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National Clinical Terminology and Information Service

Reference Set Library v2.0

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National E-Health Transition Authority

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IHTSDO (SNOMED CT)

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Document information

Key information

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1 Introduction

1.1 Purpose of this document

This document is a register of clinical reference sets developed for the clinical terminology community of practice. This includes reference sets pertaining to both SNOMED CT®-AU[1] and the Australian Medicines Terminology (AMT).

1.2 Intended audience

This document has been written for those in the clinical terminology community of practice who have a solid understanding of SNOMED CT and the AMT, as well as their associated concept models, scope and underlying description logic.

1.3 Clinical terminology overview

Clinical terminology contributes to the improvement of healthcare through supporting the recording, display and exchange of healthcare information and the ability to deliver decision support services to healthcare providers. Healthcare consumers benefit from the use of terminology to more clearly describe and accurately record their healthcare information. The application of clinical terminology has a range of benefits, including:

- Clinical efficiency and a consistent vocabulary across all healthcare domains.
- Reduced error rates and better recording of clinical information at the required level of granularity.
- Consistent retrieval, exchange and analysis of recorded clinical information.
- Reduced risk of incorrect interpretation of clinical information.

In addition, clinical terminology supports or enables:

- Semantic interoperability between disparate clinical information systems.
- Reusability of clinical information (record once, use many times).
- Consistent representation of clinical terms.
- Machine processing of clinical information.
- Extensibility, which in turn enables the terminology to improve and evolve to meet changing needs.

These benefits are major drivers for organisations to adopt terminology. However, to support the realisation of these benefits, those working to develop, integrate and maintain terminology within a healthcare software system require a comprehensive understanding of the ontology. This is not insignificant given the amount and, at times, complex nature of the information that needs to be understood. Areas of coverage include, but are not limited to, file formats, terminology components, relationship types, hierarchies, reference sets and the interaction between the terminology and the information model.

[1] "SNOMED" and "SNOMED CT" are registered trademarks of the International Health Terminology Standards Development Organisation (IHTSDO).

Terminology adoption requires much more than just an in-depth understanding of terminology. Various groups of skilled professionals from different backgrounds and knowledge domains are needed to support the adoption process.

1.4 Related documents

The documents listed below provide the context for development of the reference sets described in this document, and should be read in conjunction with this document to enhance understanding of our approach to terminology development.

- *NCTIS - Development Approach for Reference Sets* (NEHTA, 2015)
- *SNOMED CT-AU - Australian Implementation Guidance* (NEHTA, 2015)

Both documents are available at: http://www.nehta.gov.au/implementation-resources/ehealth-foundations/snomed-ct-au-common.

1.5 Reference set implementation considerations

The scope and context within which the reference set is intended to be used needs to be fully understood. This information (much of which is included in this document) is provided as part of the release documentation of any NCTIS-produced reference set. The scope and type of the reference set are key parts of the implementer's analysis, which in turn helps to ensure that the required attributes will be correctly imported.

It is **not** possible to implement reference sets in isolation. The implementation type will determine the extent of terminology data required, but reference sets will always demand the use of additional files. Reasons for this include:

- Referenced concepts have their descriptions held within the descriptions file. The descriptions file not only enables the display of concepts' terms, but also the ability to use the wide range of Synonyms required for effective search.
- The *Australian dialect reference set* holds information about the acceptability of Synonyms for use within an Australian context. Most importantly, this language reference set can be used to determine which Synonym is preferred and therefore should be the display term of a reference set member.
- Implementations are required to understand and handle the receipt of unexpected codes. This may occur when the sender or receiver has a more recent release or version of the reference set in their system. If a concept is received, but is not a member of the expected reference set, additional information can be found either in the history of the reference set or in the core terminology files.
- It will assist in the maintenance processes required to keep reference sets up to date (see Section 4.6 in the *SNOMED CT-AU Australian Implementation Guidance* (NEHTA, 2015)).

1.6 Presentation of information

In this reference set library, all reference sets released by the NCTIS are described, each in a tabular format, with the exception of the structural reference sets.[2] This format allows readers to easily determine if a reference set exists, which terminology it is from and whether it meets their needs.

1.7 Acronyms

The following acronyms are used in this document.

Acronym	Description
AMT	Australian Medicines Terminology
DCM	Detailed Clinical Model
IHTSDO	International Health Terminology Standards Development Organisation
NCTIS	National Clinical Terminology and Information Service
SDT	Structured Document Template
SNOMED CT-AU	SNOMED CT, Australian release

1.8 Filename conventions

The filenames used to identify NCTIS reference sets adhere to the following convention:

```
der2_<Descriptor>_<RefsetName>
<ReleaseType>_AU<Namespace>_<DateOrVersion>.txt
```

where the placeholders (represented in angled brackets) have the meanings tabulated below.

Table 1: Filename key

Item	Description
Descriptor	Refers to the type of reference set released. For example, "Refset" pertains to Simple type reference sets and "cRefset" pertains to Attribute value reference sets.
RefsetName	Refers to the reference set name.
ReleaseType	Refers to the type of release it was released under. For example Full, Snapshot or Delta.
Namespace	Refers to the namespace of the organisation that creates and maintains the file.
DateOrVersion	Refers to the date of release.

To illustrate, a valid example of this convention is:

der2_Refset_BodyStructureFoundationSnapshot_AU1000036_20130531.txt

[2] Structural reference sets are described in the *SNOMED CT Technical Implementation Guide* (IHTSDO, 2015), Chapter 5.6 "Release Format 2 - Reference Sets Guide".

Note: Throughout this document, by default, all SCTIDs used are concept IDs and all descriptions used are Australian preferred terms unless specified otherwise.

2 Adverse reaction agent reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Adverse reaction agent reference set* provides terminology to support the accurate recording of the most common agents that may be responsible for causing adverse reactions. It is intended that this reference set be used in association with the *Clinical manifestation reference set*, which provides values describing the clinical manifestation of adverse events.
Scope	This reference set can be used: • Within implementations of the *Adverse Reaction DCM* (NEHTA, 2011). • Within implementations where use-case specific reference sets for adverse reaction agents are yet to be developed. • As the basis for developing further use-case specific reference sets for adverse reaction agents through a process of constraint, or expanding upon. • Alongside other reference sets, such as any of the AMT medicinal or trade product reference sets to supplement the recording of non-medicinal agents.
Target client	This reference set can be used where developers are implementing NEHTA clinical information models containing the *Substance/Agent* data element or the *Adverse Reaction DCM*.
Other clients	Australian e-health clinical information systems.
Definitive bindings	The *Adverse reaction agent reference set* is bound to the *Substance/Agent* data element within the *Adverse Reaction DCM*.
Example of content	• 256350002 |*Almond*| • 387494007 |*Codeine*|
Plan for future work	This reference set is subject to further development based on feedback from implementations and the current *Substance* hierarchy re-design project being undertaken at the international level.
File name and version	der2_Refset_AdverseReactionAgent*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20131130
Initial no. of members	1,113
Contact	help@nehta.gov.au

3 Adverse reaction type reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Adverse reaction type reference set* provides terminology to support the recording of the type of adverse reaction experienced, as determined by the clinician.
Scope	This reference set can be used within implementations of the *Adverse Reaction DCM* (NEHTA, 2011).
Target client	This reference set is developed for those who are implementing the *Adverse Reaction DCM*.
Other clients	
Definitive bindings	The *Adverse reaction type reference set* is bound to the *Reaction Type* data element within the *Adverse Reaction DCM*.
Example of content	• 12263007 |*Hypersensitivity reaction type I*| • 419076005 |*Allergic reaction*| • 609406000 |*Non-allergic reaction*|
Plan for future work	
File name and version	der2_Refset_AdverseReactionType*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20120531
Initial no. of members	15
Contact	help@nehta.gov.au

4 Anatomical location name reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Anatomical location name reference set* provides terminology to support the recording of anatomical locations. It is void of information that represents body structures with laterality and it represents a subset of the *Anatomical site reference set*.
Scope	This reference set can be used within implementations of the DCMs that contain the *Name of Location* data element. The reference set also supports a wide variety of uses that require human anatomical sites to be described.
Target client	This reference set is developed for those implementing the NEHTA-developed DCMs.
Other clients	
Definitive bindings	The *Anatomical location name reference set* is bound to the *Name of Location* data element within: • *Adverse Reaction DCM* (NEHTA, 2011); • *Pathology Test Result DCM* (NEHTA, 2011); • *Imaging Examination Result DCM* (NEHTA, 2011); • *Procedure DCM* (NEHTA, 2011); and • *Problem/Diagnosis DCM* (NEHTA, 2011).
Example of content	• 48467007 |*Aortic tunica media*| • 245524004 |*Entire lobe of lung*| • 87342007 |*Bone structure of fibula*|
Plan for future work	
File name and version	der2_Refset_AnatomicalLocationName*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20130531
Initial no. of members	23,337
Contact	help@nehta.gov.au

5 Anatomical site reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Anatomical site reference set* provides terminology to describe human anatomical sites.
Scope	This reference set can be used within implementations of the *Pathology Result Report SDT* (NEHTA, 2009). The reference set also supports a wide variety of uses that require human anatomical sites to be described.
Target client	This reference set is developed for those implementing the *Pathology Result Report SDT*.
Other clients	This reference set may be useful to any implementer requiring anatomical sites to be described.
Definitive bindings	This reference set is bound to the *Specimen Anatomical Site* data element (DE-11010) which is under the *Specimen Detail* data group (DG-11005) within the *Pathology Result Report SDT*.
Example of content	• 362209008 |*Entire left kidney*| • 8966001 |*Left eye structure*|
Plan for future work	
File name and version	der2_Refset_AnatomicalSite*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	24,983
Contact	help@nehta.gov.au

