nehta

National Discharge Summary

Data Content Specifications

Version 1.0 – 21/12/2006

National E-Health Transition Authority

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Document information

Change history

Version	Date	Author	Comments
1.0	21-12-2006	Dr Sistine Barretto Dr Stephen Chu Dr Eric Browne Dr Wayne Clapton	Initial public release

Acknowledgements

NEHTA would like to thank the following organisations and individuals for their contribution to these Data Specifications:-

- Standards Australia
- Royal Australian College of General Practitioners
- Society of Hospital Pharmacists of Australia
- Members of the Australian DataTypes Project
- Australian Institute of Health & Welfare
- Ocean Informatics

List of Acronyms

AIHW	Australian Institute of Health & Welfare
EHR	Electronic Health Record
HL7	Health Level Seven
METeOR	METadata Online Registry (http://meteor.aihw.gov.au)
NEHTA	National E-Health Transition Authority
SEHR	Shared Electronic Health Record
SNOMED CT®	Systematised NOmenclature of MEDicine - Clinical Terms[a]
WHO	World Health Organization

a. SNOMED and SNOMED CT are registered trademarks of the College of American Pathologists.

1 Introduction

1.1 Purpose and Scope

This document describes a specification for standardising the content of a discharge summary. The specification is a template that divides the discharge summary into sections based upon topic-specific data groups such as medications, problems/ diagnoses, diagnostic investigations, etc. The template is part of the care record summary suite of specifications that NEHTA is developing for the Australian health informatics community. One of NEHTA's goals is to standardise the suite of priority care record summaries and their data content to achieve semantic interoperability amongst healthcare provider systems.

A second goal is to publish specifications in machine-readable formats that can be directly incorporated into systems and used by applications with minimal requirement for interpretation by software developers. This discharge summary specification represents a step towards that goal.

Statistics from USA[1] reveal that over 38% of the population (95 million out of the total population of 250 million) suffers one or more chronic conditions. Those suffering from chronic illnesses may benefit significantly from effective disease management by an integrated/shared care team of providers. Discharge Summary has been considered by the healthcare industry as one of the high priority care record summaries to facilitate effective health information sharing and integrated care delivery. This requirement is one of the key drivers for the NEHTA Discharge Summary template. It is designed to facilitate the effective interchange of consistent clinical information regarding a subject of care's hospital encounter which could either be an emergency department (ED) visit or an admitted (e.g. day surgery or longer term in-patient) encounter.

1.2 Intended Audience

This document is intended to be read by jurisdictional ICT managers, clinicians involved in Clinical Information System specifications, software architects and developers, and implementers of Clinical Information Systems and discharge summary exchange applications in various healthcare settings. It is reasonably technical in nature and expects the audience to be familiar with the language of health data specification and have some familiarity with Australian Standards for Health Messaging, and/or repositories of data specifications such as the Australian Institute of Health and Welfare's METeOR[2] Knowledgebase, which houses the National Health Data Dictionary.

1.3 Reader's Feedback

This document is being released for comment. Individuals or organisations may provide feedback to NEHTA via the clininfo@nehta.gov.au email address or by mail to:-

NEHTA Clinical Information Initiative
Ground Floor, 162 Grenfell St.
Adelaide, SA 5000

Feedback will be considered by NEHTA in future revisions of this document.

1. http://www.icarehealthmonitoring.com/resources-chronicillnessstatistics.php
2. METadata Online Registry, http://meteor.aihw.gov.au

1.4 Background

Development of the Discharge Summary specification and the associated data groups began in 2003 by the Clinical Information Program. This specification builds on that work, which was primarily undertaken to support the design and implementation of shared health event summaries within the Health*Connect* initiative. Significant further development of the template occurred during 2004-05 under the NEHTA work program, whose focus is to support the requirements of each of the jurisdictions and to enable key clinical information to be shared and exchanged at a national level. To this end the template and data group development processes involved two groups of activities to ensure that the template and data group specification have broad appeal and relevancy in the acute and primary care settings:

- Thorough review of existing work which included:
  - Discharge/separation summaries from all Australian jurisdictions
  - International standards/specifications including the US Continuity of Care Records (CCR) and Care Record Summary (CRS)
  - HL7 V2.3.1 and V2.4 specification for Referral, Discharge and Health Record Messaging developed by Standards Australia
  - HL7 V3 Clinical Document Architecture refined message information model (R-MIM), the Care Record Domain Information Model and related information structures including the Clinical Statement Pattern.

- Extensive and iterative consultations were undertaken with key contributors from jurisdictional and professional organisations which provided critical information for requirement analysis and subsequent improvements of the specification design. These participant groups included:
  - Jurisdictions (including jurisdictional Health Departments and Discharge Summary project teams)
  - Queensland Health: Safe Medication Practice Unit and Infoinvestment Branch
  - Clinical Information Initiative (CII) Clinical Reference Group
  - General Practice Divisions
  - Professional Colleges

Detailed analysis of the referral – discharge life cycle and workflows were also conducted to ensure that appropriate context information and meta-data required for proper version control and tracking of discharge summaries were included in the specification.

It is assumed that the data groups contained within the discharge summary template will be used in conjunction with other standard specifications and services such as the Australian Medicine Terminology, other clinical terminologies, and provider/client identification services as they become available.

1.5 The NEHTA Event Summary Metamodel

The NEHTA Event Summary and Clinical Data Standards metamodel is used to provide a high level overview of a family of care record summaries which include the Discharge Summary. Within this metamodel clinical information is organised hierarchically into five levels: *event summary*, *section*, *data group*, *data element* and *value domain*. Figure 1 shows the relationship of an event summary in a shared EHR environment.

1.5.1 Event Summary

An ‘event summary’ is a collection of health information pertinent to a subject of care and is derived from a healthcare event that is relevant to the ongoing care of that individual. The event summary (which consists of a family of care record summaries) is composed of one or more data groups and/or possibly data elements, which are organised into section(s) (see Section 1.5.2 below). Examples of commonly used care record summaries include *Referral, Hospital Discharge* and *Pathology Results*.

