual Pathology Test Result Value	Essential		Single

4.66 Individual Pathology Test Result Value Normal Status

Identification

Name	Individual Pathology Test Result Value Normal Status
Metadata Type	Data Element
Identifier	DE-16572
OID	1.2.36.1.2001.1001.101.103.16572

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	INDIVIDUAL PATHOLOGY TEST RESULT	Optional		Single

4.67 Individual Pathology Test Result Value Normal Status Values

Identification

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

Definition

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

Value Domain

Source	HL7 V3: ObservationInterpretationNormality code set

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Individual Pathology Test Result Value Normal Status	Essential		Single

4.68 INDIVIDUAL PATHOLOGY TEST RESULT VALUE REFERENCE RANGE DETAILS

Identification

Name	INDIVIDUAL PATHOLOGY TEST RESULT VALUE REFERENCE RANGE DETAILS
Metadata Type	Data Group
Identifier	DG-16325
OID	1.2.36.1.2001.1001.101.102.16325

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	INDIVIDUAL PATHOLOGY TEST RESULT	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Individual Pathology Test Result Value Reference Range Meaning	Essential		Single
	Individual Pathology Test Result Value Reference Range	Essential		Single

4.69 Individual Pathology Test Result Value Reference Range Meaning

Identification

Name	Individual Pathology Test Result Value Reference Range Meaning
Metadata Type	Data Element
Identifier	DE-16574
OID	1.2.36.1.2001.1001.101.103.16574

Definition

Definition	Term whose value indicates the meaning of this range.
Definition Source	NEHTA
Synonymous Names	
Notes	Default value is "normal".
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[9] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	INDIVIDUAL PATHOLOGY TEST RESULT VALUE REFERENCE RANGE DETAILS	Essential		Single

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

4.70 Individual Pathology Test Result Value Reference Range

Identification

Name	Individual Pathology Test Result Value Reference Range
Metadata Type	Data Element
Identifier	DE-16566
OID	1.2.36.1.2001.1001.101.103.16566

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	INDIVIDUAL PATHOLOGY TEST RESULT VALUE REFERENCE RANGE DETAILS	Essential		Single

4.71 Individual Pathology Test Result Comment

Identification

Name	Individual Pathology Test Result Comment
Metadata Type	Data Element
Identifier	DE-16466
OID	1.2.36.1.2001.1001.101.103.16466

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	INDIVIDUAL PATHOLOGY TEST RESULT	Optional		Multiple

4.72 Individual Pathology Test Reference Range Guidance

Identification

Name	Individual Pathology Test Reference Range Guidance
Metadata Type	Data Element
Identifier	DE-16467
OID	1.2.36.1.2001.1001.101.103.16467

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	INDIVIDUAL PATHOLOGY TEST RESULT	Optional		Single

4.73 Individual Pathology Test Result Status

Identification

Name	Individual Pathology Test Result Status
Metadata Type	Data Element
Identifier	DE-11029
OID	1.2.36.1.2001.1001.101.103.11029

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	INDIVIDUAL PATHOLOGY TEST RESULT	Essential		Single

4.74 RESULT GROUP SPECIMEN DETAIL

Identification

Name	RESULT GROUP SPECIMEN DETAIL
Metadata Type	Data Group
Identifier	DG-16156
OID	1.2.36.1.2001.1001.101.102.16156

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PATHOLOGY TEST RESULT GROUP	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Specimen Tissue Type	Optional		Single
	Collection Procedure	Optional		Single
	ANATOMICAL LOCATION	Optional		Multiple
	PHYSICAL PROPERTIES OF AN OBJECT	Optional		Multiple
	COLLECTION AND HANDLING	Optional		Single
	HANDLING AND PROCESSING	Optional		Single
	IDENTIFIERS	Optional		Single

4.75 Specimen Tissue Type

Identification

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

Definition

Definition	The type of specimen to be collected.
Definition Source	NEHTA
Synonymous Names	
Notes	The categorisation of the sample taken from an individual and submitted for pathology investigation.
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[10] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

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

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	RESULT GROUP SPECIMEN DETAIL	Optional		Single

4.76 Collection Procedure

Identification

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

Definition

Definition	The method of collection to be used.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[11] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Venepuncture 2. Biopsy 3. Resection

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	RESULT GROUP SPECIMEN DETAIL	Optional		Single

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

4.77 ANATOMICAL LOCATION

Identification

Name	ANATOMICAL LOCATION
Metadata Type	Data Group
Identifier	DG-16150
OID	1.2.36.1.2001.1001.101.102.16150

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	RESULT GROUP SPECIMEN DETAIL	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	SPECIFIC LOCATION	Optional		Single
	Anatomical Location Description	Optional		Single
	Anatomical Location Image	Optional		Multiple

4.78 SPECIFIC LOCATION

Identification

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

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ANATOMICAL LOCATION	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Anatomical Location Name	Optional		Single
	Side	Optional		Single

4.79 Anatomical Location Name

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	SPECIFIC LOCATION	Optional		Single

4.80 Body Structure Foundation Reference Set

Identification

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Anatomical Location Name	Essential		Single

4.81 Side

Identification

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

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	SPECIFIC LOCATION	Optional		Single

4.82 Laterality Reference Set

Identification

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Side	Essential		Single

4.83 Anatomical Location Description

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ANATOMICAL LOCATION	Optional		Single

4.84 Anatomical Location Image

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ANATOMICAL LOCATION	Optional		Multiple

4.85 PHYSICAL PROPERTIES OF AN OBJECT

Identification

Name	PHYSICAL PROPERTIES OF AN OBJECT
Metadata Type	Data Group
Identifier	DG-16166
OID	1.2.36.1.2001.1001.101.102.16166

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	RESULT GROUP SPECIMEN DETAIL	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Weight	Optional		Single
	DIMENSIONS	Optional		Single
	Object Description	Optional		Single
	Image	Optional		Single

4.86 Weight

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PHYSICAL PROPERTIES OF AN OBJECT	Optional		Single

4.87 DIMENSIONS

Identification

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

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PHYSICAL PROPERTIES OF AN OBJECT	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Volume	Optional		Single

4.88 Volume

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	DIMENSIONS	Optional		Single

4.89 Object Description

Identification

Name	Object Description
Metadata Type	Data Element
Identifier	DE-16621
OID	1.2.36.1.2001.1001.101.103.16621

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PHYSICAL PROPERTIES OF AN OBJECT	Optional		Single

4.90 Image

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PHYSICAL PROPERTIES OF AN OBJECT	Optional		Single

4.91 COLLECTION AND HANDLING

Identification

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

Definition

Definition	Collection and handling requirements.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	RESTULT GROUP SPECIMEN DETAIL	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Sampling Preconditions	Optional		Single

4.92 Sampling Preconditions

Identification

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

Definition

Definition	Any conditions to be met before the sample should be taken.
Definition Source	NEHTA
Synonymous Names	
Notes	Can also be used to document any known deviations from collection or handling instructions, e.g. patient was not fasted. Examples include fasting, 'full bladder', 'sterile field' or any special instructions on the handling or immediate processing of the sample e.g. centrifuge on receipt.
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[12] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	COLLECTION AND HANDLING	Optional		Single

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

4.93 HANDLING AND PROCESSING

Identification

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

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	RESULT GROUP SPECIMEN DETAIL	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Collection DateTime	Optional		Single
	Collection Setting	Optional		Single
	DateTime Received	Optional		Single

4.94 Collection DateTime

Identification

Name	Collection DateTime
Metadata Type	Data Element
Identifier	DE-11013
OID	1.2.36.1.2001.1001.101.103.11013

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	HANDLING AND PROCESSING	Optional		Single

4.95 Collection Setting

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	HANDLING AND PROCESSING	Optional		Single

4.96 DateTime Received

Identification

Name	DateTime Received
Metadata Type	Data Element
Identifier	DE-11014
OID	1.2.36.1.2001.1001.101.103.11014

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	HANDLING AND PROCESSING	Optional		Single

4.97 IDENTIFIERS

Identification

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

Definition

Definition	Sample identifications.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	RESULT GROUP SPECIMEN DETAIL	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Specimen Identifier	Optional		Single
	Parent Specimen Identifier	Optional		Single
	Container Identifier	Optional		Single

4.98 Specimen Identifier

Identification

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

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IDENTIFIERS	Optional		Single

4.99 Parent Specimen Identifier

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IDENTIFIERS	Optional		Single

4.100 Container Identifier

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IDENTIFIERS	Optional		Single

4.101 Pathological Diagnosis

Identification

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

Definition

Definition	Single word, phrase or brief description representing the diagnostic statement as asserted by the reporting pathologist.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[13] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PATHOLOGY TEST RESULT	Optional		Multiple

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

4.102 Pathology Test Conclusion

Identification

Name	Pathology Test Conclusion
Metadata Type	Data Element
Identifier	DE-16403
OID	1.2.36.1.2001.1001.101.103.16403

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PATHOLOGY TEST RESULT	Optional		Single

4.103 Test Result Representation

Identification

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

Definition

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

Usage

Conditions of Use	Used for results unable to be sent and or received as structured information. Multiple formats are allowed but they **SHALL** be semantically equivalent.
Conditions of Use Source	NEHTA
Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PATHOLOGY TEST RESULT	Optional		Single

4.104 Test Comment

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PATHOLOGY TEST RESULT	Optional		Single

4.105 TEST REQUEST DETAILS

Identification

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

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PATHOLOGY TEST RESULT	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Test Requested Name	Optional		Multiple
	Laboratory Test Result Identifier	Optional		Single

4.106 Test Requested Name

Identification

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

Definition

Definition	Identification of pathology test requested, where the test requested differs from the test actually performed.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[14] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	TEST REQUEST DETAILS	Optional		Multiple

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

4.107 Laboratory Test Result Identifier

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	TEST REQUEST DETAILS	Optional		Single

4.108 Pathology Test Result DateTime

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PATHOLOGY TEST RESULT	Essential		Single

4.109 IMAGING EXAMINATION RESULT

Identification

Name	IMAGING EXAMINATION RESULT
Metadata Type	Data Group
Identifier	DG-16145
OID	1.2.36.1.2001.1001.101.102.16145

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	DIAGNOSTIC INVESTIGATIONS	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Imaging Examination Result Name	Essential		Single
	Imaging Modality	Optional		Single
	ANATOMICAL LOCATION	Optional		Multiple
	Imaging Examination Result Status	Essential		Single
	Clinical Information Provided	Optional		Single
	Findings	Optional		Single
	IMAGING EXAMINATION RESULT GROUP	Optional		Multiple
	Examination Result Representation	Optional		Single
	EXAMINATION REQUEST DETAILS	Optional		Multiple
	Imaging Examination Result DateTime	Essential		Single

4.110 Imaging Examination Result Name

Identification

Name	Imaging Examination Result Name
Metadata Type	Data Element
Identifier	DE-16498
OID	1.2.36.1.2001.1001.101.103.16498

Definition

Definition	Identification of the imaging examination or procedure performed, typically including modality and anatomical location (including laterality).
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[15] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGING EXAMINATION RESULT	Essential		Single

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

4.111 Imaging Modality

Identification

Name	Imaging Modality
Metadata Type	Data Element
Identifier	DE-16500
OID	1.2.36.1.2001.1001.101.103.16500

Definition

Definition	The imaging method used to perform the examination.
Definition Source	NEHTA
Synonymous Names	
Context	For identification/description of the diagnostic imaging modalities that are: • Available for request; or • Used in reporting.
Context Source	NEHTA
Notes	The imaging method, including the electro-magnetic energy type, applied to produce diagnostic quality images of body structures or internal organs performed during a diagnostic imaging procedure. If the modality is specified by a code in the Examination result name, then this field is not required.
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[16] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

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

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGING EXAMINATION RESULT	Optional		Single

4.112 ANATOMICAL LOCATION

Identification

Name	ANATOMICAL LOCATION
Metadata Type	Data Group
Identifier	DG-16150
OID	1.2.36.1.2001.1001.101.102.16150

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGING EXAMINATION RESULT	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	SPECIFIC LOCATION	Optional		Single
	Anatomical Location Description	Optional		Single
	Anatomical Location Image	Optional		Multiple

4.113 SPECIFIC LOCATION

Identification

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

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ANATOMICAL LOCATION	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Anatomical Location Name	Optional		Single
	Side	Optional		Single

4.114 Anatomical Location Name

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	SPECIFIC LOCATION	Optional		Single

4.115 Body Structure Foundation Reference Set

Identification

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Anatomical Location Name	Essential		Single

4.116 Side

Identification

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

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	SPECIFIC LOCATION	Optional		Single

4.117 Laterality Reference Set

Identification

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Side	Essential		Single

4.118 Anatomical Location Description

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ANATOMICAL LOCATION	Optional		Single

4.119 Anatomical Location Image

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ANATOMICAL LOCATION	Optional		Multiple

4.120 Imaging Examination Result Status

Identification

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

Definition

Definition	The status of the examination result as a whole.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodedText
Value Domain	*Not specified.* 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*[17] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

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

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGING EXAMINATION RESULT	Essential		Single

4.121 Clinical Information Provided

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGING EXAMINATION RESULT	Optional		Single

4.122 Findings

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGING EXAMINATION RESULT	Optional		Single

4.123 IMAGING EXAMINATION RESULT GROUP

Identification

Name	IMAGING EXAMINATION RESULT GROUP
Metadata Type	Data Group
Identifier	DG-16504
OID	1.2.36.1.2001.1001.101.102.16504

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGING EXAMINATION RESULT	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Imaging Examination Result Group Name	Essential		Single
	INDIVIDUAL IMAGING EXAMINATION RESULT	Essential		Multiple
	ANATOMICAL LOCATION	Optional		Single

4.124 Imaging Examination Result Group Name

Identification

Name	Imaging Examination Result Group Name
Metadata Type	Data Element
Identifier	DE-16504
OID	1.2.36.1.2001.1001.101.103.16504

Definition

Definition	The name of a group of structured results.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[18] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGING EXAMINATION RESULT GROUP	Essential		Single

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

4.125 INDIVIDUAL IMAGING EXAMINATION RESULT

Identification

Name	INDIVIDUAL IMAGING EXAMINATION RESULT
Metadata Type	Data Group
Identifier	DG-16505
OID	1.2.36.1.2001.1001.101.102.16505

Definition

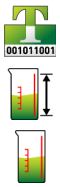
Definition	Specific detailed result, including both the value of the result item and additional information that may be useful for clinical interpretation.
Definition Source	NEHTA
Synonymous Names	
Notes	Results include whatever specific data items imaging services report as part of the clinical service;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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGING EXAMINATION RESULT GROUP	Essential		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Individual Imaging Examination Result Name	Essential		Single
	Imaging Examination Result Value	Optional		Single
	Imaging Examination Result Value Normal Status	Optional		Single
	IMAGING EXAMINATION RESULT VALUE REFERENCE RANGE DETAILS	Optional		Multiple