6 Body structure foundation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Body structure foundation reference set* provides the broadest possible terminology to support the recording of anatomical structures in Australian e-health implementations.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for body structure are yet to be developed. • As the basis for developing further use-case specific reference sets for body structure, through a process of constraint. • As a benchmark, against which use-case specific reference sets developed by the SNOMED CT-AU user community, can be tested to assure that they are logical constraints of the body structure content.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 91134007 |*Mitral valve structure*| • 18639004 |*Left kidney structure*|
Plan for future work	
File name and version	der2_Refset_BodyStructureFoundation*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	30,445
Contact	help@nehta.gov.au

7 Cardiovascular finding reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Cardiovascular finding reference set* is a broad context reference set that provides the broadest possible terminology to support the recording of cardiovascular findings in Australian e-health implementations. This reference set has been developed from the *Clinical finding foundation reference set*.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for cardiovascular findings are yet to be developed. • As the basis for developing further use-case specific reference sets for cardiovascular findings through a process of constraint. • As a benchmark against which use-case specific reference sets that have been developed by the SNOMED CT-AU user community can be tested to assure that they are logical constraints of content relating to cardiovascular findings.
Target client	Australian e-health clinical information systems, for example, in Cardiology.
Other clients	
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 1939005 |*Abnormal vascular flow*| • 70908000 |*Decreased blood volume*|
Plan for future work	This reference set may be used as a basis to develop more specific reference sets based on terminology requirements within different professional groups and delivery settings.
File name and version	der2_Refset_CardiovascularFinding*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20100531
Initial no. of members	5,599
Contact	help@nehta.gov.au

8 Change status reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Change status reference set* is developed to provide terminology to indicate whether a change has been made to a medication or if a recommendation for change has been made.
Scope	This reference set can be used within implementations of the *Medication Instruction and Action DCM* (NEHTA, 2013).
Target client	This reference set is developed for those implementing the *Medication Instruction and Action DCM*.
Other clients	
Definitive bindings	The *Change status reference set* is bound to the *Change Status* data element within the *Medication Instruction and Action DCM*.
Example of content	• 703466009 |*Change recommended*| • 703465008 |*Change made*|
Plan for future work	
File name and version	der2_Refset_ChangeStatus*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20141130
Initial no. of members	2
Contact	help@nehta.gov.au

9 Change type reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Change type reference set* is developed to provide terminology to support the recording of the way in which the current medication instruction differs from the previous one.
Scope	This reference set can be used within implementations of the *Medication Instruction and Action DCM* (NEHTA, 2013).
Target client	This reference set is developed for those implementing the *Medication Instruction and Action DCM*.
Other clients	
Definitive bindings	The *Change type reference set* is bound to the *Change Type* data element within the *Medication Instruction and Action DCM*.
Example of content	• 385655000 |*Suspended*| • 385656004 |*Ceased*| • 89925002 |*Cancelled*|
Plan for future work	
File name and version	der2_Refset_ChangeType*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20120531
Initial no. of members	4
Contact	help@nehta.gov.au

10 Clinical finding foundation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Clinical finding foundation reference set* provides the broadest possible terminology to support the recording of clinical findings and disorders in Australian e-health implementations.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for clinical findings and disorders are yet to be developed. • As the basis for developing further use-case specific reference sets for clinical findings and disorders, through a process of constraint. • As a benchmark against which use-case specific reference sets that have been developed by the SNOMED CT-AU user community can be tested to assure that they are logical constraints of content related to clinical finding and disorders.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 56717001 |*Tuberculosis*| • 48348007 |*Normal breath sounds*|
Plan for future work	
File name and version	der2_Refset_ClinicalFindingFoundation*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	95,543
Contact	help@nehta.gov.au

11 Clinical finding grouper exclusion reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Clinical finding grouper exclusion reference set* is designed to exclude *Clinical finding* concepts that are not considered suitable for recording the findings, symptoms and disorders within a patient record.
Scope	The *Clinical finding grouper exclusion reference set* can be used in implementations as a means to further constrain any reference set built using the *Clinical finding* hierarchy. It functions to exclude clinically non-specific concepts that can be distracting to the end-user, and has been built using the *Clinical findings foundation reference set*.
Target client	Australian e-health clinical information systems.
Other clients	
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 69449002 |*Drug action (finding)*| • 118240005 |*Finding by method (finding)*|
Plan for future work	This reference set will be subject to further refinement if feedback is received from implementations about the presence of non-grouper concepts or the absence of known groupers, and further analysis by the NCTIS.
File name and version	der2_Refset_ClinicalFindingGrouperExclusion*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20140531
Initial no. of members	4,011
Contact	help@nehta.gov.au

12 Clinical manifestation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Clinical manifestation reference set* was developed collaboratively with a number of different health jurisdictions as a part of the SNOMED CT-AU Adverse Reactions Reference Sets Project. It is intended that this reference set be used in association with the *Adverse reaction agent reference set*, which provides values describing the common agents that may be responsible for causing adverse reactions.
Scope	This reference set can be used: • Within implementations of the *Adverse Reaction DCM* (NEHTA, 2011). • Within implementations where use-case specific reference sets for clinical manifestations are yet to be developed. • As the basis for developing further use-case specific reference sets for clinical manifestations through a process of constraint, or expanding upon.
Target client	This reference set can be used where developers are implementing NEHTA clinical information models containing the *Manifestation* data element or the *Adverse Reaction DCM*.
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is bound to the *Manifestation* data element (DE-15564) within the *Adverse Reaction DCM*.
Example of content	• 267038008 |*Oedema*| • 62315008 |*Diarrhoea*|
Plan for future work	This reference set is subject to further development based on feedback from implementations.
File name and version	der2_Refset_ClinicalManifestation*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20131130
Initial no. of members	746
Contact	help@nehta.gov.au

13 Collection procedure reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Collection procedure reference set* provides terminology to support the recording of the method of collection to be used. It is to be used to provide values for collection procedures specifically used for the collection of pathology specimens.
Scope	This reference set can be used within implementations of the *Pathology Test Result DCM* (NEHTA, 2011).
Target client	This reference set is developed for those implementing the *Pathology Test Result DCM*.
Other clients	
Definitive bindings	The *Collection procedure reference set* is bound to the *Collection Procedure* data element within the *Pathology Test Result DCM*.
Example of content	• 439336003 |*Brush biopsy*| • 9911007 |*Core needle biopsy*| • 2475000 |*Urine specimen collection, 24 hours*|
Plan for future work	
File name and version	der2_Refset_CollectionProcedure*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20120531
Initial no. of members	120
Contact	help@nehta.gov.au

14 Contained trade product pack reference set

Terminology	AMT
Reference set developer	NCTIS
Description	The *Contained trade product pack reference set* provides terminology to describe the packaged product (medication) that is supplied for direct patient use including details of the container type to be recorded in a health record.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of medicines information between clinicians for medication management and the recording of adverse reactions.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is bound to the following data elements within specific DCMs: • The *Medicine* data element within the *Medication Instruction and Action DCM* (NEHTA, 2013). • The *Substance/Agent* data element within the *Adverse Reaction DCM* (NEHTA, 2011). • The *Specific Substance/Agent* data element within the *Adverse Reaction DCM*.
Example of content	• 18830011000036103 |*Alphamox 250 mg capsule: hard, 20 capsules, blister pack*| • 20675011000036100 |*Diaformin-1000 1 g tablet: film-coated, 90 tablets, bottle*|
Plan for future work	
File name and version	der2_Refset_ContaineredTradeProductPack*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	v2.21 March 2011
Initial no. of members	13,176
Contact	help@nehta.gov.au

15 CORE problem list subset of SNOMED CT

Terminology	SNOMED CT
Reference set developer	United Medical Language System® (UMLS®)
Description	The *CORE problem list subset of SNOMED CT* (reference set) was developed by the UMLS CORE (Clinical Observations Recording and Encoding) Project based on source information from seven institutions to support documentation and encoding of clinical information at a summary level such as for problems lists, discharge diagnosis or reason of encounter. This reference set is designed to identify frequently used SNOMED CT concepts to assist the implementation of SNOMED CT in clinical systems. This reference set contains this list, as well as actual frequency of usage in clinical databases. Australian users are encouraged to assess its applicability for local implementations prior to use. Information on this reference set is provided to the SNOMED CT-AU community to ensure that international resources which may be applicable for use in Australia are available.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for terminology for summary level documentation are yet to be developed. • As the basis for developing further use-case specific reference sets for terminology. • As a benchmark, against which use-case specific reference sets developed by the SNOMED CT user community can be tested.
Target client	E-health clinical information systems.
Other clients	
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 95570007 |*Renal calculus*| • 12441001 |*Epistaxis*|
Plan for future work	
File name and version	SNOMEDCT_CORE_SUBSET_*yyyymm*.txt
Link to access reference set	http://www.nlm.nih.gov/research/umls/Snomed/core_subset.html
Date of initial release	20090731
Initial no. of members	6,179
Contact	Direct contact details for UMLS on website link or contact: help@nehta.gov.au