1.5.2 Section

The contents of an event summary may be organised into one or more 'sections'. A section is an organising 'container'. Its purpose is to organise information in the manner that is suitable for the primary purpose it is collected, and that is useful for healthcare providers. It should also support safe re-used for secondary purposes. A section also provides a way to navigate through the data items within an event summary, thereby enabling more efficient querying to be made.

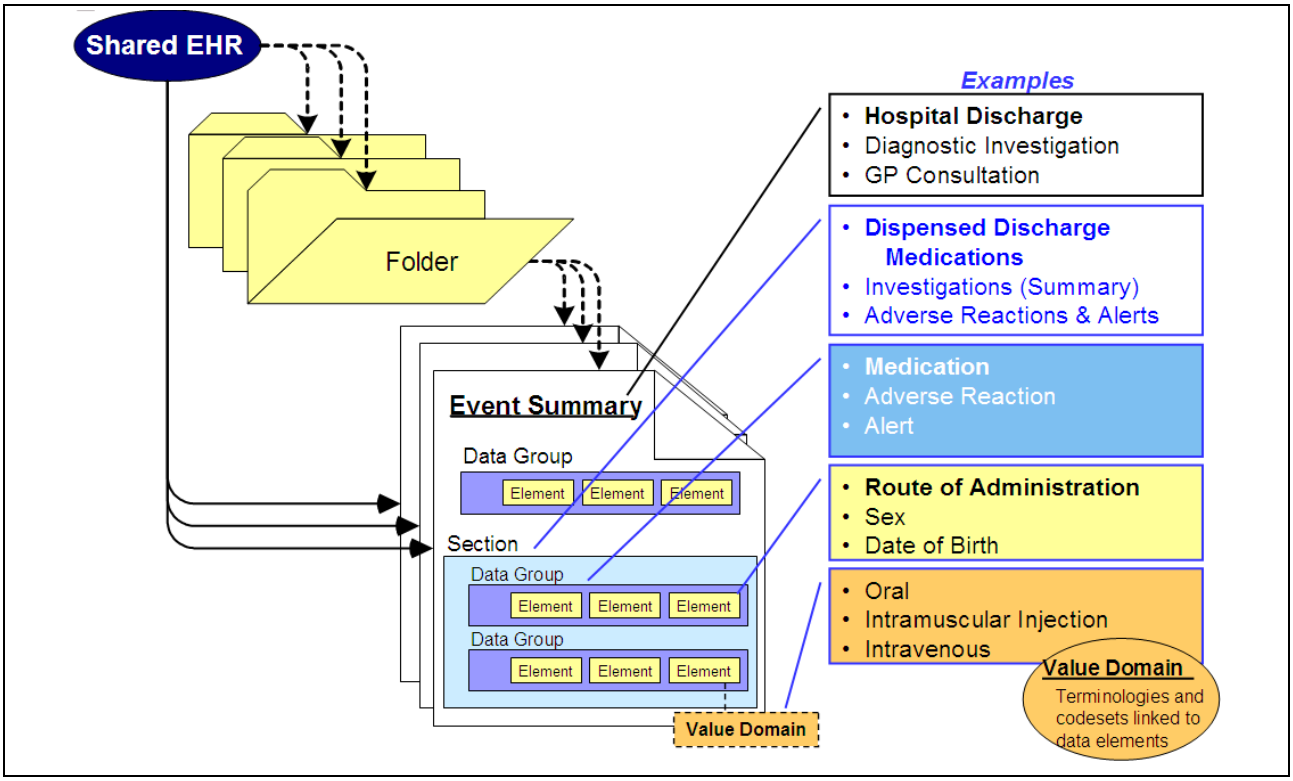


Figure 1 Event summary collection in Shared EHR System

1.5.3 Data Group

A 'data group' is a composite data structure (a collection of data elements or smaller data groups) for holding related items of information. Values of all the component data elements are often required to provide unambiguous meaning in a given context. A data group "organises" the data it holds. A data group can only be assigned values through the data elements that are contained within it. Examples of data groups are ADVERSE REACTION, ALERT, and MEDICATION.

1.5.4 Data Element

A 'data element' is the smallest named unit of information in the model that can be assigned a value. Data elements are identified as either simple or component. A data element that occurs as a member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The distinction between simple and component data elements is strictly a matter of context since a data element can be used in either capacity [1].

The permissible values for a data element are constrained by a value domain (see Section 1.5.5). The same data element can be reused in any number of data groups. For example, the "DateTime:Start" data element is used in the ADVERSE REACTION and the ALERT data groups. The "Problem/Diagnosis Description" data element is used by the "PROBLEM/DIAGNOSIS" data group in different context (e.g. to describe

1. Adapted from the Texas Department of State Health Services, *THCIC Hospital Discharge Data Collection, THCIC 837 Technical Specifications* (version 13), November 19, 2004.

the Principal diagnosis or complications). As such, a data element may *refer* to different value domains depending on the context it is used.

1.5.5 Value Domain

A 'value domain' constrains a data element's permissible values to a subset of those of its generic **datatype**. Value domains are reusable components, and therefore, the same value domain can be referred to by different data elements in different situations.

Value domains typically constrain by either specifying a lower and/or an upper bound on the range of permissible values or else specifying a finite set of prescribed values. Such a set of prescribed values can be specified directly with the definition of the data element, or in a separate, but associated specification, or else by reference to one or more external vocabulary/terminology sets. Table 1 (below) shows examples of value domains.