Data Type	Name	Obligation	Condition	Occurrence
T	Result Comment	Optional		Multiple

4.126 Individual Imaging Examination Result Name

Identification

Name	Individual Imaging Examination Result Name
Metadata Type	Data Element
Identifier	DE-16568
OID	1.2.36.1.2001.1001.101.103.16568

Definition

Definition	The name of a specific detailed result.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[19] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	INDIVIDUAL IMAGING EXAMINATION RESULT	Essential		Single

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

4.127 Imaging Examination Result Value

Identification

Name	Imaging Examination Result Value
Metadata Type	Data Element
Identifier	DE-11023
OID	1.2.36.1.2001.1001.101.103.11023

Definition

Definition	Actual value of the result.
Definition Source	NEHTA
Synonymous Names	
Notes	Most result values will be numerical measurements, but others may be coded concepts or free text.
Data Type	CodeableText QuantityRange Quantity
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[20] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

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

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	INDIVIDUAL IMAGING EXAMINATION RESULT	Optional		Single

4.128 Imaging Examination Result Value Normal Status

Identification

Name	Imaging Examination Result Value Normal Status
Metadata Type	Data Element
Identifier	DE-16572
OID	1.2.36.1.2001.1001.101.103.16572

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	INDIVIDUAL IMAGING EXAMINATION RESULT	Optional		Single

4.129 Imaging Examination Result Value Normal Status Values

Identification

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

Definition

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

Value Domain

Source	HL7 V3: ObservationInterpretationNormality code set

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Imaging Examination Result Value Normal Status	Essential		Single

4.130 IMAGING EXAMINATION RESULT VALUE REFERENCE RANGE DETAILS

Identification

Name	IMAGING EXAMINATION RESULT VALUE REFERENCE RANGE DETAILS
Metadata Type	Data Group
Identifier	DG-16325
OID	1.2.36.1.2001.1001.101.102.16325

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	INDIVIDUAL IMAGING EXAMINATION RESULT	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Imaging Examination Result Value Reference Range Meaning	Essential		Single
	Imaging Examination Result Value Reference Range	Essential		Single

4.131 Imaging Examination Result Value Reference Range Meaning

Identification

Name	Imaging Examination Result Value Reference Range Meaning
Metadata Type	Data Element
Identifier	DE-16574
OID	1.2.36.1.2001.1001.101.103.16574

Definition

Definition	Term whose value indicates the meaning of this range.
Definition Source	NEHTA
Synonymous Names	
Notes	Default value is "normal".
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[21] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGING EXAMINATION RESULT VALUE REFERENCE RANGE DETAILS	Essential		Single

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

4.132 Imaging Examination Result Value Reference Range

Identification

Name	Imaging Examination Result Value Reference Range
Metadata Type	Data Element
Identifier	DE-16566
OID	1.2.36.1.2001.1001.101.103.16566

Definition

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

Usage

Examples	1. Critical.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGING EXAMINATION RESULT VALUE REFERENCE RANGE DETAILS	Essential		Single

4.133 Result Comment

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	INDIVIDUAL IMAGING EXAMINATION RESULT	Optional		Multiple

4.134 ANATOMICAL LOCATION

Identification

Name	ANATOMICAL LOCATION
Metadata Type	Data Group
Identifier	DG-16150
OID	1.2.36.1.2001.1001.101.102.16150

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGING EXAMINATION RESULT GROUP	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	SPECIFIC LOCATION	Optional		Single
	Anatomical Location Description	Optional		Single
	Anatomical Location Image	Optional		Multiple

4.135 SPECIFIC LOCATION

Identification

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

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ANATOMICAL LOCATION	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Anatomical Location Name	Optional		Single
	Side	Optional		Single

4.136 Anatomical Location Name

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	SPECIFIC LOCATION	Optional		Single

4.137 Body Structure Foundation Reference Set

Identification

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
001011001	Anatomical Location Name	Essential		Single

4.138 Side

Identification

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

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	SPECIFIC LOCATION	Optional		Single

4.139 Laterality Reference Set

Identification

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

Definition

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

Value Domain

Source	SNOMED CT-AU

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Side	Essential		Single

4.140 Anatomical Location Description

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ANATOMICAL LOCATION	Optional		Multiple

4.141 Anatomical Location Image

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ANATOMICAL LOCATION	Optional		Multiple

4.142 Examination Result Representation

Identification

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

Definition

Definition	Rich text representation of the entire result as issued by the diagnostic service.
Definition Source	NEHTA
Synonymous Names	
Data Type	EncapsulatedData

Usage

Conditions of Use	Multiple formats are allowed but they **SHALL** be semantically equivalent.
Conditions of Use Source	NEHTA
Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGING EXAMINATION RESULT	Optional		Single

4.143 EXAMINATION REQUEST DETAILS

Identification

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

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGING EXAMINATION RESULT	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Examination Requested Name	Optional		Multiple
	DICOM Study Identifier	Optional		Single
	Report Identifier	Optional		Single
	IMAGE DETAILS	Optional		Multiple

4.144 Examination Requested Name

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	EXAMINATION REQUEST DETAILS	Optional		Multiple

4.145 DICOM Study Identifier

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	EXAMINATION REQUEST DETAILS	Optional		Single

4.146 Report Identifier

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	EXAMINATION REQUEST DETAILS	Optional		Single

4.147 IMAGE DETAILS

Identification

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

Definition

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	EXAMINATION REQUEST DETAILS	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Image Identifier	Optional		Single
	DICOM Series Identifier	Optional		Single
	Image View Name	Optional		Single
	Subject Position	Optional		Single
	Image DateTime	Optional		Single
	Image	Optional		Single

4.148 Image Identifier

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGE DETAILS	Optional		Single

4.149 DICOM Series Identifier

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGE DETAILS	Optional		Single

4.150 Image View Name

Identification

Name	Image View Name
Metadata Type	Data Element
Identifier	DE-16198
OID	1.2.36.1.2001.1001.101.103.16198

Definition

Definition	The name of the imaging view e.g. Lateral or Antero-posterior (AP).
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[22] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGE DETAILS	Optional		Single

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

4.151 Subject Position

Identification

Name	Subject Position
Metadata Type	Data Element
Identifier	DE-16519
OID	1.2.36.1.2001.1001.101.103.16519

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGE DETAILS	Optional		Single

4.152 Image DateTime

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGE DETAILS	Optional		Single

4.153 Image

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGE DETAILS	Optional		Single

4.154 Imaging Examination Result DateTime

Identification

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

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	IMAGING EXAMINATION RESULT	Essential		Single

5 Medications Section

5.1 MEDICATIONS

Identification

Name	MEDICATIONS
Metadata Type	Section
Identifier	S-16022
OID	1.2.36.1.2001.1001.101.101.16022

Definition

Definition	Therapeutic Goods which are/were prescribed for the subject of care or which the subject of care has/had been taking.
Definition Source	NEHTA
Synonymous Names	
Notes	This section outlines the data groups and data elements for Current and Ceased Medications for the discharge summary.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY	Essential		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	CURRENT MEDICATIONS ON DISCHARGE	Essential		Single
	CEASED MEDICATIONS	Essential		Single

5.2 CURRENT MEDICATIONS ON DISCHARGE

Identification

Name	CURRENT MEDICATIONS ON DISCHARGE
Metadata Type	Section
Identifier	S-16146
OID	1.2.36.1.2001.1001.101.101.16146

Definition

Definition	Medications that the subject of care will continue or commence on discharge.
Definition Source	NEHTA
Synonymous Names	Discharge Medications Medications on Discharge
Notes	The CURRENT MEDICATIONS ON DISCHARGE section in a discharge summary includes: • Admission Medications – i.e. medications known on admission which are continued on discharge; and • Medications prescribed during the encounter, which are to be continued on discharge. The "Admission Medications" included in this section include both those that are continued unchanged on discharge or continued with some changes on discharge.

Usage

Conditions of Use	The Status of the Item Detail **SHALL** not equal "Ceased".
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	MEDICATIONS	Essential		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	EXCLUSION STATEMENT - MEDICATIONS	Optional		Single
	THERAPEUTIC GOOD	Optional		Multiple

5.3 EXCLUSION STATEMENT - MEDICATIONS

Identification

Name	EXCLUSION STATEMENT - MEDICATIONS
Metadata Type	Data Group
Identifier	DG-16136
OID	1.2.36.1.2001.1001.101.102.16136

Definition

Definition	Assertion that no medication information is included in this section of the document.
Definition Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	CURRENT MEDICATIONS ON DISCHARGE	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Global Statement	Essential		Single

5.4 Global Statement

Identification

Name	Global Statement
Metadata Type	Data Element
Identifier	DE-16302
OID	1.2.36.1.2001.1001.101.103.16302

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	EXCLUSION STATEMENT - MEDICATIONS	Optional		Multiple

5.5 Global Statement Values

Identification

Name	Global Statement Values
Metadata Type	Value Domain
Identifier	VD-16299
OID	1.2.36.1.2001.1001.101.104.16299

Definition

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

Value Domain

Source	NEHTA	
Permissible Values	*Not asked*	No information about medications is available because the patient was not asked or not able to be asked
	None known	No information about medications is known
	None supplied	No information about medications is supplied

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Global Statement	Essential		Single

5.6 THERAPEUTIC GOOD

Identification

Name	THERAPEUTIC GOOD
Metadata Type	Data Group
Identifier	DG-16211
OID	1.2.36.1.2001.1001.101.102.16211

Definition

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

Usage

Conditions of Use	Recording legal substances such as over-the-counter medications, complementary and alternative medications, and prescribed medications.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	CURRENT MEDICATIONS ON DISCHARGE	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Therapeutic Good Identification	Essential		Single
	DOSAGE	Essential		Single
	Unit of Use Quantity Dispensed	Optional		Single
	Reason for Therapeutic Good	Optional		Single
	Additional Comments	Optional		Single
	MEDICATION HISTORY	Essential		Single

5.7 Therapeutic Good Identification

Identification

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

Definition

Definition	Identifies a therapeutic good, which is broadly defined as a good which is represented in any way to be, or is likely to be taken to be, for therapeutic use (unless specifically excluded or included under Section 7 of the Therapeutic Goods Act 1989). Therapeutic use means use in or in connection with: • preventing, diagnosing, curing or alleviating a disease, ailment, defect or injury; • influencing, inhibiting or modifying a physiological process; • testing the susceptibility of persons to a disease or ailment; • influencing, controlling or preventing conception; • testing for pregnancy; or • replacement or modification of parts of the anatomy.
Definition Source	Therapeutic Goods Administration
Synonymous Names	Item Name
Context	This includes medications and medical devices. It includes drugs, appliances, dressings and reagents.
Context Source	NEHTA
Notes	The formal definition of a therapeutic good (from the Therapeutic Goods Act 1989) can be found at: [TGA2008a].
Data Type	CodeableText
Value Domain	Therapeutic Good Identification Values

Usage

Conditions of Use	Where the therapeutic good can be identified by an AMT (Australian Medicines Terminology) concept, this **SHALL** be the AMT ConceptID and Preferred Term. For details see Therapeutic Good Identification Values. For items without an AMT code (including some extemporaneous preparations), a text description is suitable. For a medication this **SHALL** include the name of

	the medication (brand name or generic name equivalent), strength and dose form, where appropriate.
Conditions of Use Source	NEHTA
Examples	Some examples of AMT ConceptID and their AMT Preferred Term are: 1. 293049011000036110, Paracetamol 500 mg + codeine phosphate 30 mg tablet 2. 327004011000036118, Paracetamol 500 mg + codeine phosphate 30 mg tablet, 20 3. 234184011000036115, Panadeine Forte tablet: uncoated, 20 tablets 4. 192727011000036112, Panadeine Forte (paracetamol 500 mg + codeine phosphate 30 mg) tablet: uncoated, 1 tablet 5. 278453011000036118, Panadeine Forte tablet: uncoated, 20 tablets, blister pack 6. 315236011000036113, Bandage compression 10 cm x 3.5 m bandage: high stretch, 1 bandage 7. 186324011000036116, Eloflex (2480) (bandage compression 10 cm x 3.5 m) bandage: high stretch, 1 bandage
Misuse	Detailing the formula of a compounded (extemporaneous) medication.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	THERAPEUTIC GOOD	Essential		Single

5.8 Therapeutic Good Identification Values

Identification

Name	Therapeutic Good Identification Values
Metadata Type	Value Domain
Identifier	VD-16115
OID	1.2.36.1.2001.1001.101.104.16115

Definition

Definition	The set of values consists of ConceptIDs and Preferred Terms from AMT (Australian Medicines Terminology) concepts which have one of the following modelled relationships: • **IS A** Medicinal Product Unit of Use (MPUU); • **IS A** Medicinal Product Pack (MPP); • **IS A** Trade Product Unit of Use (TPUU); • **IS A** Trade Product Pack (TPP); *or* • **IS A** Containered Trade Product Pack (CTPP). Specifically for MPUU: only MPUU concepts that have no child MPUUs are to be included. Where an MPUU concept is a parent of another MPUU, the parent MPUU is to be omitted.
Definition Source	NEHTA
Notes	An explanation of AMT concepts can be found in Australian Medicines Terminology Editorial Rules [NEHT2009r]. Prescribing and dispensing use different sets of values.