16 Dose based prescribing dose form reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Dose based prescribing dose form reference set* was developed collaboratively with a number of different health jurisdictions and software vendors as part of the AMT Dose Based Prescribing project. The *Dose based prescribing dose form reference set* provides terminology to support the recording of dose form for dose based prescribing. It is intended that this reference set be used in association with the: • *Dose based prescribing route of administration reference set;* and the • *Dose based prescribing dose frequency and interval reference set.* Both of these latter reference sets provide values describing routes of administration, frequencies and intervals used for dose based prescribing.
Scope	This reference set can be used: • Alongside medication terminologies, such as the AMT, to create dose based orders for patient medications. • Within implementations where use-case specific reference sets for dose based prescribing are yet to be developed. • As the basis for developing further use-case specific reference sets for dose based prescribing through a process of constraint, or expanding upon to create more expansive reference sets. While this reference set was developed with a focus on dose based prescribing, this does not preclude it from being used for any prescribing (including pack based prescribing) as there is likely to be a large area of overlap.
Target client	This reference set can be used by developers whose vendor systems create medication orders.
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specification.
Example of content	• 385099005 |*Cream*| • 385054002 |*Modified-release capsule*|
Plan for future work	This reference set is subject to further development based on feedback from implementations.
File name and version	der2_Refset_DoseBasedPrescribingDoseForm*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20151130
Initial no. of members	87
Contact	help@nehta.gov.au

17 Dose based prescribing dose frequency and interval reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Dose based prescribing dose frequency and interval reference set* was developed collaboratively with a number of different health jurisdictions and software vendors as part of the AMT Dose Based Prescribing project. The *Dose based prescribing dose frequency and interval reference set* provides terminology to support the recording of dose frequencies and dose intervals for dose based prescribing. It is intended that this reference set be used in association with the: • *Dose based prescribing route of administration reference set;* and the • *Dose based prescribing dose form reference set.* Both of these latter reference sets provide values describing routes of administration and dose forms used for dose based prescribing.
Scope	This reference set can be used: • Alongside medication terminologies, such as the AMT, to create dose based orders for patient medications. • Within implementations where use-case specific reference sets for dose based prescribing are yet to be developed. • As the basis for developing further use-case specific reference sets for dose based prescribing through a process of constraint, or expanding upon. While this reference set was developed with a focus on dose based prescribing, this does not preclude it from being used for any prescribing (including pack based prescribing) as there is likely to be a large area of overlap.
Target client	This reference set can be used by developers whose vendor systems create medication orders
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specification.
Example of content	• 69620002 |*Daily*| • 307468000 |*Every 6 hours*|
Plan for future work	This reference set is subject to further development based on feedback from implementations.
File name and version	der2_Refset_DoseBasedPrescribingDoseFrequencyAndInterval*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20151130
Initial no. of members	70
Contact	help@nehta.gov.au

18 Dose based prescribing route of administration reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Dose based prescribing route of administration reference set* was developed collaboratively with a number of different health jurisdictions and software vendors as part of the AMT Dose Based Prescribing project. The *Dose based prescribing route of administration reference set* provides terminology to support the recording of route of administration for dose based prescribing. It is intended that this reference set be used in association with the: • *Dose based prescribing dose form reference set;* and • *Dose based prescribing dose frequency and interval reference set.* These provide values describing the dose forms, frequencies and intervals used for dose based prescribing.
Scope	This reference set can be used: • Alongside medication terminologies, such as the AMT, to create dose based orders for patient medications • Within implementations where use-case specific reference sets for dose based prescribing are yet to be developed • As the basis for developing further use-case specific reference sets for dose based prescribing through a process of constraint, or expanding upon. While this reference set was developed with a focus on dose based prescribing, this does not preclude it from being used for any prescribing (including pack based prescribing) as there is likely to be a large area of overlap.
Target client	This reference set can used by developers whose vendor systems create medication orders.
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specification.
Example of content	• 47625008 |*Intravenous route*| • 26643006 |*Oral route*|
Plan for future work	This reference set is subject to further development based on feedback from implementations.
File name and version	der2_Refset_DoseBasedPrescribingRouteOfAdministration*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20151130
Initial no. of members	92
Contact	help@nehta.gov.au

19 Dose unit reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Dose unit reference set* provides terminology for the *Dose Unit* data element within the *Medication Instruction and Action DCM* (NEHTA, 2013) and the *Adverse Reaction DCM* (NEHTA, 2011).
Scope	This reference set can be used within implementations of the *Medication Instruction and Action DCM* and the *Adverse Reaction DCM*.
Target client	This reference set has been developed for those who are implementing the *Medication Instruction and Action DCM* and the *Adverse Reaction DCM*.
Other clients	
Definitive bindings	This reference set is bound to the *Dose Unit* data element in the *Amount of Medication* cluster within both the *Medication Instruction and Action DCM* and the *Adverse Reaction DCM*.
Example of content	• 258684004 |*mg*| • 429587008 |*Lozenge - unit of product usage*|
Plan for future work	This reference set is subject to further development based on feedback.
File name and version	der2_Refset_DoseUnit*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20110531
Initial no. of members	59
Contact	help@nehta.gov.au

20 Emergency department reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Emergency department reference set* is a superset of the Emergency department reference set (EDRS) suite and provides terminology to support the recording of presenting problems and diagnoses within Emergency department settings within Australia. It contains all of the members of the EDRS suite. The EDRS suite is comprised of the following reference sets: • *Emergency department diagnosis in presenting problem reference set* • *Emergency department diagnosis reference set* • *Emergency department findings in presenting problem reference set* • *Emergency department reason for presenting reference set.* This superset of the EDRS suite has been developed to assist implementations in providing a wide range of clinically relevant terms that are required for the capture of presenting problem and diagnosis information. Feedback has shown that the partitions between the reference sets in the EDRS suite are not well suited to clinical use. The definition of the combined superset may be more applicable for use at the clinical level while the partitioned suite remains linked to reporting.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of information between clinicians involved in a patient's care relating to that patient's presenting problem at the point of triage and diagnosis at the point of discharge from an Emergency department.
Target client	Australian Emergency department clinical information implementations.
Other clients	
Definitive bindings	This reference set is suitable for use in the *Emergency department stay—principal diagnosis, code X[X(8)]*, *Emergency department stay-additional diagnosis, code X[X(8)]*, and *Presenting Problems* data elements in Emergency department information systems.
Example of content	• 410429000 |*Cardiac arrest*| • 359820003 |*Closed fracture of neck of femur*|
Plan for future work	This reference set is subject to further development based on feedback from implementations.
File name and version	der2_Refset_EmergencyDepartment*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20140531
Initial no. of members	6,815
Contact	help@nehta.gov.au

21 Emergency department diagnosis in presenting problem reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Emergency department diagnosis in presenting problem reference set* provides terminology to support the recording of presenting problems within Emergency department settings within Australia. It should be used in conjunction with the *Emergency department findings in presenting problem reference set* and the *Emergency department reason for presenting reference set*.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of information between clinicians relating to a patient's presenting problem at the point of triage in an Emergency department.
Target client	Australian Emergency department clinical information implementations.
Other clients	
Definitive bindings	This reference set is suitable for use in the *Presenting Problems* data element in Emergency department information systems.
Example of content	• 410429000 |*Cardiac arrest*| • 283359004 |*Laceration of forehead*|
Plan for future work	This reference set is subject to further development based on feedback from implementations.
File name and version	der2_Refset_EmergencyDepartmentDiagnosisInPresentingProblem*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20100731 (Out of cycle release for early adopters of EDRS.)
Initial no. of members	232
Contact	help@nehta.gov.au

22 Emergency department diagnosis reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Emergency department diagnosis reference set* provides terminology to support the recording of diagnosis in Emergency department settings within Australia.
Scope	This reference set supports the accurate and unambiguous recording of information relating to a patient diagnosis at the point of discharge from an Emergency department. This may be used to support the communication of information to other clinicians involved in that patient's care.
Target client	Australian Emergency department clinical information implementations.
Other clients	
Definitive bindings	This reference set is suitable for use in the *Emergency department stay—principal diagnosis, code X[X(8)]* (Emergency department stay—principal diagnosis, code X[X(8)], n.d.) and the *Emergency department stay-additional diagnosis, code X[X(8)]* (Emergency department stay—additional diagnosis, code X[X(8)], n.d.) data elements in Emergency department information systems.
Example of content	• 111286002 |*Acute bacterial endocarditis*| • 359820003 |*Closed fracture of neck of femur*|
Plan for future work	This reference set is subject to further development based on feedback from implementations.
File name and version	der2_Refset_EmergencyDepartmentDiagnosis*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20100731 (Out of cycle release for early adopters of EDRS.)
Approximate no. of members[3]	6,766 (Release 20140531)
Contact	help@nehta.gov.au

[3] The approximate number of members is cited here instead of the initial number of members because this reference set has been significantly expanded since its initial release.