Data element	Datatype	Example of Value Domain
Severity	Coded text	"mild", "disabling", "life threatening"
Diagnosis	Coded text	Refer to terminology: SNOMED CT®

Table 1 - Value domain examples

1.5.6 Classification Scheme

A 'classification scheme' is a terminology system used to classify objects. It is organised in some specified structure, limited in content by a scope, and designed for assigning objects to concepts defined within it. Concepts are usually assigned to an object by linking the terms representing those concepts in the terminological system to the object. This process is called classification, and the terms assigned through classification are used for retrieval. In general, any terminological system is a classification scheme if its intent is for classifying objects. [1]

A classification scheme is used to encompass *terminologies* and *vocabularies* intended for various uses such as direct clinical use and statistical analysis. Classification schemes are referred to in the NEHTA data specifications where they exist externally and are required in value domains. Often these classifications schemes are underpinned by a set of codes, where each code maps to one or more entries in the classification scheme. Thus, classification schemes are sometimes referred to as *codesets*.

A value domain may consist of permissible values sourced from zero or more existing, external classification schemes, depending upon the completeness and sufficiency of those classification schemes. Values that are not available in one classification scheme may be obtained from other classification schemes, or depending upon the context and/or local system requirements, a *preferred* classification scheme may be used from a selection of valid classification schemes for that value domain.

1.6 The Discharge Summary Template Structure

Based on the event summary and clinical data standards metamodel the Discharge Summary specification comprises a hierarchy of sections, data groups and data elements as shown in Figure 2. Within the discharge summary a data group can be nested within another data group or bound within a section. This hierarchical organisation of sections and data groups is based on the context under which clinical data are captured and expected to be used within clinical information systems and discharge summaries, For example, the "Problem/Diagnosis" data group appears in a number of sections and subsections including, "Principal Problem/Diagnosis",

1. As defined by ISO/IEC 11179.

"Secondary Problems/Diagnoses", "Complications", and "Associated Problems or Comorbidities". The context and hence meaning of each "Problem/Diagnosis" data group bound within the different sections varies accordingly. Each data group, in turn, contains a number of data elements. The values for each data element are constrained in some way according to their datatype. Where data elements have values of type "Coded Text" or "Codeable Text", their values are generally expected to be constrained to a specific terminology / classification / vocabulary system or a subset thereof. In case of the "Medication Item" data group, for example, the terminology that supports key data element values such as medication names is the Australian Medicine Terminology, which is likely to derive from a special SNOMED CT® Reference Set. This reference set is currently being developed by NEHTA.

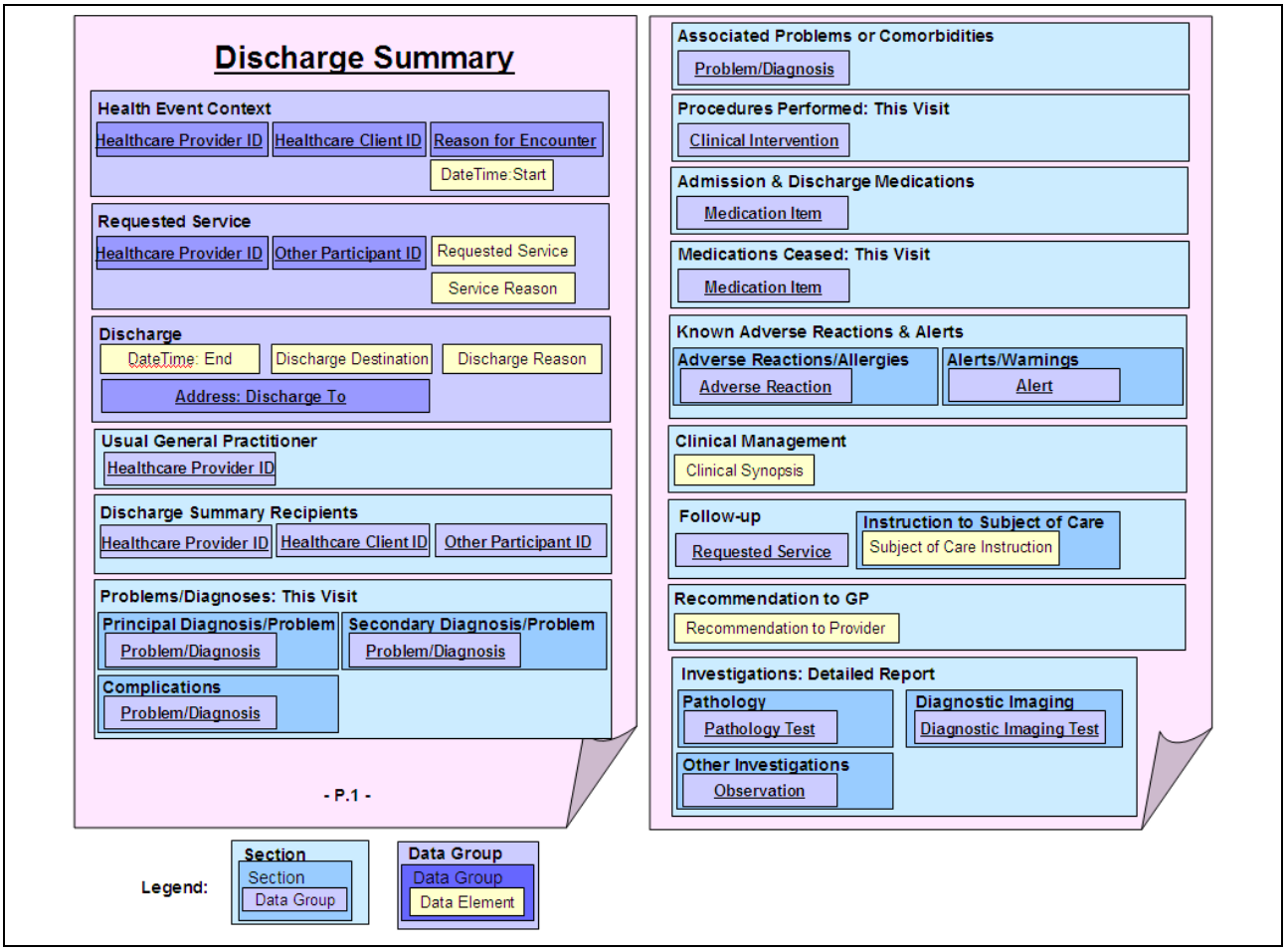


Figure 2 The Discharge Summary Template Structure

Similar to the HL7 Clinical Document Architecture (CDA) the Discharge Summary Template provides data structures fully capable of Level 4 semantic interoperability and also data structures for information that can only be captured in free text format. "Medication Item", "Problem/Diagnosis", "Clinical Intervention", "Adverse Reaction" all contain key data elements having values of type "codeable" or "coded" text. They have the format of <terminology code value> + <terminology system name> + <terminology system version number> + <concept display name> which gives the data element L4 semantic interoperability capacity. Data group/element such as "Clinical Synopsis" allows the capture of free text information.