Value Domain

Source	Australian Medicines Terminology

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Therapeutic Good Identification	Essential		Single

5.9 DOSAGE

Identification

Name	DOSAGE
Metadata Type	Data Group
Identifier	DG-16007
OID	1.2.36.1.2001.1001.101.102.16007

Definition

Definition	The regimen governing the amount (in a single administration, i.e. dose quantity), the frequency, the route, and the number of doses of a therapeutic agent to be administered to a subject of care.
Definition Source	Based on Mosby's Medical Dictionary, 8th Edition [MOSB2008a].
Synonymous Names	
Scope	This data group is used to provide details of dose instructions for medication dispensing and administration.
Scope Source	NEHTA
Notes	The dosage data group in this release of the SDT is designed to support simple dosage instructions. Clinical input is being sought to modify the data group in order to support more complex dosing instructions such as variable and alternate dosing and multi-component medicines. This is an evolving process and will be supported by the development of an implementation guide outlining how the dosage data group is to be implemented. In the meantime, implementers may wish to examine the NHS Dose Syntax Model [NHS2009a]. That model, while different to this data group, provides many similarities.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	THERAPEUTIC GOOD	Essential		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Dose Instruction	Essential		Single

5.10 Dose Instruction

Identification

Name	Dose Instruction
Metadata Type	Data Element
Identifier	DE-16008
OID	1.2.36.1.2001.1001.101.103.16008

Definition

Definition	A description of the dose quantity, frequency, route instruction and cautionary advice that determines how the prescribed therapeutic substance is administered to, or taken by, the subject of care.
Definition Source	NEHTA
Synonymous Names	Dosage Instruction
Data Type	Text

Usage

Conditions of Use	This **SHOULD** include the dose quantity, frequency, route, administration schedule and any additional instructions required to safely describe the appropriate dosage. If appropriate, this **MAY** also include the site of administration.
Conditions of Use Source	NEHTA
Examples	1. One tablet twice a day every 12 hours, before or with the first mouthful of food. 2. Apply thin layer to affected area 3-4 times daily; reassess after 7 days if no response.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	DOSAGE	Essential		Single

5.11 Unit of Use Quantity Dispensed

Identification

Name	Unit of Use Quantity Dispensed
Metadata Type	Data Element
Identifier	DE-10145
OID	1.2.36.1.2001.1001.101.103.10145

Definition

Definition	A statement of the total number of units or physical amount of the therapeutic good that is prescribed, dispensed or supplied to the subject of care.
Definition Source	NEHTA
Synonymous Names	Quantity Prescribed Quantity Ordered Unit of Use Quantity Prescribed Quantity Supplied Unit of Use Quantity Supplied Dispensed Unit of Use Quantity
Data Type	Text

Usage

Examples	1. “40 tablets” (In the case of 2 packs of 20 tablets.) 2. “10 vials” (In the case of 1 box of 10 vials of an injection, e.g. Injection 600 micrograms in 10 x 1 mL vials.)

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	THERAPEUTIC GOOD	Optional		Single

5.12 Reason for Therapeutic Good

Identification

Name	Reason for Therapeutic Good
Metadata Type	Data Element
Identifier	DE-10141
OID	1.2.36.1.2001.1001.101.103.10141

Definition

Definition	The clinical justification (e.g. specific therapeutic effect intended) for this subject of care's use of the therapeutic good.
Definition Source	NEHTA
Synonymous Names	Reason for prescribing
Data Type	Text

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	THERAPEUTIC GOOD	Optional		Single

5.13 Additional Comments

Identification

Name	Additional Comments
Metadata Type	Data Element
Identifier	DE-16044
OID	1.2.36.1.2001.1001.101.103.16044

Definition

Definition	Any additional information that may be needed to ensure the continuity of supply, proper use, or appropriate medication management.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	THERAPEUTIC GOOD	Optional		Single

5.14 MEDICATION HISTORY

Identification

Name	MEDICATION HISTORY
Metadata Type	Data Group
Identifier	DG-16117
OID	1.2.36.1.2001.1001.101.102.16117

Definition

Definition	Details of the history of the use of this therapeutic good by the subject of care.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	THERAPEUTIC GOOD	Essential		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Item Status	Essential		Single
	CHANGE DETAIL	Optional		Single
	Medication Duration	Optional		Single

5.15 Item Status

Identification

Name	Item Status
Metadata Type	Data Element
Identifier	DE-16001
OID	1.2.36.1.2001.1001.101.103.16001

Definition

Definition	The status of the medication item at a specific point in time, e.g. at discharge.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodedText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[1] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Ceased 2. Current

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	MEDICATION HISTORY	Essential		Single

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

5.16 CHANGE DETAIL

Identification

Name	CHANGE DETAIL
Metadata Type	Data Group
Identifier	DG-10128
OID	1.2.36.1.2001.1001.101.102.10128

Definition

Definition	Describes information about any relevant changes made to the medication item during the subject of care's healthcare encounter, and the reason for that change.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	MEDICATION HISTORY	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Changes Made	Essential		Single
	Reason for Change	Optional		Single

5.17 Changes Made

Identification

Name	Changes Made
Metadata Type	Data Element
Identifier	DE-10176
OID	1.2.36.1.2001.1001.101.103.10176

Definition

Definition	Description of any change made during the healthcare encounter where the change is intended to continue after the end of the healthcare encounter.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[2] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Dose increased to 10mg. 2. Correction of prescription error.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	CHANGE DETAIL	Essential		Single

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

5.18 Reason for Change

Identification

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

Definition

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

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	CHANGE DETAIL	Optional		Single

5.19 Medication Duration

Identification

Name	Medication Duration
Metadata Type	Data Element
Identifier	DE-10143
OID	1.2.36.1.2001.1001.101.103.10143

Definition

Definition	The time period that the subject of care has taken or will take the prescribed medication.
Definition Source	NEHTA
Synonymous Names	
Context	Used particularly when therapeutic good information is captured retrospectively (e.g. Medical history) and the start date and/or cease date cannot be recalled.
Context Source	NEHTA
Notes	Should be expressed as a time interval with a start and/or end date (Note, if an end date is recorded, it should be after the discharge date). May also be expressed as a total prescribed duration, which indicates the elapsed time between start date and anticipated end date. If the length of time post discharge is required, then this can be derived for display.
Data Type	Duration TimeInterval

Usage

Examples	1. 2005 to 2008-05-18 2. 3 months

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	MEDICATION HISTORY	Optional		Single

5.20 CEASED MEDICATIONS

Identification

Name	CEASED MEDICATIONS
Metadata Type	Section
Identifier	S-16146
OID	1.2.36.1.2001.1001.101.101.16146

Definition

Definition	Medications that the subject of care was taking at the start of the healthcare encounter (e.g. on admission), that have been stopped during the encounter or on discharge, and that are not expected to be recommenced.
Definition Source	NEHTA
Synonymous Names	Medications Ceased This Visit Medications Ceased This Admission
Notes	The Medication Duration's End Date is on or prior to the Discharge Date.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	MEDICATIONS	Essential		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	EXCLUSION STATEMENT - MEDICATIONS	Optional		Single
	THERAPEUTIC GOOD	Optional		Multiple

5.21 EXCLUSION STATEMENT - MEDICATIONS

Identification

Name	EXCLUSION STATEMENT - MEDICATIONS
Metadata Type	Data Group
Identifier	DG-16136
OID	1.2.36.1.2001.1001.101.102.16136

Definition

Definition	Assertion that no medication information is included in this section of the document.
Definition Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	CEASED MEDICATIONS	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Global Statement	Essential		Single

5.22 Global Statement

Identification

Name	Global Statement
Metadata Type	Data Element
Identifier	DE-16302
OID	1.2.36.1.2001.1001.101.103.16302

Definition

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

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	EXCLUSION STATEMENT - MEDICATIONS	Optional		Multiple

5.23 Global Statement Values

Identification

Name	Global Statement Values
Metadata Type	Value Domain
Identifier	VD-16299
OID	1.2.36.1.2001.1001.101.104.16299

Definition

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

Value Domain

Source	NEHTA	
Permissible Values	*Not asked*	No information about medications is available because the patient was not asked or not able to be asked
	None known	No information about medications is known
	None supplied	No information about medications is supplied

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Global Statement	Essential		Single

5.24 THERAPEUTIC GOOD

Identification

Name	THERAPEUTIC GOOD
Metadata Type	Data Group
Identifier	DG-16211
OID	1.2.36.1.2001.1001.101.102.16211

Definition

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

Usage

Conditions of Use	Recording legal substances such as over-the-counter medications, complementary and alternative medications, and prescribed medications.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	CEASED MEDICATIONS	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Therapeutic Good Identification	Essential		Single
	MEDICATION HISTORY	Essential		Single

5.25 Therapeutic Good Identification

Identification

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

Definition

Definition	Identifies a therapeutic good, which is broadly defined as a good which is represented in any way to be, or is likely to be taken to be, for therapeutic use (unless specifically excluded or included under Section 7 of the Therapeutic Goods Act 1989). Therapeutic use means use in or in connection with: • preventing, diagnosing, curing or alleviating a disease, ailment, defect or injury; • influencing, inhibiting or modifying a physiological process; • testing the susceptibility of persons to a disease or ailment; • influencing, controlling or preventing conception; • testing for pregnancy; or • replacement or modification of parts of the anatomy.
Definition Source	Therapeutic Goods Administration
Synonymous Names	Item Name
Context	This includes medications and medical devices. It includes drugs, appliances, dressings and reagents.
Context Source	NEHTA
Notes	The formal definition of a therapeutic good (from the Therapeutic Goods Act 1989) can be found at: [TGA2008a].
Data Type	CodeableText
Value Domain	Therapeutic Good Identification Values

Usage

Conditions of Use	Where the therapeutic good can be identified by an AMT (Australian Medicines Terminology) concept, this **SHALL** be the AMT ConceptID and Preferred Term. For details see Therapeutic Good Identification Values. For items without an AMT code (including some extemporaneous preparations), a text description is suitable. For a medication this **SHALL** include the name of

	the medication (brand name or generic name equivalent), strength and dose form, where appropriate.
Conditions of Use Source	NEHTA
Examples	Some examples of AMT ConceptID and their AMT Preferred Term are: 1. 293049011000036110, Paracetamol 500 mg + codeine phosphate 30 mg tablet 2. 327004011000036118, Paracetamol 500 mg + codeine phosphate 30 mg tablet, 20 3. 234184011000036115, Panadeine Forte tablet: uncoated, 20 tablets 4. 192727011000036112, Panadeine Forte (paracetamol 500 mg + codeine phosphate 30 mg) tablet: uncoated, 1 tablet 5. 278453011000036118, Panadeine Forte tablet: uncoated, 20 tablets, blister pack 6. 315236011000036113, Bandage compression 10 cm x 3.5 m bandage: high stretch, 1 bandage 7. 186324011000036116, Eloflex (2480) (bandage compression 10 cm x 3.5 m) bandage: high stretch, 1 bandage
Misuse	Detailing the formula of a compounded (extemporaneous) medication.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	THERAPEUTIC GOOD	Essential		Single

5.26 Therapeutic Good Identification Values

Identification

Name	Therapeutic Good Identification Values
Metadata Type	Value Domain
Identifier	VD-16115
OID	1.2.36.1.2001.1001.101.104.16115

Definition

Definition	The set of values consists of ConceptIDs and Preferred Terms from AMT (Australian Medicines Terminology) concepts which have one of the following modelled relationships: • **IS A** Medicinal Product Unit of Use (MPUU); • **IS A** Medicinal Product Pack (MPP); • **IS A** Trade Product Unit of Use (TPUU); • **IS A** Trade Product Pack (TPP); *or* • **IS A** Containered Trade Product Pack (CTPP). Specifically for MPUU: only MPUU concepts that have no child MPUUs are to be included. Where an MPUU concept is a parent of another MPUU, the parent MPUU is to be omitted.
Definition Source	NEHTA
Notes	An explanation of AMT concepts can be found in Australian Medicines Terminology Editorial Rules [NEHT2009r]. Prescribing and dispensing use different sets of values.

Value Domain

Source	Australian Medicines Terminology

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Therapeutic Good Identification	Essential		Single

5.27 MEDICATION HISTORY

Identification

Name	MEDICATION HISTORY
Metadata Type	Data Group
Identifier	DG-16117
OID	1.2.36.1.2001.1001.101.102.16117

Definition

Definition	Details of the history of the use of this therapeutic good by the subject of care.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	THERAPEUTIC GOOD	Essential		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Item Status	Essential		Single
	CHANGE DETAIL	Essential		Single

5.28 Item Status

Identification

Name	Item Status
Metadata Type	Data Element
Identifier	DE-16001
OID	1.2.36.1.2001.1001.101.103.16001

Definition

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

Usage

Examples	1. Ceased 2. Current

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	MEDICATION HISTORY	Essential		Single

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

5.29 CHANGE DETAIL

Identification

Name	CHANGE DETAIL
Metadata Type	Data Group
Identifier	DG-10128
OID	1.2.36.1.2001.1001.101.102.10128

Definition

Definition	Describes information about any relevant changes made to the medication item during the subject of care's healthcare encounter, and the reason for that change.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	MEDICATION HISTORY	Essential		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Changes Made	Essential		Single
	Reason for Change	Essential		Single

5.30 Changes Made

Identification

Name	Changes Made
Metadata Type	Data Element
Identifier	DE-10176
OID	1.2.36.1.2001.1001.101.103.10176

Definition

Definition	Description of any change made during the healthcare encounter where the change is intended to continue after the end of the healthcare encounter.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[4] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Ceased.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	CHANGE DETAIL	Essential		Single

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

5.31 Reason for Change

Identification

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

Definition

Definition	The reason why the medication was ceased.
Definition Source	NEHTA
Synonymous Names	Reason for Alteration Reason for Modification
Data Type	Text

Usage

Examples	1. Adverse drug interaction. 2. HRT side effect.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	CHANGE DETAIL	Essential		Single

6 Health Profile Section

6.1 HEALTH PROFILE

Identification

Name	HEALTH PROFILE
Metadata Type	Section
Identifier	S-16011
OID	1.2.36.1.2001.1001.101.101.16011

Definition

Definition	Information pertaining to the health status or general health of the subject of care. Contains information related to the subject of care that is not specific to the healthcare encounter described by the discharge summary.
Definition Source	NEHTA
Synonymous Names	
Notes	The data in this section is not restricted to the context of this document. The purpose of this section is to differentiate the data groups that are specific to the event, for which the discharge summary is created, from those that are generic to the subject of care overall. For example, the subject of care's nominated primary healthcare provider is not specifically related to the encounter. Similarly the subject of care's adverse reactions are likely to be applicable after the event.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY	Essential		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	HEALTHCARE PROVIDERS	Optional		Single
	ADVERSE REACTIONS	Essential		Single
	ALERTS	Optional		Single

6.2 HEALTHCARE PROVIDERS

Identification

Name	HEALTHCARE PROVIDERS
Metadata Type	Data Group
Identifier	DG-20002
OID	1.2.36.1.2001.1001.101.102.20002

Definition

Definition	The subject of care's healthcare providers.
Definition Source	NEHTA
Synonymous Names	
Notes	This item currently only includes the Nominated Primary Healthcare Provider, but may include other providers in the future. However, not all subjects of care will have a Nominated Primary Healthcare Provider, and as such this data group is optional. It is recommended that the author of the discharge summary should be providing and including this information.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	HEALTH PROFILE	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	NOMINATED PRIMARY HEALTHCARE PROVIDER	Essential		Multiple

6.3 NOMINATED PRIMARY HEALTHCARE PROVIDER

Identification

Name	NOMINATED PRIMARY HEALTHCARE PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	A healthcare provider (person or organisation) nominated by the subject of care as being primarily responsible for their ongoing healthcare.
Definition Source	NEHTA
Synonymous Names	Usual General Practitioner Usual Healthcare Provider Nominated Primary Healthcare Provider