23 Emergency department findings in presenting problem reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Emergency department presenting problem reference set* provides terminology to support the recording of presenting problems within Emergency department settings within Australia. It should be used in conjunction with the *Emergency department diagnosis in presenting problem reference set* and the *Emergency department reason for presenting reference set*.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of information between clinicians relating to a patient's presenting problem at the point of triage in an Emergency department.
Target client	Australian Emergency department clinical information implementations.
Other clients	
Definitive bindings	This reference set is suitable for use in the *Presenting Problems* data element in Emergency department information systems.
Example of content	• 30989003 |*Knee pain*| • 309774006 |*Weakness of limb*|
Plan for future work	This reference set is subject to further development based on feedback from implementations.
File name and version	der2_Refset_EmergencyDepartmentFindingsInPresentingProblem*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20100731 (Out of cycle release for early adopters of EDRS.)
Initial no. of members	217
Contact	help@nehta.gov.au

24 Emergency department reason for presenting reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Emergency department reason for presenting reference set* provides terminology to support the recording of presenting problem within Emergency department settings within Australia. It should be used in conjunction with the *Emergency department diagnosis in presenting problem reference set* and the *Emergency department findings in presenting problem reference set*.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of information between clinicians relating to a patient's presenting problem at the point of triage in an Emergency department.
Target client	Australian Emergency department clinical information implementations
Other clients	
Definitive bindings	This reference set is suitable for use in the *Presenting Problems* data element in Emergency department information systems.
Example of content	• 18949003 |*Change of dressing*| • 116859006 |*Transfusion of a blood product*|
Plan for future work	This reference set is subject to further development based on feedback from implementations.
File name and version	der2_Refset_EmergencyDepartmentReasonForPresenting*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20100731 (Out of cycle release for early adopters of EDRS.)
Initial no. of members	71
Contact	help@nehta.gov.au

25 Environment or geographical location foundation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Environment or geographical location foundation reference set* provides the broadest possible terminology to support the recording of information about types of environments or named locations such as countries, states and regions in Australian e-health implementations.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for types of environments or geographical locations are yet to be developed. • As the basis for developing further use-case specific reference sets for types of environments or geographical locations, through a process of constraint. • As a benchmark against which use-case specific reference sets that have been developed by the SNOMED CT-AU user community can be tested to assure that they are logical constraints of content relating to types of environment or geographical locations.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 309904001 |*Intensive care unit*| • 419590001 |*Stepdown unit*|
Plan for future work	
File name and version	der2_Refset_EnvironmentOrGeographicalLocationFoundation*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	1,711
Contact	help@nehta.gov.au

26 Event foundation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Event foundation reference set* provides the broadest possible terminology to support the recording of information related to occurrences (excluding procedures and interventions) in Australian e-health implementations.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for events are yet to be developed. • As the basis for developing further use-case specific reference sets for events, through a process of constraint. • As a benchmark, against which use-case specific reference sets developed by the SNOMED CT-AU user community can be tested, to assure that they are logical constraints of content relating to events.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 8766005 |*Earthquake*| • 242292001 |*Accidental exposure to corrosive or caustic chemical*|
Plan for future work	
File name and version	der2_Refset_EventFoundation*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	3,645
Contact	help@nehta.gov.au

27 Exclusion statement reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Exclusion statement reference set* provides terminology to record global statements about the absence or exclusion of information from within a patient record.
Scope	This reference set can be used within implementations of various DCMs containing the *Global Statement* data element.
Target client	This reference set is developed for those implementing the NEHTA-developed DCMs.
Other clients	
Definitive bindings	This reference set is bound to the *Global Statement* data element within the following DCMs: • *Adverse Reaction DCM* (NEHTA, 2011); • *Medication Instruction and Action DCM* (NEHTA, 2013); • *Procedure DCM* (NEHTA, 2011); and • *Problem/Diagnosis DCM* (NEHTA, 2011).
Example of content	• 61000036101 |*Not asked*| • 81000036106 |*None known*| • 91000036108 |*None supplied*|
Plan for future work	In the above-mentioned DCMs, the value domains specified have some additional values not currently included in this reference set. A review of these additional values is planned.
File name and version	der2_Refset_ExclusionStatement*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20120531
Initial no. of members	3
Contact	help@nehta.gov.au

28 Fracture finding reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Fracture finding reference set* is a broad context reference set that supports the recording of fracture findings in Australian e-health implementations. This reference set has been derived from the *Clinical finding foundation reference set*.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for fracture findings are yet to be developed. • As the basis for developing further use-case specific reference sets for fracture findings, through a process of constraint. • As a benchmark, against which use-case specific reference sets that have been developed by the SNOMED CT-AU user community can be tested to assure that they are logical constraints of content relating to fracture findings.
Target client	Australian e-health clinical information systems, for example, in Orthopaedics and Radiology.
Other clients	
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 25415003 |*Closed fracture of femur*| • 207782002 |*Open fracture of maxilla*|
Plan for future work	This reference set may be used as a basis to develop more specific reference sets based on terminology requirements within different professional groups and delivery settings.
File name and version	der2_Refset_FractureFinding*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20100531
Initial no. of members	1,677
Contact	help@nehta.gov.au

29 Imaging procedure reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Imaging procedure reference set* is a broad context reference set that supports the recording of imaging procedures in Australian e-health implementations. This reference set has been derived from the *Procedure foundation reference set*.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for imaging procedures are yet to be developed. • As the basis for developing further use-case specific reference sets for imaging procedures, through a process of constraint. • As a benchmark against which use-case specific reference sets that have been developed by the SNOMED CT-AU user community can be tested to assure that they are logical constraints of content relating to imaging procedures.
Target client	Australian e-health clinical information systems, for example, in Radiology.
Other clients	
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 77477000 |*Computerised axial tomography*| • 113109007 |*MRI of lower extremity*|
Plan for future work	This reference set may be used as a basis to develop more specific reference sets based on terminology requirements within different professional groups and delivery settings.
File name and version	der2_Refset_ImagingProcedure*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20100531
Initial no. of members	4,171
Contact	help@nehta.gov.au

30 Laterality reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Laterality reference set* provides terminology to support recording of the side of the body in relation to anatomical structures.
Scope	This reference set can be used within implementations of the DCMs that contain the *Side* data element.
Target client	This reference set is developed for those implementing the NEHTA-developed DCMs.
Other clients	
Definitive bindings	This reference set is bound to the *Side* data element in the *Specific Location* data group within the following DCMs: • Adverse Reaction DCM (NEHTA, 2011); • Pathology Test Result DCM (NEHTA, 2011); • Imaging Examination Result DCM (NEHTA, 2011); • Procedure DCM (NEHTA, 2011); and • Problem/Diagnosis DCM (NEHTA, 2011).
Example of content	• 24028007 |*Right*| • 419161000 |*Unilateral left*|
Plan for future work	
File name and version	der2_Refset_Laterality*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20110531
Initial no. of members	5
Contact	help@nehta.gov.au

31 Medication form reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Medication form reference set* provides terminology to support the recording of the form of a medicine or therapeutic good.
Scope	This reference set can be used within implementations of the *Medication Instruction and Action DCM* (NEHTA, 2013).
Target client	This reference set has been developed for those who are implementing the *Medication Instruction and Action DCM*.
Other clients	
Definitive bindings	This reference set is bound to the *Form* data element in the *Chemical Description of Medication* cluster within the *Medication Instruction and Action DCM*.
Example of content	• 385267006 |*Impregnated pad*| • 385049006 |*Capsule*|
Plan for future work	
File name and version	der2_RefsetMedicationForm*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20110531
Initial no. of members	402
Contact	help@nehta.gov.au

32 Medicinal product reference set

Terminology	AMT
Reference set developer	NCTIS
Description	The *Medicinal product reference set* provides terminology to describe in the health record the abstract representation of an active ingredient or substance (devoid of strength and form). The *Medicinal product reference set* supports "generic prescribing" in a healthcare setting.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of medicines information between clinicians for medication management and the recording of adverse reactions.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is bound to the following data elements within specific DCMs: • The *Medicine* data element within the *Medication Instruction and Action* DCM (NEHTA, 2013). • The *Substance/Agent* data element within the *Adverse Reaction* DCM (NEHTA, 2011). • The *Specific Substance/Agent* data element within the *Adverse Reaction* DCM.
Example of content	• 21823011000036103 |*adrenaline*| • 44940011000036106 |*meropenem*|
Plan for future work	
File name and version	der2_Refset_MedicinalProduct*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	v2.21 March 2011
Initial no. of members	1,661
Contact	help@nehta.gov.au

33 Medicinal product pack reference set

Terminology	AMT
Reference set developer	NCTIS
Description	The *Medicinal product pack reference set* provides terminology to describe in a health record an abstract concept representing the properties of one or more quantitatively and clinically equivalent Trade Product Packs (TPPs).
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of medicines information between clinicians for medication management and the recording of adverse reactions.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is bound to the following data elements within specific DCMs: • The *Medicine* data element within the *Medication Instruction and Action* DCM (NEHTA, 2013). • The *Substance/Agent* data element within the *Adverse Reaction* DCM (NEHTA, 2011). • The *Specific Substance/Agent* data element within the *Adverse Reaction* DCM.
Example of content	• 46470011000036101 |*aciclovir 5% (50 mg/g) cream, 10 g*| • 63748011000036109 |*pseudoephedrine hydrochloride 120 mg tablet, 10*|
Plan for future work	
File name and version	der2_Refset_MedicinalProductPack*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	v2.21 March 2011
Initial no. of members	7,755
Contact	help@nehta.gov.au