1.7 Using the Discharge Summary Template

The following sections are included to facilitate understanding of how the Discharge Summary Template would be generated and used in the shared care environment.

1.7.1 Intended Use

The discharge summary is produced by a hospital clinician at, or soon after, the discharge of the subject of care.

1.7.2 Inappropriate Use

The **Discharge Summary** should not be used as a referral for explicitly referring the subject of care to another provider. A **Referral** should be used when an explicit request for healthcare services is required of the referred to provider. A Referral allows the "Referred to Provider" the opportunity to respond with an acceptance or rejection.

1.7.3 The Discharge Summary Sender(s)

Clinicians of the private or public hospitals involved in providing or managing the care of the subject during the encounter may send the discharge summary by either clinical information systems or electronic healthcare record systems using standard compliant eHealth message or traditional manual methods.

1.7.4 The Discharge Summary Recipients

A healthcare provider (person or organisation) who/which is involved in the care of the subject may receive the discharge summary either via a clinical information system capable of receiving standard compliant e-health message or by traditional manual methods. The most common recipient is the GP but it could be any healthcare provider on the subject-of-care's care team.

The discharge summary may also be received by a shared EHR System.

1.7.5 Delivery Mechanisms

The Discharge Summary may be sent by a dedicated, secure, e-health message via the internet or by traditional communication methods including fax, secure email as plain text or by post.

1.7.6 Implementation Considerations

Correct identification of the subject of care and healthcare providers (healthcare facilities and clinicians) is necessary to provide a degree of identification and information accuracy (i.e. identifying the correct package of information pertinent to the correct subject of care and providers) and security. Certain demographic details about the subject of care and providers are required for inclusion in the discharge summaries for this purpose. The Council of Australian Governments has committed Australia's healthcare system to a national system of uniquely identifying healthcare providers and individuals for healthcare purposes. NEHTA is currently developing this national approach. A unique identifier for these parties will be sufficient as access to NEHTA's national unique identifier (UHI) services for client and provider identification becomes available to both senders and recipients.

AS4700.6, the HL7 V2.4 standard for "Discharge, Referral and Health Record Messaging" has been published by Standards Australia. A significant amount of mapping effort would be required to represent the contents of the discharge summary template as the HL7 V2.4 "Discharge" message.

Likewise, contents of the discharge summary template can also be represented using the HL7 Clinical Document Architecture (CDA) structure. The HL7 V3 Care Record family of message structures which incorporate the Clinical Statement pattern are continuing to evolve. It is anticipated that the Care Record message structure may eventually provide sufficient structure for mapping of the complete content from the discharge summary template.

In conjunction with its EHR Design and Secure Messaging activities, NEHTA will be developing implementation specifications to support the packaging and transmission of discharge summaries in a standardised, interoperable fashion within Australia.

1.8 Discharge Summary Generation and Life-Cycle

A discharge summary is expected to be generated by the clinician(s) involved in the care of the subject at discharge (or soon after the discharge) of the subject of care. Figure 3 illustrates the typical process of discharge summary generation and Figure 4 represents its typical life cycle.