Usage

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

	Other additional constraints where the nominated primary healthcare provider is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a **PERSON**): • Participation Type **SHALL** have an implementation-specific fixed value equivalent to “Nominated Primary Healthcare Provider”. • Role **SHOULD** have a value chosen from 1220.0 - ANZSCO - Australia and New Zealand Standard Classification of Occupations, First Edition, 2006 - METeOR 350899. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used. • The value of Entity Identifier **SHALL** be an Australian HPI-I. • AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON. Additional obligation and occurrence constraints when the nominated primary healthcare provider is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an **ORGANISATION**): • Participation Period is **PROHIBITED**. • LOCATION OF PARTICIPATION is **PROHIBITED**. • Entity Identifier is **ESSENTIAL**. • ADDRESS is **ESSENTIAL**. • ELECTRONIC COMMUNICATION DETAIL is **ESSENTIAL**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**. Other additional constraints when the nominated primary healthcare provider is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an **ORGANISATION**): • Participation Type **SHALL** have an implementation-specific fixed value equivalent to “Nominated Healthcare Provider”. • Role **SHALL** have a value representing the type of Facility e.g. Hospital, Clinic. • The value of Entity Identifier **SHALL** be an Australian HPI-O. • AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a ORGANISATION.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	HEALTHCARE PROVIDERS	Essential		Multiple

6.4 ADVERSE REACTIONS

Identification

Name	ADVERSE REACTIONS
Metadata Type	Section
Identifier	S-20113
OID	1.2.36.1.2001.1001.101.101.20113

Definition

Definition	A section that groups together adverse reaction information about the subject of care that is known to the provider/provider facility during a healthcare visit/encounter.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	HEALTH PROFILE	Essential		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	EXCLUSION STATEMENT - ADVERSE REACTION	Optional		Single
	ADVERSE REACTION	Optional		Multiple

6.5 EXCLUSION STATEMENT - ADVERSE REACTION

Identification

Name	EXCLUSION STATEMENT - ADVERSE REACTION
Metadata Type	Data Group
Identifier	DG-16137
OID	1.2.36.1.2001.1001.101.102.16137

Definition

Definition	Assertion that no adverse reaction information is included in this section of the document.
Definition Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ADVERSE REACTIONS	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Global Statement	Essential		Single

6.6 Global Statement

Identification

Name	Global Statement
Metadata Type	Data Element
Identifier	DE-16302
OID	1.2.36.1.2001.1001.101.103.16302

Definition

Definition	Global statements about the exclusion.
Definition Source	openEHR Foundation
Synonymous Names	
Context	This can be used to capture any information that is needed to be explicitly recorded as being absent or excluded within the record.
Context Source	openEHR Foundation
Data Type	CodedText
Value Domain	Global Statement Values

Usage

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	EXCLUSION STATEMENT - ADVERSE REACTION	Optional		Multiple

6.7 Global Statement Values

Identification

Name	Global Statement Values
Metadata Type	Value Domain
Identifier	VD-16299
OID	1.2.36.1.2001.1001.101.104.16299

Definition

Definition	The set of values for the global statements about the exclusion.
Definition Source	openEHR Foundation

Value Domain

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Global Statement	Essential		Single

6.8 ADVERSE REACTION

Identification

Name	ADVERSE REACTION
Metadata Type	Data Group
Identifier	DG-15517
OID	1.2.36.1.2001.1001.101.102.15517

Definition

Definition	A known adverse reaction for the subject of care (including allergies and intolerances), and any relevant reaction details.
Definition Source	NEHTA
Synonymous Names	Allergy/Adverse Reaction

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ADVERSE REACTIONS	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Agent Description	Essential		Single
	Adverse Reaction Type	Essential		Single
	REACTION DETAIL	Optional		Multiple

6.9 Agent Description

Identification

Name	Agent Description
Metadata Type	Data Element
Identifier	DE-15521
OID	1.2.36.1.2001.1001.101.103.15521

Definition

Definition	The agent causing the adverse reaction experienced by the subject of care.
Definition Source	NEHTA
Synonymous Names	Agent Substance
Notes	An agent can be a substance such as food, drug or an environmental allergen.
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[1] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Animal protein 2. Latex 3. Peanut 4. Penicillin 5. Bee venom

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ADVERSE REACTION	Essential		Single

6.10 Adverse Reaction Type

Identification

Name	Adverse Reaction Type
Metadata Type	Data Element
Identifier	DE-15554
OID	1.2.36.1.2001.1001.101.103.15554

Definition

Definition	The type of reaction experienced by the subject of care to an agent.
Definition Source	NEHTA
Synonymous Names	
Context	This field is used to identify the type of adverse reaction as determined by: • the signs and/or symptoms experienced by the subject of care; • information provided by a relevant individual; • previously documented history; and/or • a clinical assessment by a healthcare provider.
Context Source	NEHTA
Data Type	CodedText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[2] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Allergy. 2. Idiosyncracy. 3. Interactions. 4. Intolerance / sensitivity. 5. Pseudoallergy / anaphylactoid reaction.

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

6. Side effects.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ADVERSE REACTION	Essential		Single

6.11 REACTION DETAIL

Identification

Name	REACTION DETAIL
Metadata Type	Data Group
Identifier	DG-15511
OID	1.2.36.1.2001.1001.101.102.15511

Definition

Definition	Undesirable responses to an agent.
Definition Source	NEHTA
Synonymous Names	
Notes	Undesirable responses experienced/exhibited by the subject of care after exposure to an agent. Instances of this data group form part of a subject of care's health profile or health summaries including discharge summary and referral.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ADVERSE REACTION	Optional		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Reaction Description	Essential		Single

6.12 Reaction Description

Identification

Name	Reaction Description
Metadata Type	Data Element
Identifier	DE-15563
OID	1.2.36.1.2001.1001.101.103.15563

Definition

Definition	The signs and/or symptoms experienced or exhibited by the subject of care as a consequence of the adverse reaction to the specific agent.
Definition Source	NEHTA
Synonymous Names	Reaction
Notes	The signs, symptoms, severity and/or certainty of the adverse reaction are relevant as it contributes towards the decision as to the immediacy and extent of treatment to be provided, as determined by a healthcare provider. Given that an adverse reaction has occurred, it is important to determine the manifestations of that reaction.
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[3] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Itchy eyes. 2. Dysphagia. 3. Tinnitus.

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	REACTION DETAIL	Essential		Single

6.13 ALERTS

Identification

Name	ALERTS
Metadata Type	Section
Identifier	S-20112
OID	1.2.36.1.2001.1001.101.101.20112

Definition

Definition	Describes alerts pertaining to the subject of care that may require special consideration or action by the recipients.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	HEALTH PROFILE	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	ALERT	Essential		Multiple

6.14 ALERT

Identification

Name	ALERT
Metadata Type	Data Group
Identifier	DG-15518
OID	1.2.36.1.2001.1001.101.102.15518

Definition

Definition	Describes information pertaining to a subject of care that may: • need special consideration by a healthcare provider before making a decision about his/her actions to avert an unfavourable healthcare event; • need consideration and/or action by a healthcare provider or facility in relation to the care and safety of the subject of care, staff and/or other individuals; or • notify the healthcare provider of special circumstances that may be relevant in delivering care and/or interacting with the subject of care.
Definition Source	NEHTA
Synonymous Names	Warning
Assumptions	Only alerts judged significant by a healthcare provider should be recorded. All alerts will require regular review.
Assumptions Source	NEHTA

Usage

Misuse	Recording adverse reactions.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ALERTS	Essential		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Alert Type	Essential		Single
	Alert Description	Essential		Single

6.15 Alert Type

Identification

Name	Alert Type
Metadata Type	Data Element
Identifier	DE-15584
OID	1.2.36.1.2001.1001.101.103.15584

Definition

Definition	The type of alert (e.g. infection risk, special needs, clinical, discharge circumstances, vulnerable families, psychosocial alerts etc.).
Definition Source	NEHTA
Synonymous Names	Warning type Alert class
Data Type	CodeableText
Value Domain	*Not specified.* In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the *HL7 code set registration procedure*[4] with an appropriate object identifier (OID), and **SHALL** be publicly available. When national standard code sets become available, they **SHALL** be used and the non-standard code sets **SHALL** be deprecated.

Usage

Examples	1. Administrative 2. Clinical or Medical 3. Home environment 4. Infection risk 5. Safety and security 6. Special mental health 7. Special needs and/or preferences 8. Psychosocial

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ALERT	Essential		Single

6.16 Alert Description

Identification

Name	Alert Description
Metadata Type	Data Element
Identifier	DE-15585
OID	1.2.36.1.2001.1001.101.103.15585

Definition

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

Usage

Examples	1. Animals present at subject of care's home 2. Anaesthetic risk 3. Pacemaker present 4. Subject of care is a risk to others 5. Subject of care speaks no English

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ALERT	Essential		Single

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

7 Plan Section

7.1 PLAN

Identification

Name	PLAN
Metadata Type	Section
Identifier	S-16020
OID	1.2.36.1.2001.1001.101.101.16020

Definition

Definition	The services requested for the subject of care and the recommendations to the recipient healthcare providers and/or the subject of care.
Definition Source	NEHTA
Synonymous Names	Follow up
Notes	Such activities may include arranged services such as home nursing or community health services, or follow-up management by the GP or specialists. Also includes information or instructions to subject of care regarding the planned or requested services and recommendations to providers. Excludes specific medication prescriptions and/or diagnostic test orders made by current providers (at the time of discharge).

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY	Essential		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	ARRANGED SERVICES	Optional		Single
	RECORD OF RECOMMENDATIONS AND INFORMATION PROVIDED	Essential		Single

7.2 ARRANGED SERVICES

Identification

Name	ARRANGED SERVICES
Metadata Type	Section
Identifier	S-16021
OID	1.2.36.1.2001.1001.101.101.16021

Definition

Definition	Describes services that have been provided for or arranged for the subject of care.
Definition Source	NEHTA
Synonymous Names	Arranged Services

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PLAN	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	ARRANGED SERVICE	Essential		Multiple

7.3 ARRANGED SERVICE

Identification

Name	ARRANGED SERVICE
Metadata Type	Data Group
Identifier	DG-20158
OID	1.2.36.1.2001.1001.101.102.20158

Definition

Definition	Describes the types of service requested for, or provided to, the subject of care.
Definition Source	NEHTA
Synonymous Names	
Notes	This item does not include details of specific medication prescriptions and/or diagnostic test orders made by current providers (at the time of discharge). If the service provision has not been confirmed then, the service date and/or provider may not be recorded.

Usage

Misuse	Used to specify medication prescriptions or diagnostic test requests.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ARRANGED SERVICES	Essential		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	Arranged Service Description	Essential		Single
	Service Commencement Window	Optional		Single
	Service Booking Status	Essential		Single
	PROTOCOL	Optional		Single

7.4 Arranged Service Description

Identification

Name	Arranged Service Description
Metadata Type	Data Element
Identifier	DE-20117
OID	1.2.36.1.2001.1001.101.103.20117

Definition

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

Usage

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

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ARRANGED SERVICE	Essential		Single

7.5 Service Commencement Window

Identification

Name	Service Commencement Window
Metadata Type	Data Element
Identifier	DE-20173
OID	1.2.36.1.2001.1001.101.103.20173

Definition

Definition	The datetime or date range at/during which the arranged service is scheduled to be provided to the subject of care.
Definition Source	NEHTA
Synonymous Names	Service Commences
Context	For use in the healthcare settings. This data element is used to specify the range of time within which the requesting provider would like the requested service(s) to be provided to the subject of care.
Context Source	NEHTA
Notes	Specifies the range of time within which the requesting provider is expecting the arranged service to be provided to the subject of care.
Data Type	TimeInterval

Usage

Conditions of Use	Where possible, exact dates should be used. Incomplete dates should generally only be used for retrospective data collection.
Conditions of Use Source	NEHTA
Examples	See: Appendix B: *Specification Guide for Use*
Misuse	Entering approximate dates when an exact date is available.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ARRANGED SERVICE	Optional		Single

7.6 Service Booking Status

Identification

Name	Service Booking Status
Metadata Type	Data Element
Identifier	DE-16056
OID	1.2.36.1.2001.1001.101.103.16056

Definition

Definition	An indication of the booking status of the arranged service.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodedText
Value Domain	Service Booking Status Values

Usage

Examples	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ARRANGED SERVICE	Essential		Single

7.7 Service Booking Status Values

Identification

Name	Service Booking Status Values
Metadata Type	Value Domain
Identifier	VD-16055
OID	1.2.36.1.2001.1001.101.104.16055

Definition

Definition	The set of values for an indication of the booking status of the arranged service.
Definition Source	NEHTA

Value Domain

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

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	Service Booking Status	Essential		Single

7.8 PROTOCOL

Identification

Name	PROTOCOL
Metadata Type	Data Group
Identifier	DG-16131
OID	1.2.36.1.2001.1001.101.102.16131

Definition

Definition	Relevant non-clinical information.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	ARRANGED SERVICE	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	SERVICE PROVIDER	Optional		Single

7.9 SERVICE PROVIDER

Identification

Name	SERVICE PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	The provider (individual or organisation) that has been arranged to provide the service.
Definition Source	NEHTA
Synonymous Names	Referred To Provider Referred To Healthcare Provider Identification: Referred To
Notes	This item captures identification information on the Healthcare Provider Person or Organisation who/which is arranged to provide a service after discharge of the subject of care from the healthcare facility at which the healthcare encounter has been completed.

Usage

Conditions of Use	This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v]. The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B: *Specification Guide for Use*. Additional obligation and occurrence constraints where the service provider is an individual (PERSON OR ORGANISATION OR DEVICE is instantiated as a **PERSON**): • Participation Period is **PROHIBITED**. • LOCATION OF PARTICIPATION is **PROHIBITED**. • Entity Identifier is **ESSENTIAL**. • ADDRESS is **ESSENTIAL**. • Relationship to Subject of Care is **PROHIBITED**. • DEMOGRAPHIC DATA is **PROHIBITED**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**.