34 Medicinal product unit of use reference set

Terminology	AMT
Reference set developer	NCTIS
Description	The *Medicinal product unit of use reference set* provides terminology to describe in a health record an abstract concept representing the properties of one or more equivalent Trade Product Units of Use (TPUUs).
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of medicines information between clinicians for medication management and the recording of adverse reactions.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is bound to the following data elements within specific DCMs: • The *Medicine* data element within the *Medication Instruction and Action* DCM (NEHTA, 2013). • The *Substance/Agent* data element within the *Adverse Reaction* DCM (NEHTA, 2011). • The *Specific Substance/Agent* data element within the *Adverse Reaction* DCM.
Example of content	• 23550011000036101 |*amoxycillin 250 mg capsule*| • 23529011000036106 |*iloprost 20 microgram/2 ml inhalation, ampoule*|
Plan for future work	
File name and version	der2_Refset_MedicinalProductUnitOfUse*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	v2.21 March 2011
Initial no. of members	4,237
Contact	help@nehta.gov.au

35 Mental health disorder reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Mental health disorder reference set* is a broad context reference set that supports the recording of mental health disorders and diagnoses in Australian e-health implementations. This reference set has been derived from the *Clinical finding foundation reference set*.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for mental health disorders are yet to be developed. • As the basis for developing further use-case specific reference sets for mental health disorders, through a process of constraint. • As a benchmark against which use-case specific reference sets that have been developed by the SNOMED CT-AU user community can be tested to assure that they are logical constraints of content relating to mental health disorders.
Target client	Australian e-health clinical information systems, for example, in mental health settings.
Other clients	
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 441704009 |*Affective psychosis*| • 58703003 |*Postpartum depression*|
Plan for future work	This reference set may be used as a basis to develop more specific reference sets based on terminology requirements within different professional groups and delivery settings.
File name and version	der2_Refset_MentalHealthDisorder*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20100531
Initial no. of members	1,219
Contact	help@nehta.gov.au

36 Microorganism reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Microorganism reference set* is a broad context reference set that supports the recording of microorganisms in Australian e-health settings. This reference set has been derived from the *Organism foundation reference set*.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for microorganisms are yet to be developed. • As the basis for developing further use-case specific reference sets for microorganisms, through a process of constraint. • As a benchmark, against which use-case specific reference sets developed by the SNOMED CT-AU user community, can be tested to assure that they are logical constraints of content relating to microorganisms.
Target client	Australian e-health clinical information systems, for example, within Pathology or Infectious disease groups.
Other clients	
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 409808003 |*Drug resistant Streptococcus pneumoniae*| • 114061003 |*Microbacterium flavescens*|
Plan for future work	This reference set may be used as a basis to develop more specific reference sets based on terminology requirements within different professional groups and delivery settings.
File name and version	der2_Refset_Microorganism*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20100531
Initial no. of members	16,329
Contact	help@nehta.gov.au

37 Musculoskeletal finding reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Musculoskeletal finding reference set* is a broad context reference set that supports the recording of musculoskeletal findings in Australian e-health implementations. This reference set has been derived from the *Clinical finding foundation reference set*.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for substances are yet to be developed. • As the basis for developing further use-case specific reference sets for substances, through a process of constraint. • As a benchmark, against which use-case specific reference sets that have been developed by the SNOMED CT-AU user community can be tested to assure that they are logical constraints of content relating to substances.
Target client	Australian e-health clinical information systems, for example, within Rheumatology groups.
Other clients	
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 111245009 |*Compartment syndrome*| • 427683007 |*Adhesion of tendon of hand*|
Plan for future work	This reference set may be used as a basis to develop more specific reference sets based on terminology requirements within different professional groups and delivery settings.
File name and version	der2_Refset_MusculoskeletalFinding*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20100531
Initial no. of members	10,571
Contact	help@nehta.gov.au

38 Neoplasm and/or hamartoma reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Neoplasm and/or hamartoma reference set* is a broad context reference set that supports the recording of neoplasm and/or hamartoma findings in Australian e-health settings. This reference set has been derived from the *Clinical finding foundation reference set*.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for neoplasm and/or hamartomas are yet to be developed. • As the basis for developing further use-case specific reference sets for neoplasm and/or hamartomas, through a process of constraint. • As a benchmark, against which use-case specific reference sets that have been developed by the SNOMED CT-AU user community can be tested to assure that they are logical constraints of content relating to neoplasms and/or hamartomas.
Target client	Australian e-health clinical information systems, for example, within Oncology groups.
Other clients	
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 403966009 |*Arteriovenous haemangioma*| • 314990009 |*Metastasis from malignant tumour of bone*|
Plan for future work	This reference set may be used as a basis to develop more specific reference sets based on terminology requirements within different professional groups and delivery settings.
File name and version	der2_Refset_NeoplasmAndOrHamartoma*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20100531
Initial no. of members	6,629
Contact	help@nehta.gov.au

39 Non-medicinal adverse reaction agent reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Non-medicinal adverse reaction agent reference set* provides terminology to support the accurate recording of non-medicinal agents responsible for causing adverse reactions. It is intended that this reference set be used in association with the *Clinical manifestation reference set*, which provides values describing the clinical manifestation of adverse events, and another medical terminology, such as the AMT.
Scope	This reference set can be used: • Within implementations of the *Adverse Reaction DCM.* • Within implementations where use-case specific reference sets for adverse reaction agents are yet to be developed. • As the basis for developing further use-case specific reference sets for adverse reaction agents through a process of constraint, or expanding upon. • Alongside other reference sets, such as any of the AMT Medicinal or Trade Product reference sets to supplement the recording of agents.
Target client	This reference set can be used where developers are implementing NEHTA clinical information models containing the *Substance/Agent* data element or the *Adverse Reaction DCM*.
Other clients	Australian e-health clinical information systems.
Definitive bindings	The *Non-medicinal adverse reaction agent reference set* is bound to the *Substance/Agent* data element within the *Adverse Reaction DCM*.
Example of content	• 256307007 |*Banana*| • 256443002 |*Egg white*|
Plan for future work	This reference set is subject to further development based on feedback from implementations and the current *Substance* hierarchy re-design project being undertaken at the international level.
File name and version	der2_Refset_NonmedicinalAdverseReactionAgent*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20150531
Initial no. of members	2,819
Contact	help@nehta.gov.au

40 Observable entity foundation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Observable entity foundation reference set* provides the broadest possible terminology to support the recording of observable entities in Australian e-health implementations.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for observable entities are yet to be developed. • As the basis for developing further use-case specific reference sets for observable entities, through a process of constraint. • As a benchmark, against which use-case specific reference sets developed by the SNOMED CT-AU user community, can be tested to assure that they are logical constraints of the content for observable entities.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 390896004 |*Target cholesterol level*| • 405153007 |*Personal wellbeing status*|
Plan for future work	
File name and version	der2_Refset_ObservableEntityFoundation*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	7,988
Contact	help@nehta.gov.au

41 Organism foundation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Organism foundation reference set* provides the broadest possible terminology to support the recording of organisms in Australian e-health implementations.
Scope	• This reference set can be used: • Within implementations where use-case specific reference sets for organisms are yet to be developed. • As the basis for developing further use-case specific reference sets for organisms, through a process of constraint. • As a benchmark, against which use-case specific reference sets that have been developed by the SNOMED CT-AU user community can be tested to assure that they are logical constraints of content relating to organisms.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 58984003 |*Anthropozoophilic fungus*| • 80166006 |*Streptococcus pyogenes*|
Plan for future work	
File name and version	der2_Refset_OrganismFoundation*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	31,948
Contact	help@nehta.gov.au

42 Out of range indicator reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Out of range indicator reference set* provides suitable concepts for describing whether the value for a particular pathology observation is within or outside of its reference range. If the result is outside the reference range, this indicator may also describe the direction in which the result falls outside the range (that is, lower or higher). This information pertaining to pathology result reporting is required to enable the laboratory to conduct the right investigation and for the pathologist to interpret and report on the results clearly and unambiguously.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of information relating to pathology result reporting between a pathology provider to a requesting clinician, or other approved recipient. This reference set can be used within implementations of the *Pathology Test Result DCM* (NEHTA, 2011) and the *Pathology Result Report SDT* (NEHTA, 2009).
Target client	NEHTA ePathology Programme.
Other clients	
Definitive bindings	This reference set is bound to the *Result Value Normal Status* data element within the *Pathology Test Result DCM*. This reference set is also bound to the *Out of Range Indicator* data element (DE-11028) which is under the *Structured Result Entry* data group (DG-11008) within the *Pathology Result Report SDT*.
Example of content	• 281301001 |*Within reference range*| • 281303003 |*Above therapeutic range*|
Plan for future work	
File name and version	der2_Refset_OutOfRangeIndicator*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	15
Contact	help@nehta.gov.au

43 Physical force foundation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Physical force foundation reference set* provides the broadest possible terminology to support the recording of physical forces in Australian e-health implementations.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for physical forces are yet to be developed. • As the basis for developing further use-case specific reference sets for physical forces, through a process of constraint. • As a benchmark, against which use-case specific reference sets developed by the SNOMED CT-AU user community, can be tested to assure that they are logical constraints of content relating to physical forces.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 32646006 |*Electric field*| • 263762005 |*Friction*|
Plan for future work	
File name and version	der2_Refset_PhyscialForceFoundation*ReleaseType*_AU1000036_*yyyymmd*.txt
Date of initial release	20091130
Initial no. of members	171
Contact	help@nehta.gov.au