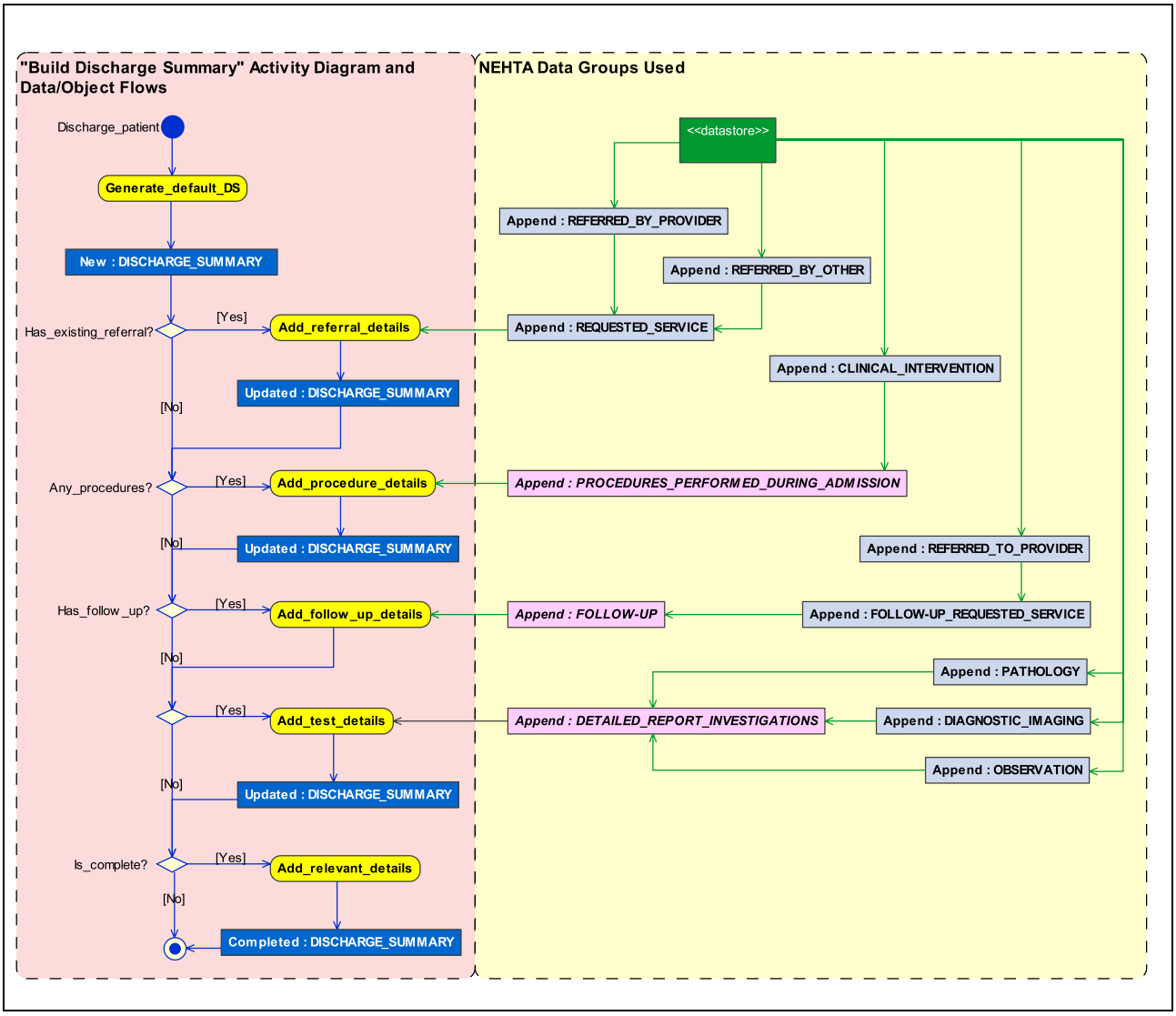


Figure 3 Discharge Summary Generation Processes

In the processes of generating a Discharge Summary, clinical information recorded during the healthcare event which is considered important for safe and effective continual management of the subject is included in the summary. It is expected to contain clinical content conforming to various NEHTA data groups depending on the investigations, findings, assessments, interventions and planned services recorded during the healthcare event.

The specific content (i.e. the NEHTA data groups) to be included in a discharge summary will depend upon the nature of the health problems/diagnoses, diagnostic tests done, assessments, medications prescribed, and interventions performed and/or planned. To cater for an optimal level of flexibility, a number of clinical data groups that are considered by the consultation processes as critical have been given the "essential" obligation. These core data groups which appear in all discharge summaries include:

- Problem/Diagnosis (which covers Clinical History, Reasons for Encounter, Principal Problem/Diagnosis, Secondary Problems/Diagnosis, and Complications),
- Adverse Reaction,
- Alert,
- Clinical Synopsis,

- Medication.

These data groups may be considered as the default discharge summary content and are automatically included in electronic discharge summary authoring application.

Other data groups either have “desirable” or “optional” obligations. They include,

- Clinical Intervention (Procedure);
- Investigation groups of data such as Pathology, Diagnostic Imaging, and Observation; and
- Requested Service, Management Plan (as part of the Follow-up group of data).

For example, the “Clinical Intervention” data group will only be included for patients who received any surgical or medical procedures (e.g. dialysis). Data groups that belong to the “Investigation” package of information such as “Pathology”, “Diagnostic Imaging” and other investigations (e.g. ECG) that are captured by “Observation” data group may or may not be included. For patients who receive simple procedures during day-stay, “management plan”, “Pathology” groups of data may not be included.