	Other additional constraints where the service provider is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a **PERSON**): • Participation Type **SHALL** have an implementation-specific fixed value equivalent to “Service Provider”. • Role **SHOULD** have a value chosen from 1220.0 - ANZSCO - Australia and New Zealand Standard Classification of Occupations, First Edition, 2006 - METeOR 350899. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used. • The value of Entity Identifier **SHALL** be an Australian HPI-I. • AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON. Additional obligation and occurrence constraints when the service provider is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an **ORGANISATION**): • Participation Period is **PROHIBITED**. • LOCATION OF PARTICIPATION is **PROHIBITED**. • Entity Identifier is **ESSENTIAL**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**. Other additional constraints when the service provider is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an **ORGANISATION**): • Participation Type **SHALL** have an implementation-specific fixed value equivalent to “Service Provider”. • Role **SHALL** have a value representing the type of Facility e.g. Hospital, Clinic. • The value of Entity Identifier **SHALL** be an Australian HPI-O. • AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a ORGANISATION.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PROTOCOL	Optional		Single

7.10 RECORD OF RECOMMENDATIONS AND INFORMATION PROVIDED

Identification

Name	RECORD OF RECOMMENDATIONS AND INFORMATION PROVIDED
Metadata Type	Section
Identifier	S-20116
OID	1.2.36.1.2001.1001.101.101.20116

Definition

Definition	Contains: • recommendations to a recipient healthcare provider and/or subject of care which are relevant to the continuity of care and management of the subject of care after discharge; and optionally • information that has been provided, including information provided to the subject of care and/or relevant parties.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	PLAN	Essential		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	RECOMMENDATIONS PROVIDED	Essential		Multiple
	INFORMATION PROVIDED	Optional		Single

7.11 RECOMMENDATIONS PROVIDED

Identification

Name	RECOMMENDATIONS PROVIDED
Metadata Type	Data Group
Identifier	DG-20116
OID	1.2.36.1.2001.1001.101.102.20116

Definition

Definition	Recommendations to a recipient healthcare provider and/or subject of care which are relevant to the continuity of care and management of the subject of care after discharge.
Definition Source	NEHTA
Synonymous Names	
Notes	Recommendations may include reminders to the GP on special management strategies.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	RECORD OF RECOMMENDATIONS AND INFORMATION PROVIDED	Essential		Multiple

Children

Data Type	Name	Obligation	Condition	Occurrence
	RECOMMENDATION RECIPIENT	Essential		Single
	Recommendation Note	Essential		Single

7.12 RECOMMENDATION RECIPIENT

Identification

Name	RECOMMENDATION RECIPIENT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	The individual or organisation to whom the information is directed.
Definition Source	NEHTA
Synonymous Names	

Usage

Conditions of Use	This is a reuse of the PARTICIPATION data group, which is described in Participation Data Specification [NEHT2011v]. The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B: *Specification Guide for Use*. Additional obligation and occurrence constraints where the recommendation recipient is an individual (PERSON OR ORGANISATION OR DEVICE is instantiated as a **PERSON**): • Participation Period is **PROHIBITED**. • LOCATION OF PARTICIPATION is **PROHIBITED**. • Entity Identifier is **ESSENTIAL**. • ADDRESS is **ESSENTIAL**. • Relationship to Subject of Care is **PROHIBITED**. • DEMOGRAPHIC DATA is **PROHIBITED**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**. Other additional constraints where the recommendation recipient is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a **PERSON**): • Participation Type **SHALL** have an implementation-specific fixed value equivalent to “Recommendation Recipient”.

	• Role **SHOULD** have a value chosen from 1220.0 - ANZSCO - Australia and New Zealand Standard Classification of Occupations, First Edition, 2006 - METeOR 350899. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used. • The value of Entity Identifier **SHALL** be an Australian HPI-I. • AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON. Additional obligation and occurrence constraints when the recommendation recipient is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an **ORGANISATION**): • Participation Period is **PROHIBITED**. • LOCATION OF PARTICIPATION is **PROHIBITED**. • Entity Identifier is **ESSENTIAL**. • ENTITLEMENT is **PROHIBITED**. • Qualifications is **PROHIBITED**. Other additional constraints when the recommendation recipient is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an **ORGANISATION**): • Participation Type **SHALL** have an implementation-specific fixed value equivalent to “Recommendation Recipient”. • Role **SHALL** have a value representing the type of Facility e.g. Hospital, Clinic. • The value of Entity Identifier **SHALL** be an Australian HPI-O. • AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as an ORGANISATION.
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	RECOMMENDATIONS PROVIDED	Essential		Single

7.13 Recommendation Note

Identification

Name	Recommendation Note
Metadata Type	Data Element
Identifier	DE-20175
OID	1.2.36.1.2001.1001.101.103.20175

Definition

Definition	Contains: • information and education that has been provided to and discussed with the subject of care, their family, carer and/or other relevant parties, including awareness or lack of awareness of diagnosed conditions, and relevant health management; • an indication of whether the subject of care or carer has understood the information or instructions provided may also be relevant; and/or • information and/or recommendations given by a healthcare provider during/at the end of a health event to another healthcare provider responsible for the ongoing care of the subject of care.
Definition Source	NEHTA
Synonymous Names	Advice to Subject of Care.
Notes	The relevant information/recommendation is important for the continuity of care and management of the subject of care after discharge. This item does not include referral details or information specific to a requested service.
Data Type	Text

Usage

Examples	1. GP to remove the staples on day 10-14. 2. Aspirin to recommence at GP's discretion. 3. Please arrange a follow up appointment with a community physiotherapist in one week to ensure that post-surgical mobility outcomes are being met.

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	RECOMMENDATIONS PROVIDED	Essential		Single

7.14 INFORMATION PROVIDED

Identification

Name	INFORMATION PROVIDED
Metadata Type	Data Group
Identifier	DG-20116
OID	1.2.36.1.2001.1001.101.102.20116

Definition

Definition	Information that has been provided, including information provided to the subject of care and/or relevant parties.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Obligation	Condition	Occurrence
	RECORD OF RECOMMENDATIONS AND INFORMATION PROVIDED	Optional		Single

Children

Data Type	Name	Obligation	Condition	Occurrence
	Information Provided to Subject of Care and/or Relevant Parties	Essential		Single

7.15 Information Provided to Subject of Care and/or Relevant Parties

Identification

Name	Information Provided to Subject of Care and/or Relevant Parties
Metadata Type	Data Element
Identifier	DE-20175
OID	1.2.36.1.2001.1001.101.103.20175

Definition

Definition	Contains: • information and education that has been provided to and discussed with the subject of care, their family, carer and/or other relevant parties, including awareness or lack of awareness of diagnosed conditions, and relevant health management; • an indication of whether the subject of care or carer has understood the information or instructions provided may also be relevant; and/or • information and/or recommendations given by a healthcare provider during/at the end of a health event to another healthcare provider responsible for the ongoing care of the subject of care.
Definition Source	NEHTA
Synonymous Names	Advice to Subject of Care.
Notes	The relevant information/recommendation is important for the continuity of care and management of the subject of care after discharge. This item does not include referral details or information specific to a requested service.
Data Type	Text

Usage

Examples	1. GP to remove the staples on day 10-14. 2. Aspirin to recommence at GP's discretion. 3. Please arrange a follow up appointment with a community physiotherapist in one week to ensure that post-surgical mobility outcomes are being met.

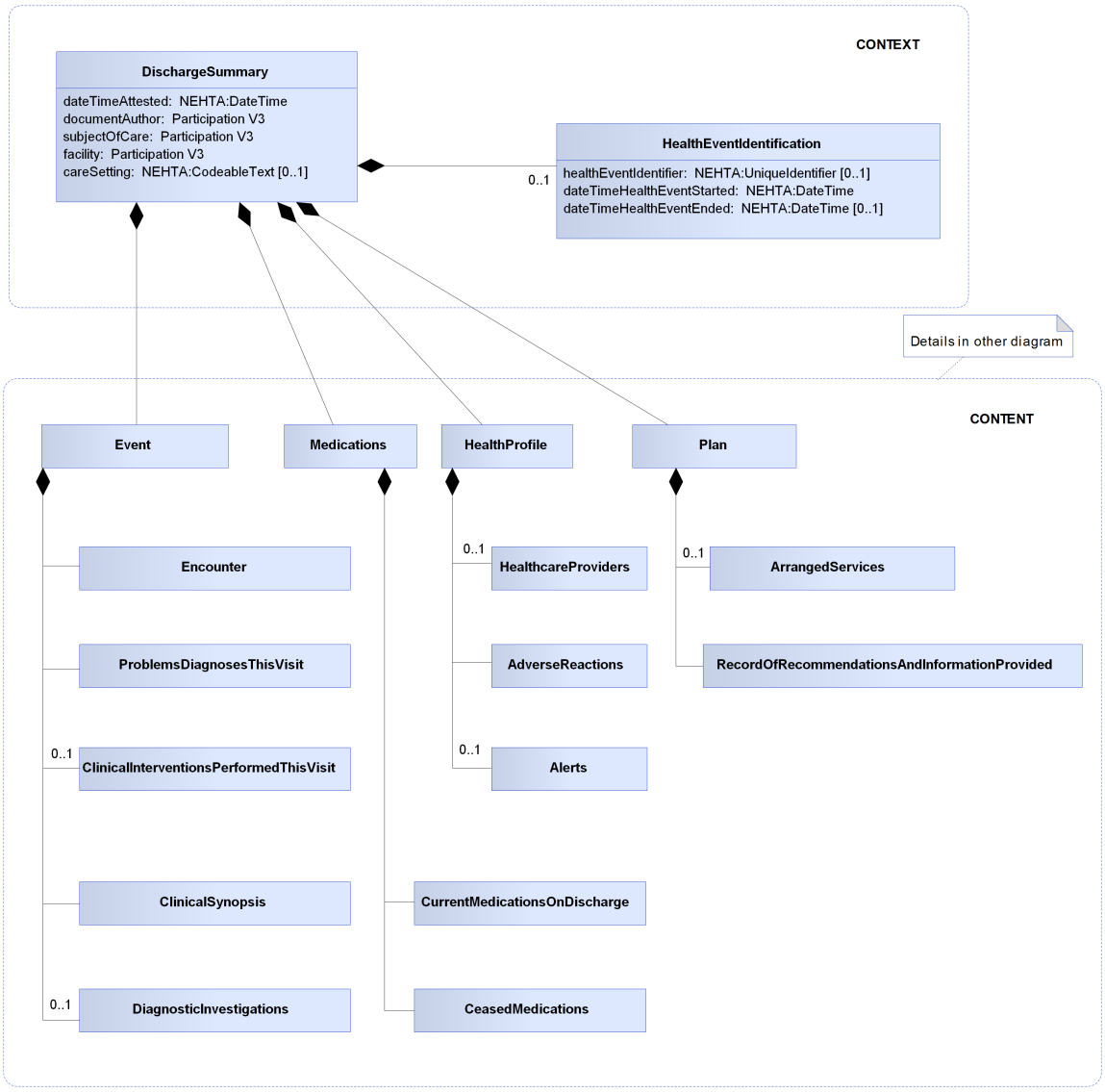
Relationships

Parents

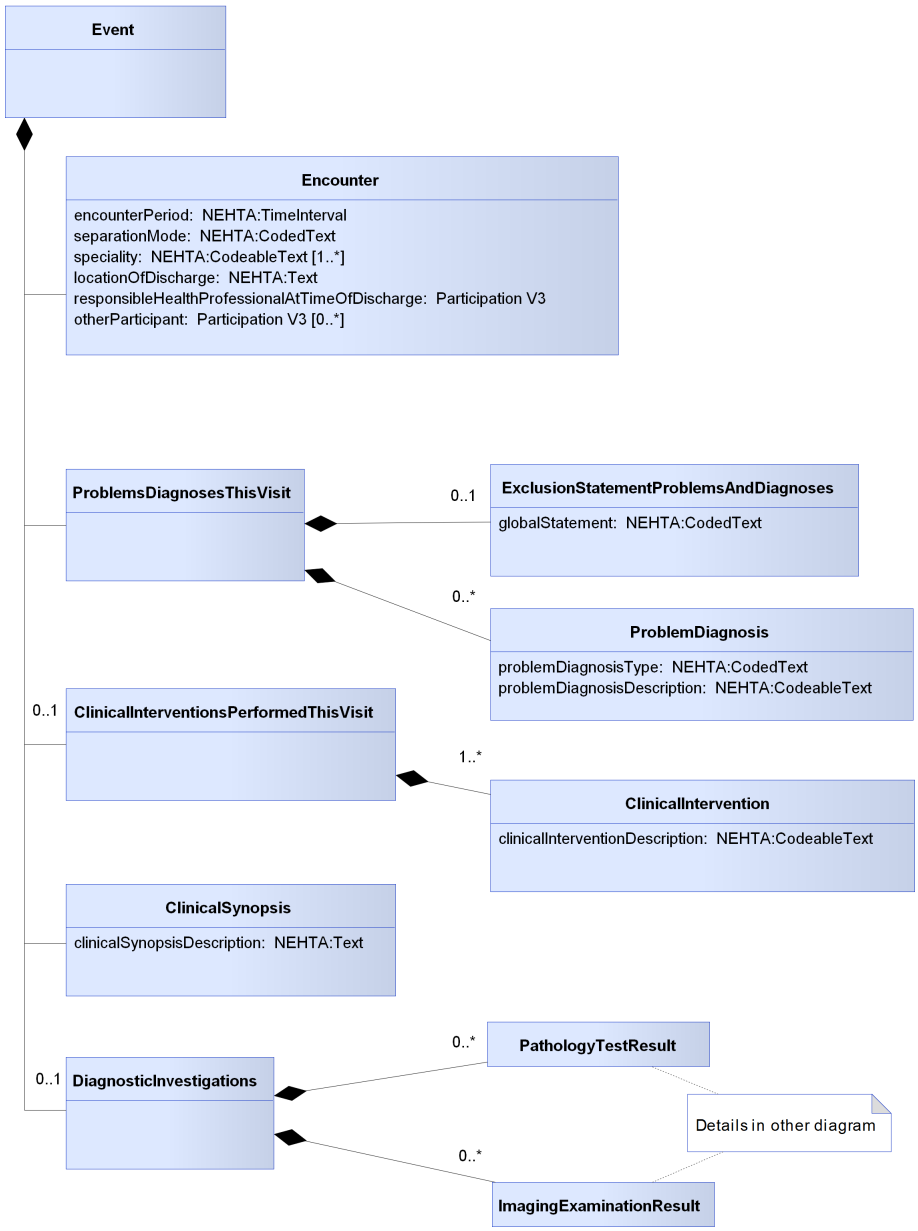
Data Type	Name	Obligation	Condition	Occurrence
	INFORMATION PROVIDED	Essential		Single