44 Physical object foundation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Physical object foundation reference set* provides the broadest possible terminology to support the recording of physical objects in Australian e-health implementations.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for physical objects are yet to be developed. • As the basis for developing further use-case specific reference sets for physical objects, through a process of constraint. • As a benchmark, against which use-case specific reference sets developed by the SNOMED CT-AU user community, can be tested to assure that they are logical constraints of content relating to physical objects.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 40388003 |*Implant, device*| • 80278003 |*Paediatric bed*|
Plan for future work	
File name and version	der2_Refset_PhysicalObjectFoundation*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	4,433
Contact	help@nehta.gov.au

45 Problem/Diagnosis reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Problem/Diagnosis reference set* provides terminology to support the recording of a patient problem or diagnosis for medical records within Australia.
Scope	This reference set can be used within implementations of the *Problem/Diagnosis DCM* (NEHTA, 2011).
Target client	This reference set has been developed for those who are implementing the *Problem/Diagnosis DCM*.
Other clients	
Definitive bindings	The *Problem/Diagnosis reference set* is bound to the *Problem/Diagnosis* data element within the *Problem/Diagnosis DCM*.
Example of content	• 78275009 |*Obstructive sleep apnoea*| • 59771005 |*Calculus of gallbladder with acute cholecystitis*|
Plan for future work	
File name and version	der2_Refset_ProblemDiagnosis*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20110531
Initial no. of members	95,515
Contact	help@nehta.gov.au

46 Procedure foundation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Procedure foundation reference set* provides the broadest possible terminology to support the recording of clinical interventions in Australian e-health implementations.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for procedures are yet to be developed. • As the basis for developing further use-case specific reference sets for procedures, through a process of constraint. • As a benchmark, against which use-case specific reference sets developed by the SNOMED CT-AU user community, can be tested to assure that they are logical constraints of content relating to procedures.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 417215002 |*Diagnostic palpation*| • 134403003 |*Urgent referral*|
Plan for future work	
File name and version	der2_Refset_ProcedureFoundation*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	50,989
Contact	help@nehta.gov.au

47 Procedure grouper exclusion reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Procedure grouper exclusion reference set* is designed to remove any concepts within the *Procedure* hierarchy that are deemed to not be useful for the recording of any procedures performed upon the subject of care in a clinical record or in the provision of healthcare in general.
Scope	The *Procedure grouper exclusion reference set* can be used in implementations as a means to further constrain any reference set built using the *Procedure* hierarchy. It functions to exclude clinically non-specific concepts that can be distracting to the end user, and has been built using the *Procedure foundation reference set*.
Target client	Australian e-health clinical information systems.
Other clients	
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 373657001 |*Nasal sinus procedure*| • 129153009 |*Procedure on axilla*|
Plan for future work	This reference set will be subject to further refinement if feedback is received from implementations about the presence of non-grouper concepts or the absence of known groupers, and further analysis by the NCTIS.
File name and version	der2_Refset_ProcedureGrouperExclusion*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20151130
Initial no. of members	1,447
Contact	help@nehta.gov.au

48 Qualifier value foundation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Qualifier value foundation reference set* provides the broadest possible terminology to support the recording of qualifying information in Australian e-health implementations.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for qualifying information are yet to be developed. • As the basis for developing further use-case specific reference sets for qualifying information, through a process of constraint. • As a benchmark, against which use-case specific reference sets developed by the SNOMED CT-AU user community, can be tested to assure that they are logical constraints of content for qualifying information.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 129300006 |*Puncture - action*| • 263675000 |*Antenatal*|
Plan for future work	
File name and version	der2_Refset_QualifierValueFoundation*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	8,872
Contact	help@nehta.gov.au

49 Record artefact foundation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Record artefact foundation reference set* provides the broadest possible terminology to support the recording of record artefacts in Australian e-health implementations.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for record artefacts are yet to be developed. • As the basis for developing further use-case specific reference sets for record artefacts, through a process of constraint. • As a benchmark, against which use-case specific reference sets developed by the SNOMED CT-AU user community, can be tested to assure that they are logical constraints of content relating to record artefacts.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 422432008 |*Family history section*| • 416868005 |*Surgical intraoperative record*|
Plan for future work	
File name and version	der2_Refset_RecordArtefactFoundation*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	199
Contact	help@nehta.gov.au

50 Related item relationship type reference set

Terminology	SNOMED CT-AU or AMT
Reference set developer	NCTIS
Description	The *Related item relationship type reference set* provides terminology to support the recording of the type of relationship that a related item (for example, a diagnosis or procedure) has with the problem/diagnosis being recorded.
Scope	This reference set can be used within implementations of the *Problem/Diagnosis DCM* (NEHTA, 2011).
Target client	This reference set is developed for those implementing the *Problem/Diagnosis DCM*.
Other clients	
Definitive bindings	The reference set is bound to the *Relationship Type* data element within the *Problem/Diagnosis DCM*.
Example of content	• 255234002 |*Following*| • 42752001 |*Caused by*|
Plan for future work	
File name and version	der2_Refset_RelatedItemRelationshipType*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20120531
Initial no. of members	2
Contact	help@nehta.gov.au

51 Relationship to subject of care reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Relationship to subject of care* reference set provides terminology to support the recording of how a person is associated with or related to the subject of care for clinical and administrative records within Australia.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of information regarding how a person is associated with or related to the subject of care within a record. This reference set can be used within implementations of the DCMs that contain the *Relationship to Subject of Care* data element.
Target client	Implementers of DCMs and the *Participation Specification* (NEHTA, 2011).
Other clients	
Definitive bindings	This reference set is bound to the *Relationship to Subject of Care* data element within the *Participation Specification*.
Example of content	• 394859001 |*Maternal grandmother*| • 45929001 |*Half-brother*|
Plan for future work	
File name and version	der2_Refset_RelationshipToSubjectOfCare*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20110531
Initial no. of members	162
Contact	help@nehta.gov.au

52 Request test name reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Request test name reference set* provides suitable concepts for describing the name of a single pathology investigation or a panel of grouped pathology investigations that may be requested by a clinician. This information pertaining to pathology result reporting is required to enable the laboratory to conduct the right investigation and the pathologist to interpret and report on the results clearly and unambiguously.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of information relating to pathology result reporting between a pathology provider to a requesting clinician, or other approved recipient. This reference set can be used within implementations of the *Pathology Result Report SDT* (NEHTA, 2009). This reference set is identical to the *Result test name reference set*.
Target client	NEHTA ePathology Programme.
Other clients	
Definitive bindings	This reference set is bound to the *Request Test Name* data element (DE-11017) which is under the *Request Detail* data group (DG-11002) within the *Pathology Result Report SDT*.
Example of content	• 71466003 |*Valproic acid measurement*| • 61594008 |*Microbial culture*|
Plan for future work	
File name and version	der2_Refset_RequestTestName*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	1,522
Contact	help@nehta.gov.au

53 Respiratory finding reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Respiratory finding reference set* is a broad context reference set that supports the recording of respiratory findings in Australian e-health implementations. This reference set has been derived from the *Clinical finding foundation reference set*.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for respiratory findings are yet to be developed. • As the basis for developing further use-case specific reference sets for respiratory findings, through a process of constraint. • As a benchmark, against which use-case specific reference sets developed by the SNOMED CT-AU user community can be tested, to assure that they are logical constraints of content relating to respiratory findings.
Target client	Australian e-health clinical information systems, for example, within Respiratory clinical groups.
Other clients	
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 421581006 |*Pharyngeal swelling*| • 312453004 |*Asthma - currently active*|
Plan for future work	This reference set may be used as a basis to develop more specific reference sets based on terminology requirements within different professional groups and delivery settings.
File name and version	der2_Refset_RespiratoryFinding*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20100531
Initial no. of members	3,920
Contact	help@nehta.gov.au

54 Result test name reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Result test name reference set* provides suitable concepts for describing the name of a single pathology investigation or a panel of grouped pathology investigations that may be requested by a clinician. This information pertaining to pathology result reporting is required to enable the laboratory to conduct the right investigation and the pathologist to interpret and report on the results clearly and unambiguously.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of information relating to pathology result reporting between a pathology provider to a requesting clinician, or other approved recipient. This reference set can be used within implementations of the *Pathology Result Report SDT* (NEHTA, 2009). This reference set is identical to the *Request test name reference set*.
Target client	NEHTA ePathology Programme.
Other clients	
Definitive bindings	This reference set is bound to the *Result Test Name* data element (DE-11031) which is under the *Result Detail* data group (DG-11007) within the *Pathology Result Report SDT*.
Example of content	• 25514001 |*Digoxin measurement*| • 77020008 |*Direct Coombs test*|
Plan for future work	
File name and version	der2_Refset_ResultTestName*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	1,522
Contact	help@nehta.gov.au

55 Route of administration reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Route of administration reference set* provides terminology to support the recording of the route by which medicines are to be administered for medications records within Australia.
Scope	This reference set can be used within implementations of the NEHTA *Electronic Transfer of Prescription* (Electronic Transfer of Prescription v1.1, n.d.), the *Medication Instruction and Action DCM* (NEHTA, 2013), or the *Adverse Reaction DCM* (NEHTA, 2011).
Target client	This reference set has been developed for those who are implementing the NEHTA *Electronic Transfer of Prescription*, the *Medication Instruction and Action DCM*, or the *Adverse Reaction DCM*.
Other clients	
Definitive bindings	This reference set is bound to the *Route* data element in the *Medication Administration* data group within the *Medication Instruction and Action DCM* and the *Adverse Reaction DCM*.
Example of content	• 404820008 |*Epidural route*| • 26643006 |*Oral route*|
Plan for future work	This reference set is subject to further development based on feedback from implementations.
File name and version	der2_Refset_RouteOfAdministration*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20110531
Initial no. of members	154
Contact	help@nehta.gov.au