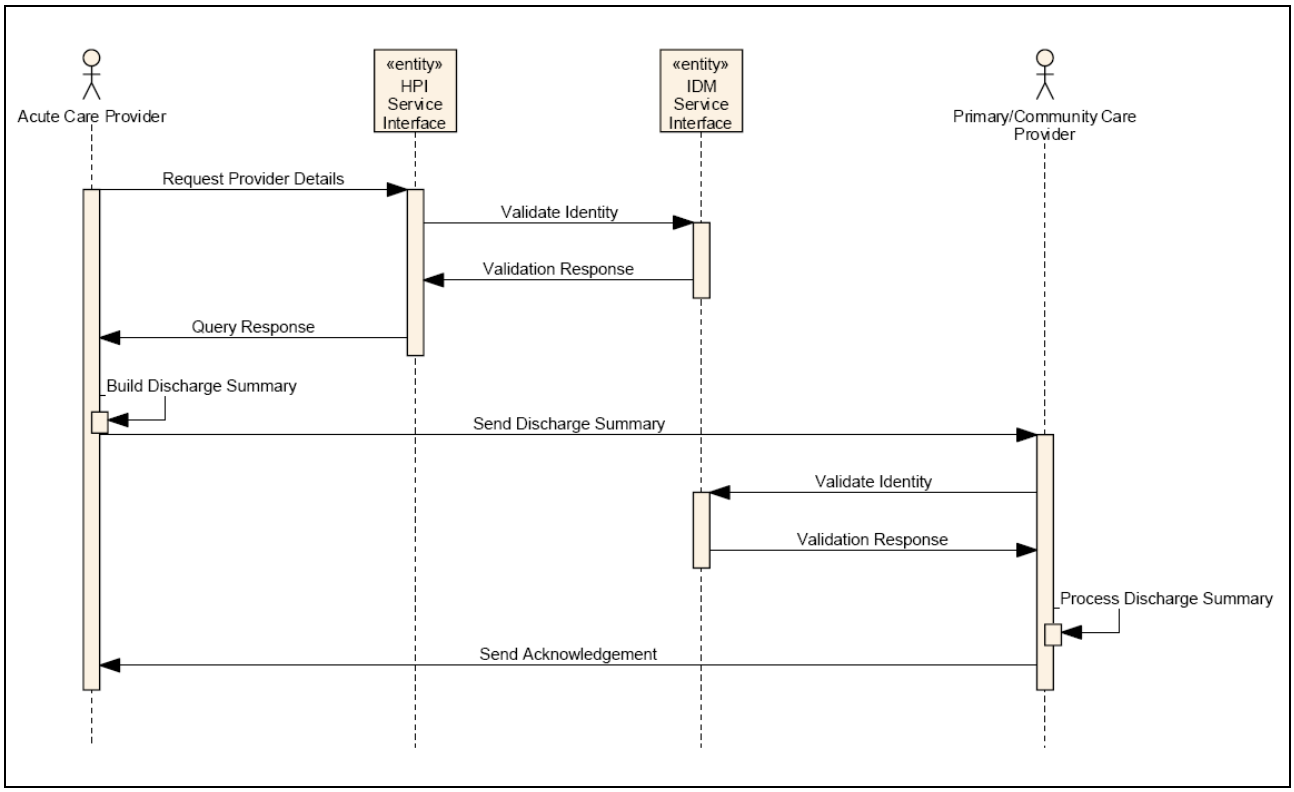


Figure 4 The Discharge Summary Life Cycle

A discharge summary may go through several iterations of authoring before or after it is sent to the recipients. For example, an interim discharge summary may be authored and sent before certain diagnostic test (e.g. histology) result is available. When such result becomes available, or the specialist may wish to add supplementary information, a new version of the discharge summary may be created. The “Version Tracking” data group contains a number of data elements to support effective version management, e.g. different versions of the discharge summary belonging to a same logical set to be uniquely identified and the different versions tracked.

The Discharge Summary as one of the care record summaries collection in shared EHR (SEHR) should also be able to be versioned within the SEHR system to support revision and proper revision tracking after the initial contribution to the SEHR system. Each version should be reproducible retrospectively including attestation details of each version.

The Discharge Summary should be recorded within the SEHR along with the general care category to support listing, grouping and retrieval as part of the complete care record summaries collection for individual subject of care.

2 Discharge Summary Layout

Discharge Summary – *Care Setting*

Facility Details:

Organisation Name
Address

Tel:Fax:
Email:
Department/Unit:
Specialist: (*Specialists Name*, *Electronic Communication Details*)
Registrar: (*Registrars Name*, *Electronic Communication Details*
RMO: (*Authors Name*, *Electronic Communication Details*

Usual General Practioner:

HPI
Provider Name
Organisation Name
Address

Tel:Fax:
Email:

Patient Details:

MRN: IHI:
Person Name
Address

Sex: DOB: Age:

Referred by: (*Referrers Name*, *Electronic Communication Details*)
Relationship to Subject of Care:
Reason for Referral:
Requested Service Description:
Admission/Encounter DateTime
Reason for Encounter Description
Reason for Encounter Note
DateTime Discharged:
Discharge Reason:
Discharge Destination:
Discharge To Address

PROBLEMS/DIAGNOSES THIS VISIT

Principal Problem / Diagnosis:

Description	Date started	Note	Awareness	Relevant person	(non)Awareness reason

Secondary Problem/Diagnosis:

Description	Date started	Note	Awareness	Relevant person	(non)Awareness reason

Complications:

Description	Date started	Note	Awareness	Relevant person	(non)Awareness reason

Comorbidities:

Description	Date started	Note	Awareness	Relevant person	(non)Awareness reason

Associated Problems:

Description	Date started	Note	Awareness	Relevant person	(non)Awareness reason

PROCEDURES PERFORMED THIS VISIT

Description	Date	Note	Awareness	Relevant Person	(non)Awareness reason

INVESTIGATIONS (SUMMARY)

Description	Date

ADMITTED/CEASED/DISPENSED MEDICATIONS

Status	Name (abstract or trade)	Form	Strength	Dose	Route	Frequency & Qualifier	Qty	Duration	Reason for med.	Change desc. & reason
Instructions										

KNOWN ADVERSE REACTIONS & ALERTS

Alerts:

Description	Date	Note

Adverse Reactions:

Agent description	Reaction	Date	Adverse Reaction Note

CLINICAL SYNOPSIS

Clinical Synopsis Comment

FOLLOW UP

Arranged Services and Planned Actions

Referred to	Reason/Service Description	Proposed start
Provider Name *occupation,* *Organisation Name* *Address* *Tel: Fax:*	Reason for Service Requested Service Description	Proposed Service start/ appointment date

Patient Instructions
Subject of Care Instruction

SUMMARY RECIPIENTS

INVESTIGATIONS - DETAILED REPORTS

Name	Address	Contact details

PATHOLOGY

Test name: Requesting Provider:
Performed Date: Reporting Pathologist:
Result Status:

Result name	Value value_units	Reference Range	Out of Range Indicator

report

note

DIAGNOSTIC IMAGING

Investigation name:

Performed Date:

Requesting Provider:

Reporting Provider:

Result Status:

report

note

OTHER INVESTIGATIONS

Date	Description	Result	Abnormal Flag

Note

3 Specifications

This document contains the discharge summary template specification which contains a hierarchy of sections, data groups, data elements and where appropriate, the value domains that constitute the integral part of the data element components. The discharge summary template references quite extensively external data groups, full descriptions of which may be found in the NEHTA data groups publications. For example, the specifications covering "subject of care identification", "healthcare provider identification", "problem/diagnosis", "medication item", "clinical intervention", "pathology", "diagnosing imaging", etc include only subsets of data elements and their associated definitions that are relevant to the discharge summary. The full specifications of some of these external data groups are evolving parts within the NEHTA's work programs. Individual data groups such as "medication item" have been published and are available on the NEHTA website[1]. A Section can be thought of as an organisational heading. A data group is a collection of related data elements and/or data groups that can be treated as a single block, which might be subject to cardinality and obligation constraints.