8 UML Diagrams

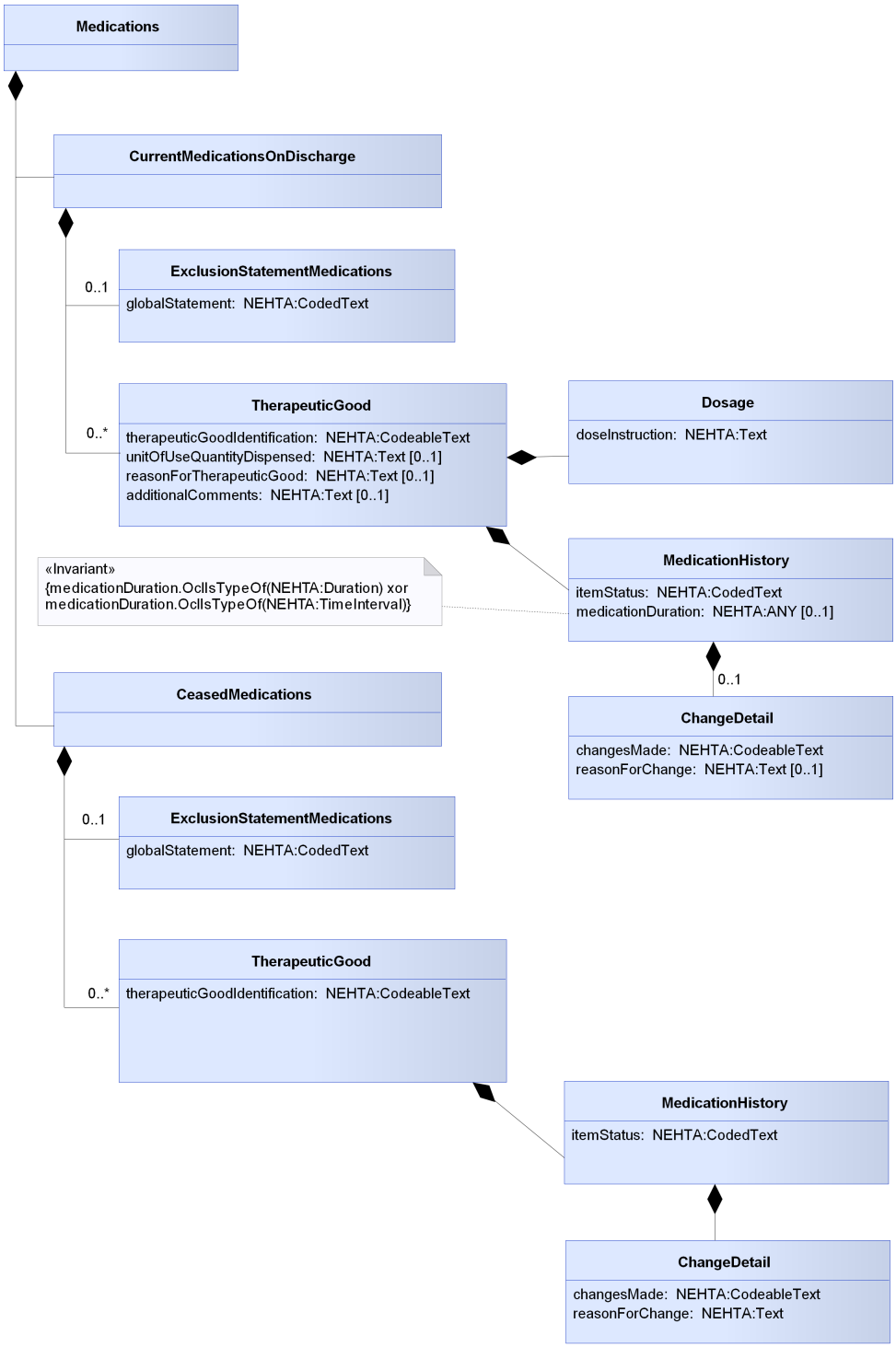
The following figures presents the data hierarchy using UML 2.0 class diagrams. The diagrams display data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes. Data groups are displayed as classes, their names are represented as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



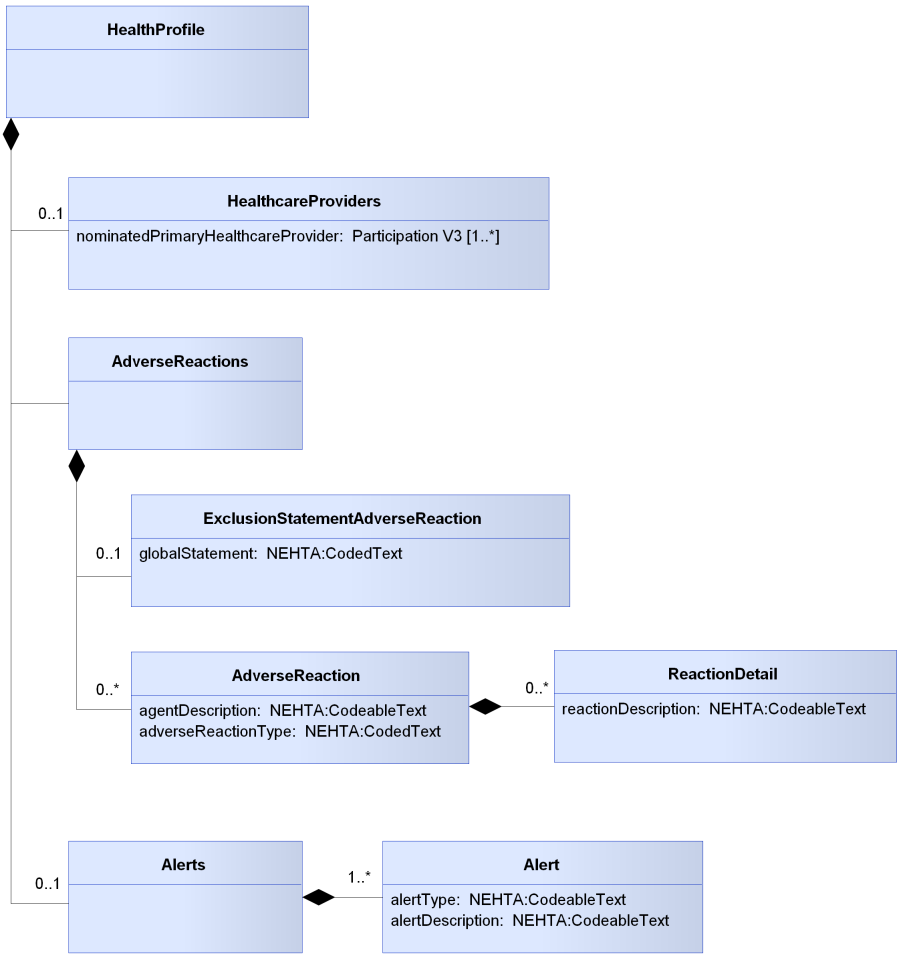
Top level UML class diagram of the Discharge Summary SDT data hierarchy.



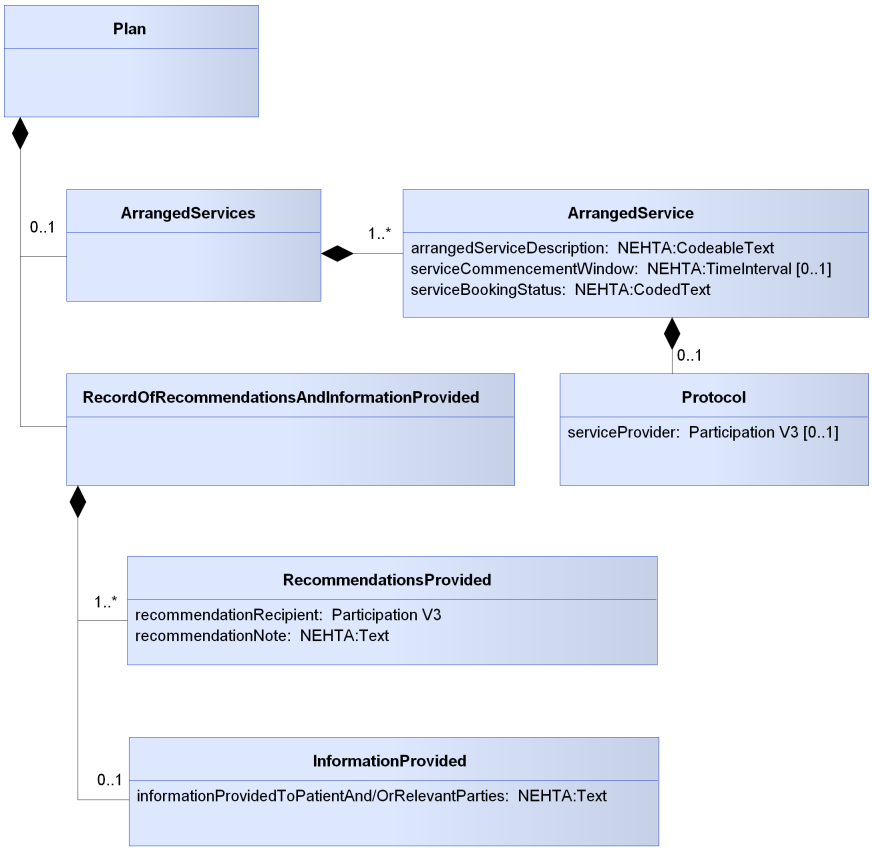
UML class diagram of the Event data hierarchy of the Discharge Summary SDT.



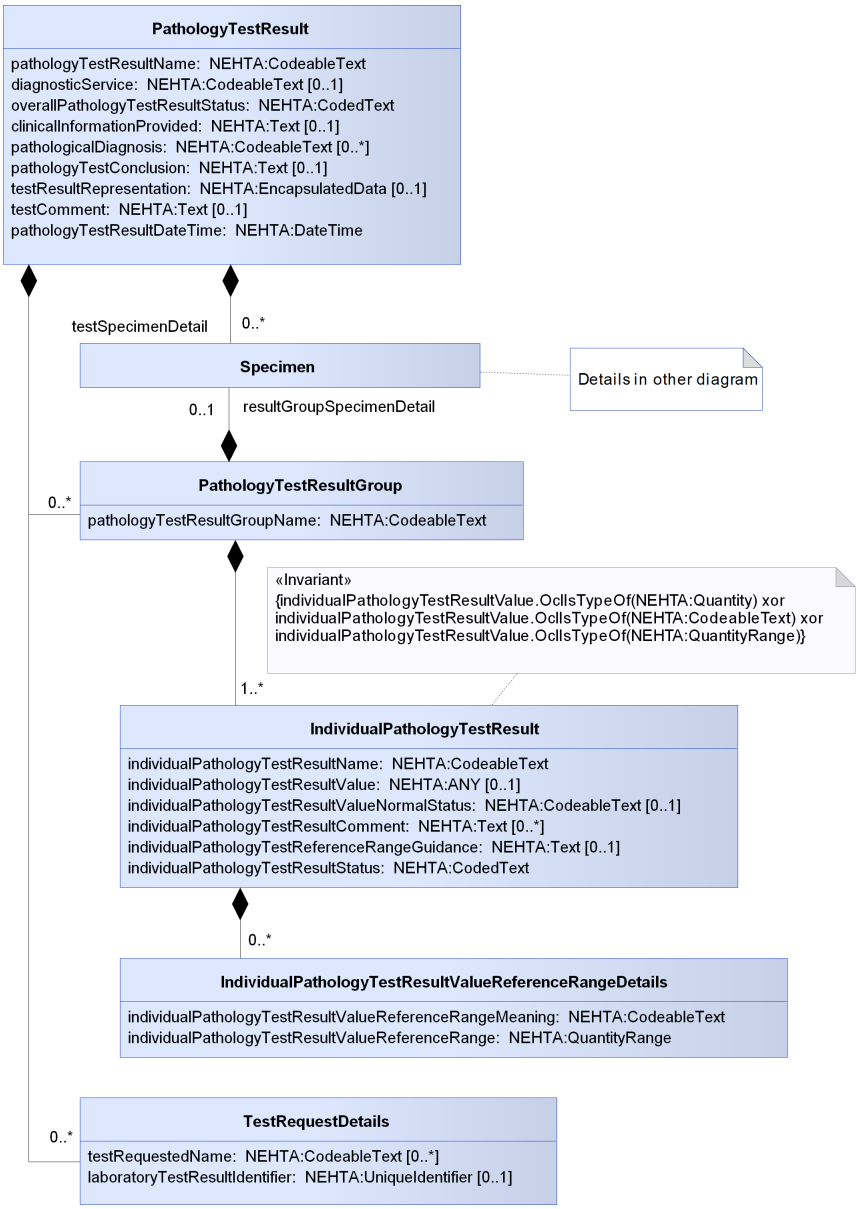
UML class diagram of the Medications data hierarchy of the Discharge Summary SDT.



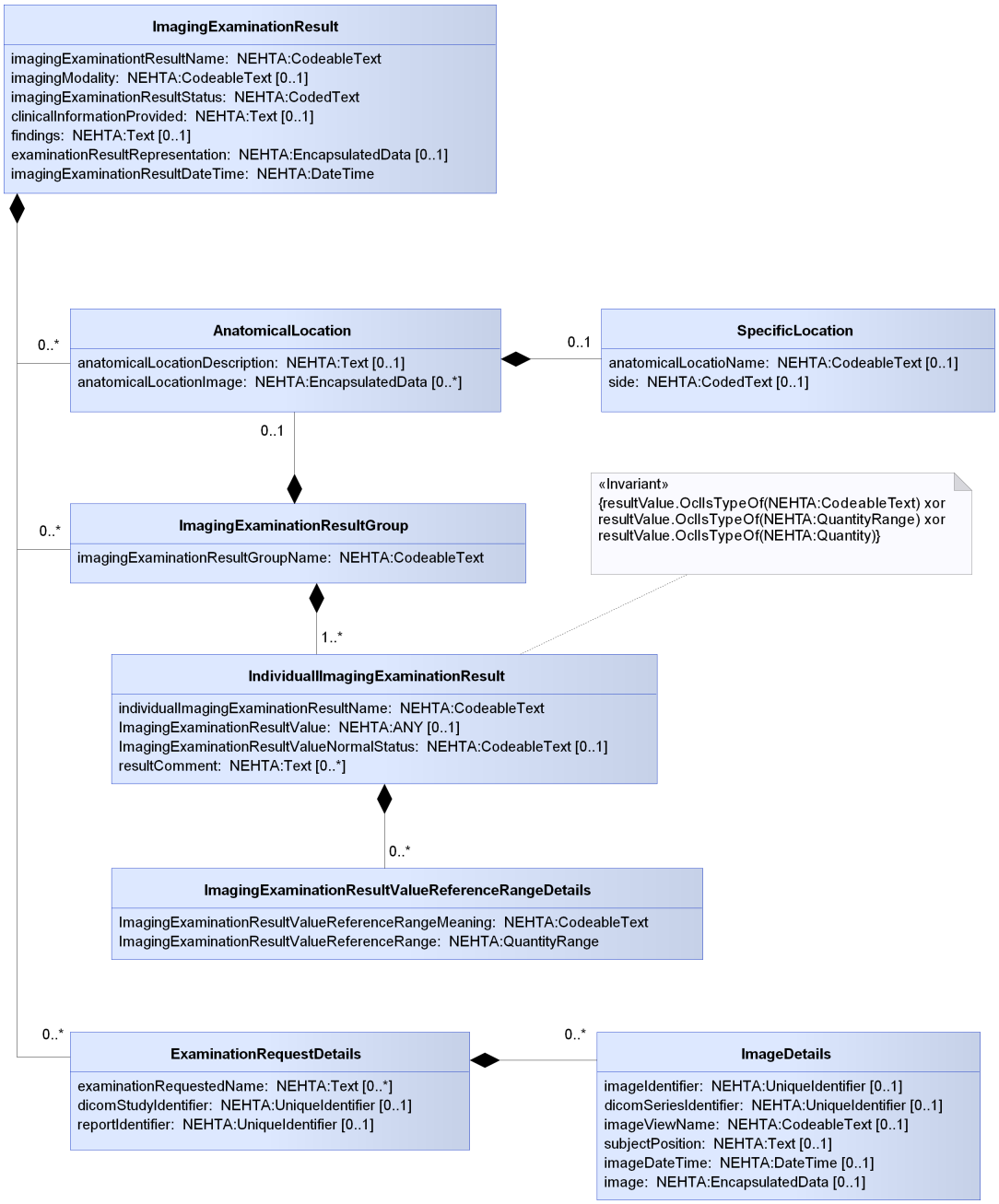
UML class diagram of the Health Profile data hierarchy of the Discharge Summary SDT.