56 Sex reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Sex reference set* provides terminology to support the recording of the person's sex.
Scope	This reference set can be used within implementations of the *Participation Specification* (NEHTA, 2011).
Target client	This reference set has been developed for those who are implementing the *Participation Specification*.
Other clients	
Definitive bindings	The *Sex reference set* is bound to the *Sex* data element within the *Participation Specification*. However, this reference set may be suitable for use outside of that specification as required.
Example of content	• 248153007 |*Male*| • 248152002 |*Female*|
Plan for future work	
File name and version	der2_Refset_Sex*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20110531
Initial no. of members	4
Contact	help@nehta.gov.au

57 Situation with explicit context foundation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Situation with explicit context foundation reference set* provides the broadest possible terminology to support the recording of clinical context-dependent information in Australian e-health implementations.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for clinical context-dependent information are yet to be developed. • As the basis for developing further use-case specific reference sets for clinical context-dependent information, through a process of constraint. • As a benchmark, against which use-case specific reference sets that have been developed by the SNOMED CT-AU user community can be tested, to assure that they are logical constraints of clinical context-dependent content.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 407625007 |*Suspected epilepsy*| • 428287001 |*History of endocarditis*|
Plan for future work	
File name and version	der2_Refset_SituationWithExplicitContextFoundation*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	3,066
Contact	help@nehta.gov.au

58 Skeletal system reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Skeletal system reference set* is a broad context reference set that provides terminology to support the recording of clinical information pertaining to the skeletal system in Australian e-health implementations. This reference set has been derived from the *Body structure foundation reference set*.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for the skeletal system are yet to be developed. • As the basis for developing further use-case specific reference sets for the skeletal system, through a process of constraint. • As a benchmark, against which use-case specific reference sets developed by the SNOMED CT-AU user community, can be tested to assure that they are logical constraints of content relating to the skeletal system.
Target client	Australian e-health clinical information systems, for example, within Orthopaedic or Radiology groups.
Other clients	
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 62413002 |*Bone structure of radius*| • 56873002 |*Bone structure of sternum*|
Plan for future work	This reference set may be used as a basis to develop more specific reference sets based on terminology requirements within different professional groups and delivery settings.
File name and version	der2_Refset_SkeletalSystem*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20100531
Initial no. of members	3,743
Contact	help@nehta.gov.au

59 Social context foundation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Social context foundation reference set* provides the broadest possible terminology to support the recording of information relating to social conditions and circumstances in Australian e-health implementations.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for social context-dependent content are yet to be developed. • As the basis for developing further use-case specific reference sets for social context-dependent content, through a process of constraint. • As a benchmark against which use-case specific reference sets that have been developed by the SNOMED CT-AU user community can be tested to assure that they are logical constraints of social context-dependent content.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 394571004 |*Employer*| • 236324005 |*Factory worker*|
Plan for future work	
File name and version	der2_Refset_SocialContextFoundation*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	4,793
Contact	help@nehta.gov.au

60 Specimen characteristic reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Specimen characteristic reference set* provides suitable concepts for describing the clinical findings on the initial morphological analysis of a specimen, identifying attributes that may impact upon the result. This information pertaining to pathology result reporting is required to enable the laboratory to conduct the right investigation and for the pathologist to interpret and report on the results clearly and unambiguously.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of information relating to pathology result reporting between a pathology provider to a requesting clinician, or other approved recipient. This reference set can be used within implementations of the *Pathology Test Result DCM* (NEHTA, 2011) and the *Pathology Result Report SDT* (NEHTA, 2009).
Target client	NEHTA ePathology Programme.
Other clients	
Definitive bindings	This reference set is bound to the *Specimen Received Issues* data element within the *Pathology Test Result DCM*. This reference set is also bound to the *Specimen Characteristic* data element of (DE-11015) which is under the *Specimen Detail* data group (DG-11005) within the *Pathology Result Report SDT*.
Example of content	• 281276009 |*Sample cloudy*| • 84567002 |*Specimen obscured by blood*|
Plan for future work	
File name and version	der2_Refset_SpecimenCharacteristic*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	33
Contact	help@nehta.gov.au

61 Specimen foundation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Specimen foundation reference set* provides the broadest possible terminology to support the recording of information about specimens that are obtained (usually from a patient) for examination or pathological analysis in Australian e-health implementations.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets with content relating to specimens are yet to be developed. • As the basis for developing further use-case specific reference sets for specimen content, through a process of constraint. • As a benchmark against which use-case specific reference sets that have been developed by the SNOMED CT-AU user community can be tested to assure that they are logical constraints of content relating to specimens.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 119350003 |*Calculus specimen*| • 119297000 |*Blood specimen*|
Plan for future work	
File name and version	der2_Refset_SpecimenFoundation*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	1,236
Contact	help@nehta.gov.au

62 Specimen qualifier reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Specimen qualifier reference set* provides suitable concepts for qualifying a description of a specimen that is relevant to a pathology investigation and is required for the purpose of specimen collection, analysis or result reporting. This information pertaining to pathology result reporting is required to enable the laboratory to conduct the right investigation and the pathologist to interpret and report on the results clearly and unambiguously.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of information relating to pathology result reporting between a pathology provider to a requesting clinician, or other approved recipient. This reference set can be used within implementations of the *Pathology Result Report SDT* (NEHTA, 2009).
Target client	NEHTA ePathology Programme.
Other clients	
Definitive bindings	This reference set is bound to the *Specimen Qualifier* data element (DE-11009) which is under the *Specimen Detail* data group (DG-11005) within the *Pathology Result Report SDT*.
Example of content	• 123027009 |*24 hours*| • 263675000 |*Antenatal*|
Plan for future work	
File name and version	der2_Refset_SpecimenQualifier*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	85
Contact	help@nehta.gov.au

63 Specimen quality reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Specimen quality reference set* provides suitable concepts for recording an indication of whether the specimen is suitable for the required laboratory tests. This information pertaining to pathology result reporting is required to enable the laboratory to conduct the right investigation and the pathologist to interpret and report on the results clearly and unambiguously.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of information relating to pathology result reporting between a pathology provider to a requesting clinician, or other approved recipient. This reference set can be used within implementations of the *Pathology Test Result DCM* (NEHTA, 2011) and the *Pathology Result Report SDT* (NEHTA, 2009).
Target client	NEHTA ePathology Programme.
Other clients	
Definitive bindings	This reference set is bound to the *Adequacy for Testing* data element within the *Pathology Test Result DCM*. This reference set is also bound to the *Specimen Quality* data element (DE-11016) which is under the *Specimen Detail* data group (DG-11005) within the *Pathology Result Report SDT*.
Example of content	• 125152006 |*Specimen satisfactory for evaluation*| • 125154007 |*Specimen unsatisfactory for evaluation*|
Plan for future work	
File name and version	der2_Refset_SpecimenQuality*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	2
Contact	help@nehta.gov.au

64 Specimen type reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Specimen type reference set* provides suitable concepts for describing the sample to be collected or tested in a pathology investigation. This information pertaining to pathology result reporting is required to enable the laboratory to conduct the right investigation and the pathologist to interpret and report on the results clearly and unambiguously.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of information relating to pathology result reporting between a pathology provider to a requesting clinician, or other approved recipient. Content has been constrained with respect to reusability and the information models to which this reference set is bound. This reference set can be used within implementations of the *Pathology Test Result DCM* (NEHTA, 2011) and the *Pathology Result Report SDT* (NEHTA, 2009).
Target client	This reference set is developed for those who are implementing the *Pathology Test Result DCM* or the *Pathology Result Report SDT*.
Other clients	NEHTA ePathology Programme.
Definitive bindings	This reference set is bound to the *Specimen Type* data element (DE-11008) which is under the: • *Specimen Detail* data group (DG-11005) within the *Pathology Result Report SDT*; and the • *Pathology Test Specimen Detail* data group (DG-16156) within the *Pathology Test Result DCM*. The data element is named *Specimen Tissue Type* in this DCM.
Example of content	• 119373006 |*Amniotic fluid specimen*| • 119350003 |*Calculus specimen*|
Plan for future work	
File name and version	der2_Refset_SpecimenType*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	102
Contact	help@nehta.gov.au

65 Staging and scales foundation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Staging and scales foundation reference set* provides the broadest possible terminology to support the recording of information about tumour staging and assessment scales in Australian e-health implementations.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for tumour staging and assessment scales are yet to be developed. • As the basis for developing further use-case specific reference sets for tumour staging and assessment scales, through a process of constraint. • As a benchmark against which use-case specific reference sets that have been developed by the SNOMED CT-AU user community can be tested to assure that they are logical constraints of content relating to tumour staging and assessment scales.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	106241006 |*Gleason grading system for prostatic cancer*|
Plan for future work	
File name and version	der2_Refset_StagingAndScalesFoundation*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	1,196
Contact	help@nehta.gov.au