3.1 Obligation Legend

The 'obligation' of the data may be:

Essential: Indicates that the data item is considered to be a core component of information and required in order for the entry to make sense. E.g. Alert without an Alert description does not make sense;

Desirable: Indicates that the data item is considered worthy of being supplied where the data is known. The data item is deemed important in terms of providing additional or supplementary information in conjunction with essential data items. The data item should be supplied to provide as much context as possible for users to make informed decisions and/or to support various implementation requirements such as efficient indexing, querying and electronic decision support;

Optional: The data item may be supplied if required within a context and if the data is available, but it is not necessary for the data entry to make sense. It is recognised that for more complex or specialised healthcare provider settings, some items deemed optional may be viewed essential to them; or

Conditional: The data item is required on the condition of some other data item(s) being supplied, or based on the value(s) of another data item(s).

3.2 NEHTA Data Specifications ICON Legend

Metadata types

Icon	Metadata type Name
	Event summary
	Section
	Data Group
	Data Element
	Value Domain

Other Icons

Icon	Explanation
C	"Choice data group" – a single data group to be chosen from a set of data groups. Data groups of the same hierarchical depth within a hierarchical data group that make up a 'choice set' are indicated using this icon.*
	Multiple occurrence*
!	Indicates an **Essential** data item
	Indicates a **Desirable** data item
a→b	Indicates a Conditional data item
	Externally sourced specification
	Externally sourced Data Group specification

1. http://www.nehta.gov.au

Datatypes

Icon	*Datatype Name*	*Explanation*
T	Text	Character strings (with optional language). Unless otherwise constrained by an implementation, can be any combination of alpha, numeric or symbols from the Unicode character set. (Sometimes referred to as free text).
T 010	CodedText	Coded text *without* exceptions; text with code mappings.
T/T 010	CodeableText	Coded text with exceptions; flexible datatype to support various ways of holding text, both free text, coded text and combinations of free + coded.
	DateTime	Used for specifying a single date and/or time. Has the ability to indicate a level of precision, as well as an indication that the date/time is estimated. String representations of known dates should conform to ISO 8601.
	Duration	The period of time during which something continues. Usage/Example: "3 hours"; "6 months"; "1 year"
123	Number	A whole number or positive integer, and where (according to ISO 11404) – *integer* is the mathematical datatype comprising the exact integral values (Usage/ Examples: 1; 50; 125).
	Boolean	A value of true or false. Usage/Example: An actual value entered by the user might be "yes", or could be chosen by a mouse click on an icon such as ☑
ID	UniqueIdenti-fier	A general unique identifier to identify a physical or virtual object or concept.
	TimeInterval	Two Date/Time values that define the initial and later points in time. Usage/Examples: 12:00 – 18:00; 1:30 a.m. – 6:00 p.m.
	Quantity	Used for recording many real world measurements and observations. Consists of the property being recorded, the magnitude value, and the units. It may also include precision and number of decimal places. Usage/Examples: Property = width, Units = centimetres, Value = 100
	Quantit-yRange	Two *Quantity* values that define the minimum and maximum values, i.e. lower and upper bounds. This is typically used for defining the valid range of values for a particular measurement or observation. Usage/Examples: Temperature range of -20 to 100 °C; 30-50 mg of a prescribed drug.
	Encapsulated-Data	Used to specify how to supply metadata such as the type of data encapsulated (such as JPEG images, HTML, etc. using RFC 1521 MIME types), whether the data is inline or passed by reference, what character set is used to encode the data, any low resolution "thumbnail" representation included, any compression algorithm or integrity check information included.
	Link	This is a general link, reference or pointer to an object, data, or application that exists logically or stored electronically in a computer system. Usage/Example: URL (Uniform Resource Locator) – the World Wide Web address of a site on the Internet, such as the URL for the Google Internet search engine – "http://www.google.com". An absolute or relative path within a file/directory structure – e.g. in Windows operating system, the 'link' or absolute path to a particular letter (Word document) may be: "C:\Documents and Settings\guestUser\My Documents\Letter.doc".
A/B	Ratio	The relative magnitudes of two Quantity values (usually expressed as a quotient). Usage/Example: 1/3; 1:3
a,b,c...	Sequence	Ordered collection of items. Usage/Example: A person's given names, e.g. "David Phillip Andrew" would be held as 3 items grouped in order to form a single entity.
{b,a,c...}	Set	Unordered collection of items with values that must be unique within the set.

3.3 Discharge Summary Overview Diagram - Components

The following diagram illustrates the major component “classes” that comprise a standard discharge summary. Each component is detailed in Section 5 UML Diagrams