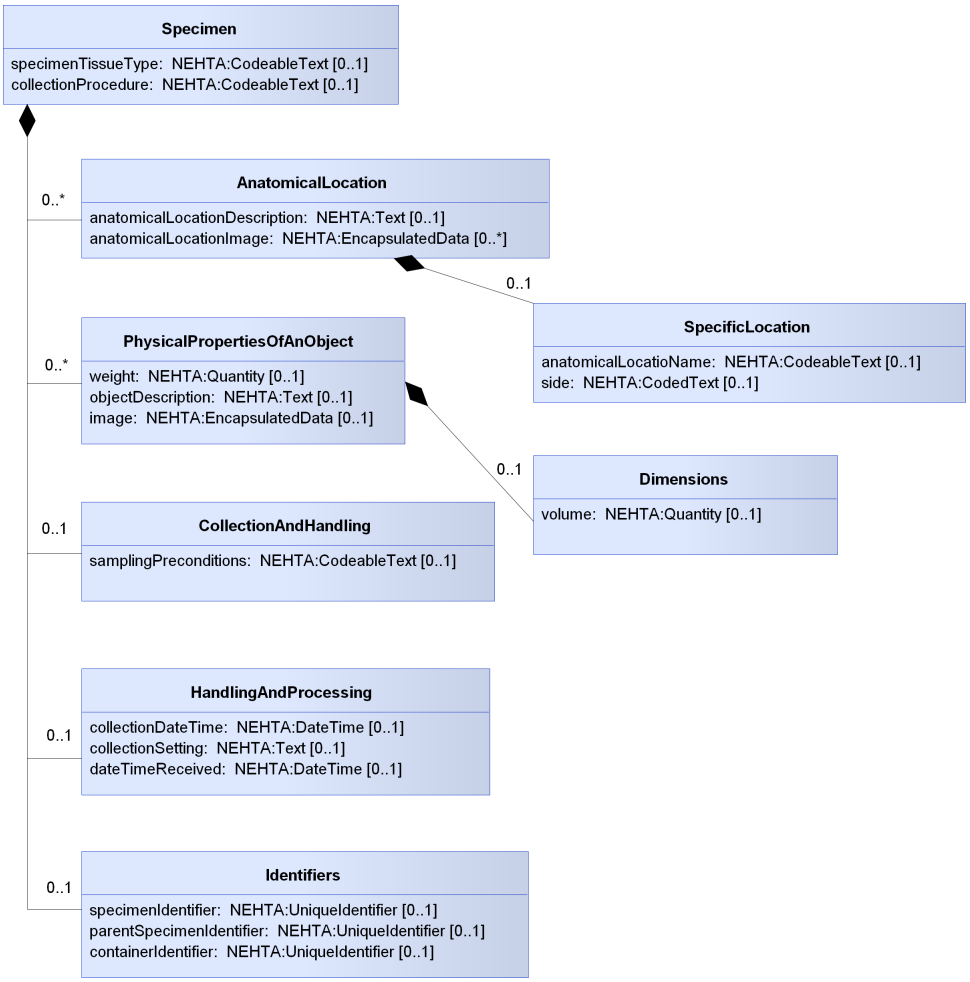
UML class diagram of the Plan data hierarchy of the Discharge Summary SDT.



UML class diagram of the Pathology Test Result data hierarchy of the Discharge Summary SDT.



UML class diagram of the Imaging Examination Result data hierarchy of the Discharge Summary SDT.



UML class diagram of the Specimen data hierarchy of the Discharge Summary SDT.

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Appendix A. Known Issues

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

Reference	Description
Document status	As a NEHTA Managed Specification, the contents of this document are the result of extensive clinical collaboration and editorial review, and the specification is considered to be “Final”. Nonetheless, as software implementations and standards review of this specification progress, normative updates may be required.
Compatibility with Structured Content Specifications (SCSs)	This Structured Document Template was not constructed using the Detailed Clinical Models (DCMs) issued in 2011 which are the foundation for recent Structured Content Specifications (SCSs), such as Event Summary, Specialist Letter and eReferral.
DateTime Health Event Started/Ended	The data elements *DateTime Health Event Started* and *DateTime Health Event Ended* should be replaced by a single data element *Health Event Period*.
Document Purpose	IT14-06-06 have asked us to include a statement in the Document Purpose section to this effect: A discharge summary does not constitute transfer of care or request for follow-up clinical interventions which would require a discharge referral. We have not yet done so because this is still a matter of discussion between NEHTA and IT14-06-06, but once the issue is finally resolved, we should update the document accordingly.
Essential vs Mandatory	Check against Standards Australia terminology of Essential vs Mandatory: This structured document template uses the concept “essential” to define data element obligations while Standards Australia uses the concept “mandatory”. The concepts “essential” and “mandatory” should be reviewed and harmonised (preferably align with Standard Australia practice).
EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	The data element *Global Statement* is not appropriate for inclusion in discharge summaries, and should be replaced.
“Global Statement Values” Value Domain (used 4 times)	The list of permissible values is probably incomplete.
Health Event	The definitions of *Health Event Identification* and *Encounter* need to be improved to prevent confusion.
Mandatory Health Identifiers	This structured document template specifies that the use of unique health identifiers (IHI; HPI-I; and HPI-O) are mandatory - legislation allows for people to opt-out, this means that this SDT specification only applies to people who have a HI. Requires further discussion between IT14-6-6 and NEHTA HI team and/or other relevant team(s).
Pathology Cancer Screening Profiles	NEHTA has defined six cancer screening profiles but they have not been included in this document.

Reference	Description
Problem/Diagnosis Type	This data element needs more research to support use for acute care.
Prohibiting Optional data components	Some data components are defined as Optional in specification such as “Participation”, and have been constrained out (i.e. prohibited) in this structured document template to align with the Core Information Components requirements. They should be left for implementers to determine whether the optional items would be implemented, e.g. *Source of Death Notification* data element in *Subject of Care* has been constrained out in this structured document template. Requires further discussion between IT14-6-6, the NEHTA Continuity of Care team, and NEHTA clinical lead(s)/Clinical Reference Group.
Pathological Diagnosis	The definition of data element *Pathological Diagnosis* does not sufficiently distinguish the data element from *Pathology Test Conclusion*.
Blank examples	The document includes Example entries with no content.

Appendix B. Specification Guide for Use

B.1 Overview

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

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

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

B.2 The Structured Content Metamodel

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

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

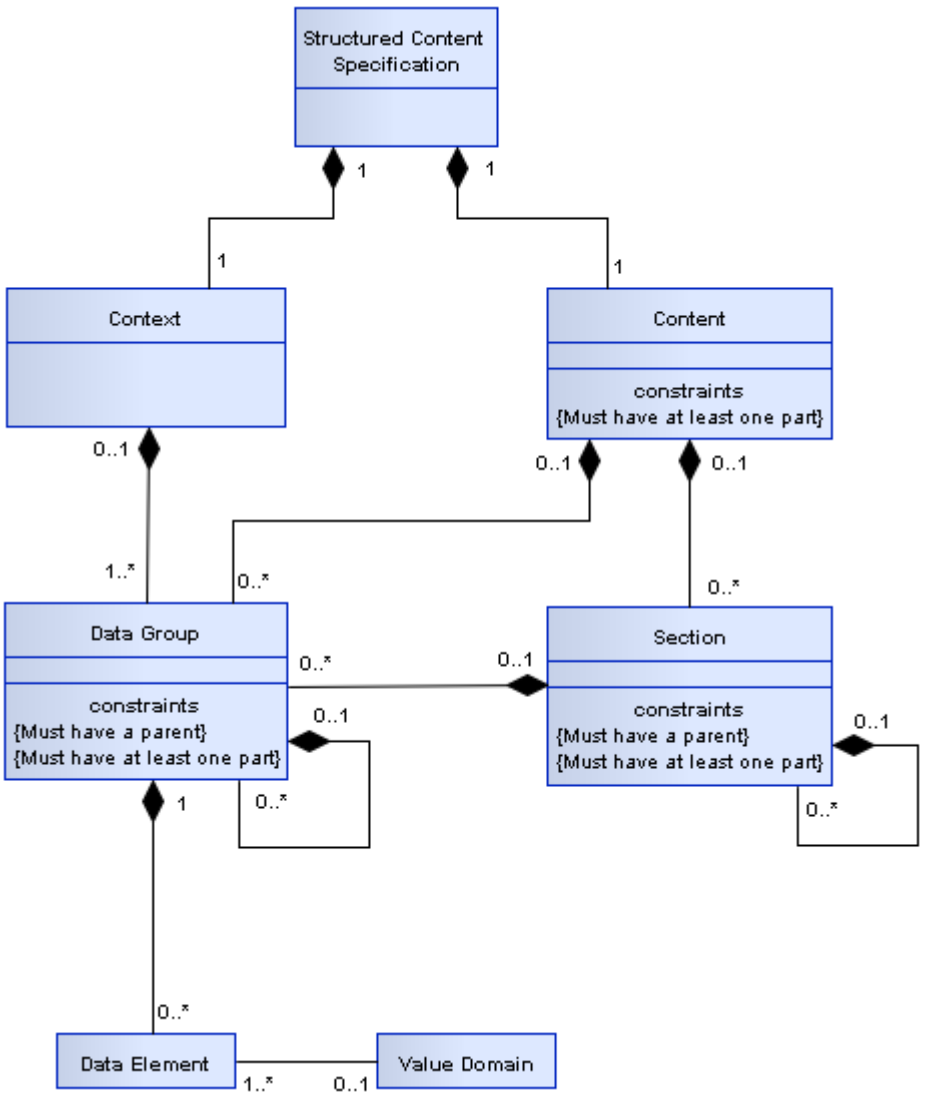

Figure 1: Structured Content Metamodel

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

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

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

- Section
- Data Group
- Data Element
- Value Domain

These components are described in more detail below.

Context

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

Content

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

Section

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

Data Group

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

Participation

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

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

[NEHT2011v] defines the full Participation specification.

Choice

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

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

Data Element

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

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

Value Domain

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

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

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

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

Table 1: Value Domain Examples

B.3 Icon Legend

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

Metadata Types Legend

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

Icon	Metadata Types
	Structured Document
	Section
	Data Group
	Participation
	Choice

Table 2: Metadata Types Legend

Data Types Legend

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

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

CodeableText

(ISO 21090: CD)

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

Usage/Examples

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

CodedText

(ISO 21090: CD)

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

Usage/Examples

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

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

DateTime

(ISO 21090: TS)

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

Usage/Examples

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

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

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

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

Table 3: Data Types Legend

Keywords Legend

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

The following table defines these keywords

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

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

Table 4: Keywords Legend

Obligation Legend

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

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

The following table defines the obligations.

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

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

Table 5: Obligations Legend

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

B.4 Information Model Specification Parts Legends

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

Data Hierarchy

The top-level component contains a data hierarchy. Each row contains information about a single data component. The entries are nested to represent inclusion of one component in another. Each entry contains three occupied cells. One contains an icon to indicate its data type. One contains the name of the component. One contains the multiplicity range for the data component.

Chapter Name

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

Identification Section Legend

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

Name	The information model name of the component. (Source NEHTA.)
Metadata Type	The metadata type of the component, e.g. section, data group or data element. (Source NEHTA.)
Identifier	A NEHTA assigned internal identifier of the concept represented by the component. (Source NEHTA.)

OID	An object identifier that uniquely identifies the concept represented by the data component. (Source NEHTA.)
External Identifier	An identifier of the concept represented by the data component which is assigned by an organisation other than NEHTA. (Source NEHTA.)

Table 6: Identification Section Legend

Definition Section Legend

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

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

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

Table 7: Definition Section Legend

Value Domain Section Legend

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

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

Table 8: Value Domain Section Legend

Usage Section Legend

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

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

Default Value	A common denomination, or at least a usable denomination, from the Value Domain where available and/or applicable, typically assigned at the creation of an instance of the component. (Source NEHTA.)

Table 9: Usage Section Legend

Relationships Section Legend

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

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

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

Table 10: Children Legend

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

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

Table 11: Parent Legend

Appendix C. Examples

This Structured Document Template sets out the logical data structure to support the electronic transmission of a discharge summary. The logical data structure does not reflect the visual presentation that a clinician would expect to see and therefore an example of a potential document layout is included to assist readers to understand how the data can be presented visually.

The following layout is a sample only and is one possible visualisation of the data elements specified in this Structured Document Template.