66 Substance foundation reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Substance foundation reference set* provides the broadest possible terminology to support the recording of substances in Australian e-health implementations.
Scope	This reference set can be used: • Within implementations where use-case specific reference sets for substances are yet to be developed. • As the basis for developing further use-case specific reference sets for substances, through a process of constraint. • As a benchmark against which use-case specific reference sets that have been developed by the SNOMED CT-AU user community can be tested to assure that they are logical constraints of content relating to substances.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is not bound to any specific clinical information specifications.
Example of content	• 52454007 |*Albumin*| • 59905008 |*Isoantibody*|
Plan for future work	
File name and version	der2_Refset_SubstanceFoundation*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	23,618
Contact	help@nehta.gov.au

67 Substance to SNOMED CT-AU mapping reference set

Terminology	AMT
Reference set developer	NCTIS
Description	The *Substance to SNOMED CT-AU mapping reference set* is developed for the implementers of AMT, SNOMED CT-AU and NEHTA DCMs to enable development of decision support systems. The AMT and SNOMED CT-AU are currently separate terminologies; therefore the relationships between AMT products, their ingredients, and SNOMED CT-AU substances are not stated. The AMT *Substance to SNOMED CT-AU mapping reference set* will contain all AMT substances that are used in a modelled AMT product with a corresponding equivalent or supertype (that is, the nearest relevant parent concept) map to a substance in SNOMED CT-AU.
Scope	This reference set can be used by decision support systems to link adverse reaction substances (recorded using SNOMED CT-AU) to AMT products with equivalent substances, and can assist with prescribing alerts.
Target client	This reference set has been developed for those who are implementing decision support systems in conjunction with the NEHTA specifications.
Other clients	N/A
Definitive bindings	N/A
Example of content	**Nicotine in AMT:** 2393011000036109 |*nicotine (AU substance)*| is mapped to **Nicotine in SNOMED CT-AU:** 68540007 |*Nicotine (substance)*|
Plan for future work	This reference set is subject to further development based on feedback from implementations. Monthly maintenance is performed on this reference set to ensure new AMT substances are mapped to SNOMED CT-AU substances. With future SNOMED CT-AU releases it is planned to further improve the coverage of substances through content submissions to the IHTSDO. This will effectively reduce supertype mappings by increasing equivalent mappings.
File name and version	der2_csRefset_SubstanceToSnomedCtauMapping*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20120330
Initial number of active members	2,015
Contact	help@nehta.gov.au

68 Testing method reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Testing method reference set* provides suitable concepts for describing the analytical methods that may be used to complete a pathology investigation. This information pertaining to pathology result reporting is required to enable the laboratory to conduct the right investigation and the pathologist to interpret and report on the results clearly and unambiguously.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of information relating to pathology result reporting between a pathology provider to a requesting clinician, or other approved recipient. This reference set can be used within implementations of the *Pathology Test Result DCM* (NEHTA, 2011) and the *Pathology Result Report SDT* (NEHTA, 2009).
Target client	NEHTA ePathology Programme.
Other clients	
Definitive bindings	This reference set is bound to the *Testing Method* data element within the *Pathology Test Result DCM*. This reference set is also bound to the *Testing Method* data element (DE-11025) which is under the *Structured Result Entry* data group (DG-11008) within the *Pathology Result Report SDT*.
Example of content	• 67047002 |*Microbial wet smear*| • 117036006 |*Alcian blue stain method*|
Plan for future work	
File name and version	der2_Refset_TestingMethod*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	1,276
Contact	help@nehta.gov.au

69 Therapeutic good benefit eligibility reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Therapeutic good benefit eligibility reference set* provides terminology for the *Medical Benefit Category Type* data element within the *ePrescription SDT* (NEHTA, 2010) and the *Prescription Request SDT* (NEHTA, 2010).
Scope	This reference set can be used within implementations of the *Medication Instruction and Action DCM* (NEHTA, 2013), *ePrescription SDT* and *Prescription Request SDT*.
Target client	This reference set has been developed for those who are implementing the *ePrescription SDT* and *Prescription Request SDT*.
Other clients	
Definitive bindings	This reference set is bound to the *Medical Benefit Category Type* data element which is within the *ePrescription SDT* and *Prescription Request SDT*. This reference set is also bound to the *Concessions Benefit* data element within the *Medication Instruction and Action DCM*.
Example of content	• 32570831000036108 |*Eligible for PBS subsidy*| • 32570861000036102 |*Not eligible for a pharmaceutical subsidy*|
Plan for future work	
File name and version	der2_Refset_TherapeuticGoodBenefitEligibility*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20110531
Initial no. of members	4
Contact	help@nehta.gov.au

70 Therapeutic good claim category reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Therapeutic good claim category reference set* provides terminology for the *Claim Category Type* data element within the *Dispense Record* specification.
Scope	This reference set can be used within implementations of the *Medication Instruction and Action DCM* (NEHTA, 2013) and the *Dispense Record SDT* (NEHTA, 2010).
Target client	This reference set has been developed for those who are implementing the *Dispense Record SDT*.
Other clients	
Definitive bindings	This reference set is bound to the *Claim Category Type* data element within the *Dispense Record SDT* and the *Medication Instruction and Action DCM*.
Example of content	• 32570741000036106 |*General PBS benefit*| • 32570781000036102 |*RPBS benefit*|
Plan for future work	
File name and version	der2_Refset_TherapeuticGoodClaimCategory*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20110531
Initial no. of members	6
Contact	help@nehta.gov.au

71 Trade product pack reference set

Terminology	AMT
Reference set developer	NCTIS
Description	The *Trade product pack reference set* provides terminology to describe in a health record the packaged product (medication) that is supplied for direct patient use.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of medicines information between clinicians for medication management and the recording of adverse reactions.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is bound to the following data elements within specific DCMs: • The *Medicine* data element within the *Medication Instruction and Action* DCM (NEHTA, 2013). • The *Substance/Agent* data element within the *Adverse Reaction* DCM (NEHTA, 2011). • The *Specific Substance/Agent* data element within the *Adverse Reaction* DCM.
Example of content	• 12167011000036107 |*Adalat 20 mg tablet: film-coated, 60 tablets*| • 11482011000036107 |*Diazepam USP (DBL) 10 mg/2 ml injection: solution, 5 x 2 ml ampoules*|
Plan for future work	
File name and version	der2_Refset_TradeProductPack*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	v2.21 March 2011
Initial no. of members	11,935
Contact	help@nehta.gov.au

72 Trade product reference set

Terminology	AMT
Reference set developer	NCTIS
Description	The *Trade product reference set* provides terminology to describe in a health record the product (medication) brand name or the grouping of products into a "family", for either single component products or components of multi-component products.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of medicines information between clinicians for medication management and the recording of adverse reactions.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is bound to the following data elements within specific DCMs: • The *Medicine* data element within the *Medication Instruction and Action DCM* (NEHTA, 2013). • The *Substance/Agent* data element within the *Adverse Reaction DCM* (NEHTA, 2011). • The *Specific Substance/Agent* data element within the *Adverse Reaction DCM*.
Example of content	• 65136011000036105 |*Brolene Eye Drops*| • 3422011000036106 |*Pepzan*|
Plan for future work	
File name and version	der2_Refset_TradeProduct*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	v2.21 March 2011
Initial no. of members	3,994
Contact	help@nehta.gov.au

73 Trade product unit of use reference set

Terminology	AMT
Reference set developer	NCTIS
Description	The *Trade product unit of use reference set* provides terminology to describe in a health record a single dose unit of a finished dose form that contains a specified amount of an active ingredient substance and is grouped within a particular Trade Product.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of medicines information between clinicians for medication management and the recording of adverse reactions.
Target client	NCTIS
Other clients	Australian e-health clinical information systems.
Definitive bindings	This reference set is bound to the following data elements within specific DCMs: • The *Medicine* data element within the *Medication Instruction and Action* DCM (NEHTA, 2013). • The *Substance/Agent* data element within the *Adverse Reaction* DCM (NEHTA, 2011). • The *Specific Substance/Agent* data element within the *Adverse Reaction* DCM.
Example of content	• 6355011000036103 |*Alprim (trimethoprim 300 mg) tablet: uncoated, 1 tablet*| • 65669011000036108 |*Nurofen (ibuprofen 5% (50 mg/g)) gel*|
Plan for future work	
File name and version	der2_Refset_TradeProductUnitOfUse*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	v2.21 March 2011
Initial no. of members	8,031
Contact	help@nehta.gov.au

74 Unexpected result indicator reference set

Terminology	SNOMED CT-AU
Reference set developer	NCTIS
Description	The *Unexpected result indicator reference set* provides suitable concepts for recording an indication of the degree of diagnostic significance associated with a pathology investigation result based on all the available clinical information. This information pertaining to pathology result reporting is required to enable the laboratory to conduct the right investigation and the pathologist to interpret and report on the results clearly and unambiguously.
Scope	This reference set supports the accurate and unambiguous electronic communication and exchange of information relating to pathology result reporting between a pathology provider to a requesting clinician, or other approved recipient.
Target client	NEHTA ePathology Programme.
Other clients	
Definitive bindings	This reference set is bound to the *Unexpected Result Indicator* data element (DE-11027) which is under the *Structured Result Entry* data group (DG-11008) within the *Pathology Result Report SDT* (NEHTA, 2009).
Example of content	• 394845008 |*Potentially abnormal*| • 260369004 |*Increasing*|
Plan for future work	
File name and version	der2_Refset_UnexpectedResultIndicator*ReleaseType*_AU1000036_*yyyymmdd*.txt
Date of initial release	20091130
Initial no. of members	28
Contact	help@nehta.gov.au

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