PATIENT: Mr William SMITH **DOB:** 01/01/1946 (63 years)

JUMP TO: Home Synopsis Medications Interventions Recommendations Supplementary

PATIENT

Name	**Mr William SMITH** Mr Bill SMITH (preferred)
MRN	542181
IHI	8003600008912385
Date of Birth	01/01/1946 (63 years)
Sex	Male
Address	Residence: 20 Chapel Street, Lilydale, VIC, 3002 Postal: PO Box 123, Lilydale, VIC, 3002
Contact	Home Phone: 03 3988 7156 Mobile: 0411 378 942

Fictitious

DISCHARGE SUMMARY

Fairhill Health Hospital
[HPI-O: 8003620000000822]

Summary Status	Final
Version Number	1
Date completed	13/11/2009 14:06
Document Author	Dr Jason LEE (Intern) Phone: 03 3256 8569 [HPI-I: 8003610000002084]

ENCOUNTER DETAILS

Admission Date	Friday 06/11/2009 09:12
Discharge Date	Friday 13/11/2009 13:22
Separation Mode	To Home
Discharge Ward	Ward 3A
Specialties	Respiratory Orthopaedic Surgery

FACILITY DETAILS

Name	Fairhill Health Hospital [HPI-O: 8003620000000822]
Address	1 Stanley Street Ringwood East VIC, 3136
Contact	Phone: 03 3256 8569 Fax: 03 3256 8888

PRIMARY RECIPIENTS

Name (+ relationship to patient)	Organisation	Address	Contact
Dr Jane ANDERSON (GP) [HPI-I: 8003610000001706]	Croydon GP Centre [HPI-O: 8003620000000541]	23 Anzac Street Croydon VIC, 3136	Phone: 03 4575 4566 Email: records@croydongp.com.au

CLINICAL SYNOPSIS

Admitted for elective, right Total Knee Replacement (cemented prosthesis). Day 3, developed bilateral basal atelectasis. The FBC showed high WCC (20.0) and high neutrophils (16.0). Commenced on doxycycline and chest physio. Due to mild anaemia prior to surgery and subsequent operative blood loss, required a blood transfusion of three units. Subsequently made steady progress, regaining good mobility in his knee and is able to mobilise with the aid of a stick. Right knee Xray showed no fracture or dislocation, with the total knee prosthesis well positioned post surgery.

PROBLEMS / DIAGNOSIS

Type	Description
Principal Diagnosis	Osteoarthritis of right knee
Comorbidities	Chronic Obstructive Pulmonary Disease
	Anaemia
Complications	Post-operative pneumonia
	Intra operative haemorrhage
	Hypotension

CURRENT MEDICATIONS ON DISCHARGE

(Status: New = 'N', Changed = '*', Unchanged = 'U', Withheld = 'W')

Status	Item Description	Dose Instructions	Reason for Medication	Duration	Change made (+ reason for change)	Quantity supplied
N	Doxycycline (100 mg) tablet	1 tablet once daily oral	Pneumonia	Continue until finished		2 tablets
N	Codalgin Forte (paracetamol 500mg + codeine phosphate 30mg) tablet	2 tablets as required oral maximum of 8 per day	Pain management	Ongoing		20 tablets
*	Lasix (frusemide 40 mg) tablet	1 tablet once daily oral	Fluid retention	Ongoing	Dose decreased from 1 tablet Twice a day (Due to hypotension)	100 tablets
U	Spiriva (tiotropium bromide 18mg per inhalation) inhalant	1 inhalation per day	COPD	Ongoing		own supply
W	Cardiprin (aspirin 100 mg) tablet	1 tablet once daily oral	Cardiovascular prophylaxis	Ongoing	Withheld (due to surgery)	30 tablets
	Additional comments	Please recommence 3 days after discharge				

CEASED MEDICATIONS

Item Description	Reason for Ceasing
Oxycodone hydrochloride (5mg) capsule	No longer required
Celebrex (celecoxib 200mg) capsule	Ceased due to scheduled surgery

Sample

NEHTA does not promote this document as the prescribed display format but one EXAMPLE ONLY of the many possible presentation permutations.

NEHTA does not promote this document as the prescribed display format but one EXAMPLE ONLY of the many possible presentation permutations.

ALLERGIES/ADVERSE REACTIONS

Agent	Reaction description
Penicillin	Severe urticaria on trunk and legs; Nausea and vomiting
Metoprolol	Acute exacerbation of Chronic Obstructive Airways Disease

CLINICAL INTERVENTIONS THIS VISIT

Primary cemented total knee replacement (R)
Lumbar epidural block
Transfusion of packed red blood cells, post-op
Physiotherapy

DIAGNOSTIC INVESTIGATIONS

Type	Date	Test Name	Status
Pathology	10/11/2009 14:06	Biochemistry Battery Tests	Final
	10/11/2009 14:06	Hepatic Function Panel	Pending
	10/11/2009 14:31	Full Blood Count	Final
Radiology	08/11/2009 09:28	X-Ray of chest	Final
	07/11/2009 13:54	Right knee x-ray	Final

RECOMMENDATIONS

To	Note
Dr Jane ANDERSON Usual GP [HPI-I: 8003610000001706]	Please remove the staples on 18 November 2009. Please ensure aspirin is recommenced 3 days post-discharge. Please follow-up anaemia.
Mr William SMITH Patient	Return to GP on 18 November 2009 to have the staples removed. Keep up regular mobility routine as guided by physiotherapist. Please recommence aspirin 3 days post discharge.

ALERTS

Type	Description
Clinical	At risk of pressure sores due to easily damaged skin
Advance Care Directive	Present

ARRANGED SERVICES

Service Date	Provider	Description	Status
13/12/2009	Dr Horace WILLIAMS (Orthopaedic Surgeon) [HPI-I: 8003610000002050] Fairhill Health Hospital [HPI-O: 8003620000000822]	Orthopaedic outpatient clinic appointment for 4 weeks post-discharge progress review	Confirmed

INFORMATION PROVIDED TO PATIENT AND/OR FAMILY

Patient was given a brochure explaining the expected post-op recovery following a total knee replacement. The physiotherapist provided a list of home exercises. The good prognosis for return to activity was discussed with the patient – likely to be able to walk with a stick at six weeks.

NOMINATED PRIMARY HEALTHCARE PROVIDERS

Name (+ role)	Organisation	Address	Contact
Dr Jane ANDERSON (General Practitioner) [HPI-I: 8003610000001706]	Croydon GP Centre [HPI-O: 8003620000000541]	23 Anzac Street Croydon VIC, 3136	Phone: 03 4575 4566 Email: records@croydongp.com.au

OTHER RECIPIENTS

Name (+ relationship to patient)	Organisation	Address	Contact
Mr Peter OWEN (Community Physiotherapist) [HPI-I: 8003610000002076]	PhysioCare Pty Ltd [HPI-O: 8003620000000814]	200 Wonga Road Warranwood VIC, 3101	Phone: 03 5214 5236 Fax: 03 5214 5244
Mr William SMITH (Patient)		20 Chapel Street, Lilydale, VIC, 3002	Home: 03 3988 7156 Mobile: 0411 378 942

OTHER PARTICIPANTS

(Responsible Health Professional = *)

Name (+ role)	Organisation	Address	Contact
Dr Jeremy McCALLISTAR * (Respiratory Consultant) [HPI-I: 8003610000001987]	Fairhill Health Hospital [HPI-O: 8003620000000822]	1 Stanley Street Ringwood East VIC, 3136	Phone: 03 3256 8569
Dr Janice SMITH (Registrar) [HPI-I: 8003610000001995]	Fairhill Health Hospital [HPI-O: 8003620000000822]	1 Stanley Street Ringwood East VIC, 3136	Phone: 03 3256 8569
Mr Charles Thomas (Pharmacist) [HPI-I: 8003610000002001]	Fairhill Health Hospital [HPI-O: 8003620000000822]	1 Stanley Street Ringwood East VIC, 3136	Phone: 03 3256 8569
Miss Kathryn Jones (Physiotherapist) [HPI-I: 8003610000002019]	Fairhill Health Hospital [HPI-O: 8003620000000822]	1 Stanley Street Ringwood East VIC, 3136	Phone: 03 3256 8569

Sample

Appendix D. Log of Changes

This appendix details the changes and feedback resulting from public comment on version 3.2, which was sent to Standards Australia in October 2010. It includes some changes made in response to a NEHTA internal review of the document.

Issue ID	Title	Requested Change/Feedback	Location/Change Made
CIDS-27	Patient, subject of care, person can be used in the same sentence	Pick one of the terms 'Patient' and 'Subject of Care' and use it consistently.	NEHTA's standard term 'Subject of Care' is now used in all cases.
CIDS-28, CIDS-29	Value domains used inconsistently	Value domains used inconsistently. Example in Sections 4.14, 5.5 and 6.7, value domain VD-16299 has sets of permissible values that are not mutually exclusive: e.g. 1- no significant medical history S4.14.3 2- not current taking any medication S5.5.3 3- no known adverse reactions S6.7.3 Some value domains do not have permissible value sets e.g. VD-15554, VD-10176	• All exclusion statements get the same value domain. • The value domain for 6.14 Adverse Reaction Type has been suppressed. • The value domain for 5.19 Changes Made has been suppressed.
CIDS-30	Poor definitions	A repeating common problem throughout the document is that extraneous content is included in definitions. This is not consistent with ISO standards.	Some definitions reviewed and revised.
CIDS-31	Definition is not consistent with Health Standard - METeOR ID: 270688	Use correct references for 4.5 Separation Mode Values.	Now references METeOR Vale Domain 270688. Other minor changes.
CIDS-32	Wrong source attribution	Use correct references for 4.4 Separation Mode.	Now references METeOR Data Element Concept 270094. Other minor changes.
CIDS-34	Poor definition of ENCOUNTER	Revise definition of ENCOUNTER.	The definition has been revised.
CIDS-36	Poor definition of EVENT	Revise definition of EVENT.	The definition has been revised.

Issue ID	Title	Requested Change/Feedback	Location/Change Made
CIDS-37	Definition should be singular	Replace 'Type(s)' with 'Type'.	Changes were made to Section 3.5 Care Setting.
CIDS-42	Paragraph contradicts content of document.	The paragraph in section 1.2 starting "Implementation which is optional to implement..." conflicts with the content of the document.	The paragraph has been removed.
CIDS-43	Use of exclusion statements is disorganised	Use revised version of Exclusion Statements.	All exclusion statements now contain the single attribute 'Global Statement'. Cardinality and description of exclusion statements revised.
CIDS-44	Use the e-Referral design of Pathology Test	Use the e-Referral version of Pathology Test Result in place of Laboratory Report.	The new version has been integrated with the SDT.
CIDS-45	Use the e-Referral design of Imaging Examination	Use the e-Referral version of Imaging Examination Result in place of Imaging Test.	The new version has been integrated with the SDT.
CIDS-51	Description Values	Add SNOMED CT-AU concept IDs where available	SNOMED CT-AU Concept IDs added to 4.18 Problem/Diagnosis Description Values and 4.22 Clinical Intervention Description Values.
CIDS-56	SNOMED CT, SNOMED CT-AU; Use of registered trademark symbol	Initial use of SNOMED CT or SNOMED-CT-AU requires a registered trademark symbol.	Paragraph added to introduction about SNOMED CT-AU and terminology.
CIDS-57	Use of Participation icon	In various locations the Data Group icon is used when it should be the Participation icon.	Icon replaced in Children relationships table for: • 4.2 ENCOUNTER - RESPONSIBLE HEALTH PROFESSIONAL AT TIME OF DISCHARGE • 4.2 ENCOUNTER - OTHER PARTICIPANT • 6.2 HEALTHCARE PROVIDERS - NOMINATED PRIMARY HEALTHCARE PROVIDER • 7.8 PROTOCOL - SERVICE PROVIDER • 7.11 RECOMMENDATIONS PROVIDED - RECOMMENDATION RECIPIENT

Issue ID	Title	Requested Change/Feedback	Location/Change Made
CIDS-83	Should use latest version of Participation Data Specification.	The Participation Specification has been updated and the latest version should be used for compatibility with other specifications.	Reference to Participation updated. Subject of Care Conditions of Use now explicitly state that Date of Birth and Sex are essential.
CIDS-84	Use current icons.	NEHTA has new (2011) icons for data specifications. Use them.	Icons changed. Guide for use appendix which describes new icons added. References to external guide for use document with old icons have been replaced with references to appendix.
CIDS-97	Nominated Primary Healthcare Provider - Conditions of Use - Missing constraints.	The Core Information Requirements for Discharge Summary have Address and Electronic Communication Details as essential.	Obligation constraint statements added to make Essential for both persons and organisations.
CIDS-100	Facility - Conditions of Use - The Entity Identifier of a Facility should be Essential.	The Core Information Requirements for Discharge Summary have this as essential.	Obligation constraint statement added to make Essential. Related value constraint adjusted.
CIDS-103	Speciality - Relationships - should be essential.	The Core Information Requirements for Discharge Summary have this as essential.	Obligation changed from Optional to Essential.
CIDS-105	Problem/Diagnosis Description; Definition is poor.	The definition should not mention coding.	Definition revised to *An identifying description of the problem/diagnosis.*
CIDS-124	Changes Made - Usage - second example not relevant	Remove the second example as it is not relevant to ceased medications.	Example 2 removed.
CIDS-125	Reason for Change - Definition - not suited to this use.	Use a more relevant definition. The notes are redundant in an essential data element.	Definition changed from “The justification for the stated change in medication.” to “The reason why the medication was ceased.” Notes “Should be completed if a change has been made.” removed.
CIDS-130	Protocol - Definition - wrong	Use a correct definition. Remove the notes.	Definition changed from “Information that is not critical to but may add value to the interpretation of a measurement.” to “Relevant non-clinical information.” Notes removed.

Issue ID	Title	Requested Change/Feedback	Location/Change Made
CIDS-133	Problem/Diagnosis Description - Value Domain is too broad.	Use the specific value domain which is now available for this data element and is used is other specifications.	Value domain *Problem/Diagnosis Description Values* replaced with *Problem/Diagnosis Reference Set*.
CIDS-134	Other Participant - Conditions of Use are wrong.	Employment Detail might be needed for a healthcare provider, make it optional. Date of Birth is Calculated From Age, DATE OF BIRTH ACCURACY INDICATOR and AGE DETAIL are only relevant to a Subject of Care, make prohibited.	Obligation constraints changed.
CIDS-135	Adverse Reaction - Definition and Synonymous Names should be single.	The definitions and synonymous names are plural. The data group contains information about a single adverse reaction.	Definition and Synonymous Names made singular.
CIDS-149	Health Event Identification should only be single.	An organisation may wish to record several values of Health Event Identification for internal processes, but there is no need for that in clinical discharge. Change multiplicity to 0..1.	Change made to 3.6 Health Event Identification.
CIDS-155	Conditions of Use sections for Participations are inconsistent in content and expression.	Standardise the conditions of use for similar uses.	Changes made to all participations.
CIG-253	Replace MUST with SHALL in Discharge Summary SDT	Use NEHTA's preferred conformance terminology of SHALL.	Conformance statements in this document now use 'SHALL' in place of 'MUST'.
PDS-315	Date of Birth and Sex should be optional for participations other than subject of care	Date of Birth and Sex should be optional for participations other than subject of care.	All participations other than Subject of Care now state that Sex and Date of Birth are optional.

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