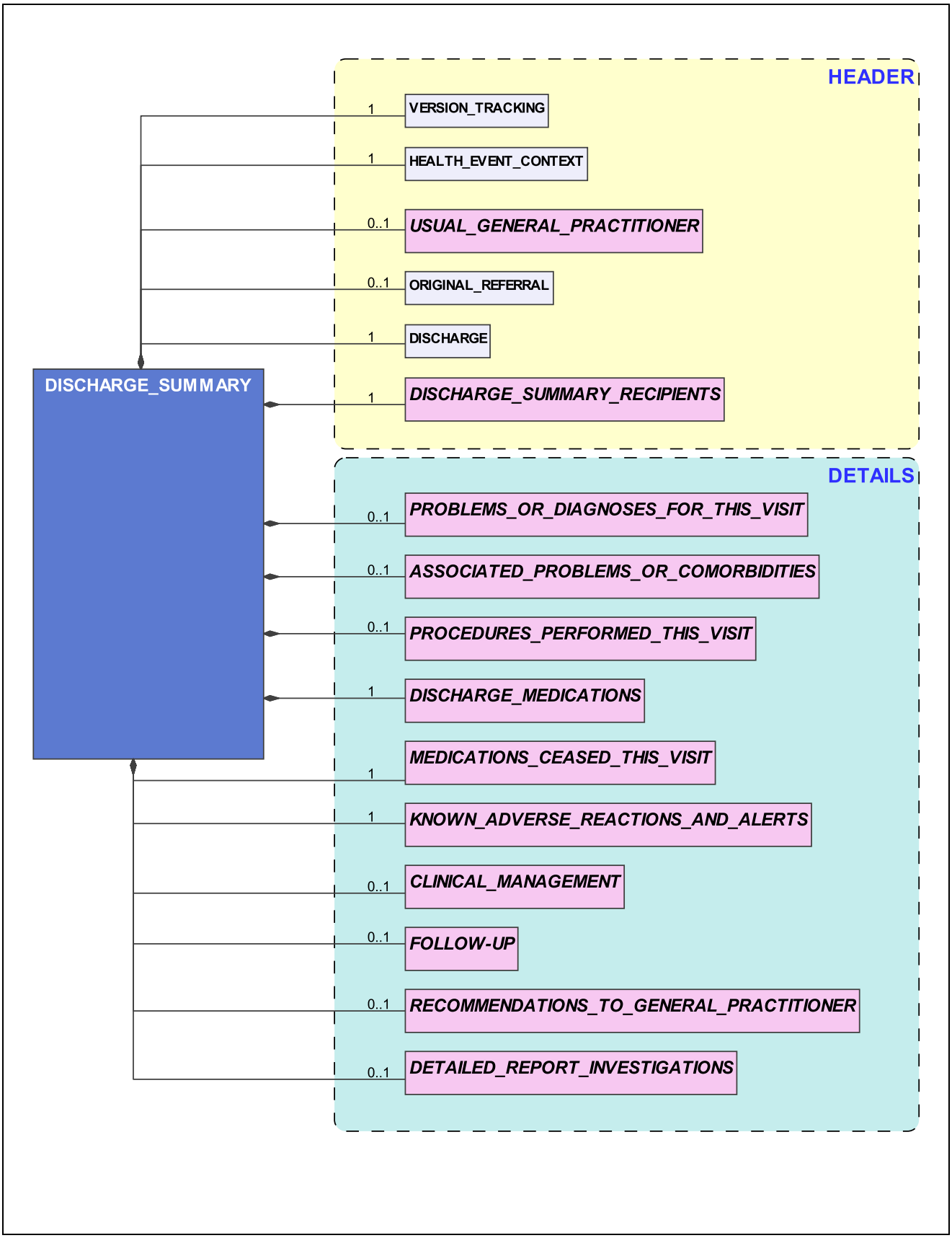


Figure 5 Discharge Summary - Overview

DISCHARGE SUMMARY

1 Identification

Name	DISCHARGE SUMMARY	
Meta-data Type	Event Summary	
Identifier	ES-20101	*External Identifier*
Version	1.0	

2 Definition

Definition	A collection of information about events during care by a provider or organisation.
Definition Source	Standards Australia IT14-6-6
Synonymous Names	
Scope	This version of the National Discharge Summary specification is primarily intended to support the discharge (also referred to as separation) of a patient from a stay in hospital, either as an inpatient, or from an Accident and Emergency department.
Scope Source	
Assumptions	A Discharge Summary is a notification of the discharge of a subject of care from a provider facility/organization, supplemented with information summarising the care given to the patient during the stay and additional information considered relevant to the ongoing care of the patient. It does not necessarily represent or enable transfer of care, nor is it necessarily intended for any particular provider or organization. Such a summary may form part of a Discharge Referral. If a Discharge Summary is intended to take on the role of discharge referral then additional constraints are applicable on content, and the full referral information and encapsulating specification should be used.
Assumption Source	Standards Australia IT14-6-6 (modified)

Hierarchical Structure

DISCHARGE SUMMARY	**Obligation** blank denotes optional
VERSION TRACKING	!
ID Discharge Summary Instance Identifier	!
IDSet Identifier	!
ID Version Number	!
T010 Discharge Summary Status	!
DateTime Authored	!
DateTime Issued	!
HEALTH EVENT CONTEXT	!
SUBJECT OF CARE	!
IDIndividual Healthcare Identifier	↻ !
Person Name	!
Address	!
T010 Sex	!

DISCHARGE SUMMARY	Obligation blank denotes optional
Date of Birth	!
Age	!
FACILITY	!
ID Healthcare Provider Identifier - Organisation	✓
T Organisation Name	!
T Department/Unit	
Address	!
Electronic Communication Details	↻ !
T/T010 Care Setting	!
Specialist	!
ID Specialists Identifier	✓
Specialists Name	!
Registrar	!
ID Registrars Identifier	✓
Registrars Name	!
Electronic Communication Details	✓
Discharge Summary Author	!
ID Authors Identifier	✓
Authors Name	!
Admission/Encounter DateTime	!
Reason for Encounter	!
T/T010 Reason for Encounter Description	!
T Reason for Encounter Note	
ORIGINAL REFERRAL	a→b
PROVIDER REFERRER	!
ID Referrer Identifier	✓
Referrers Name	!
T Organisation Name	a→b
Electronic Communication Details	↻ ✓

DISCHARGE SUMMARY	Obligation (blank denotes optional)
ALTERNATIVE REFERRER	a→b
ID Referrer Identifier	✓
Referrers Name	!
T Organisation Name	a→b
Electronic Communication Details	↷ ✓
T/T010 Relationship to Subject of Care	✓
T/T010 Requested Service Description	↷ ✓
T/T010 Reason for Referral	!
DISCHARGE	!
DateTime Discharged	!
T/T010 Discharge Reason	!
T/T010 Discharge Destination	!
Discharge To Address	
USUAL GENERAL PRACTIONER	a→b
HEALTHCARE PROVIDER IDENTIFICATION: USUAL GENERAL PRACTITIONER	!
ID Healthcare Provider Identifier - Individual	✓
Provider Name	!
Organisation Name	✓
Address	✓
Electronic Communication Details	↷
DISCHARGE SUMMARY RECIPIENTS	!
Subject of Care Recipient	✓
PERSON NAME	!
Provider Recipient	↷ !
HEALTHCARE PROVIDER IDENTIFIER - INDIVIDUAL	✓
PERSON NAME	!
HEALTHCARE PROVIDER IDENTIFIER - ORGANISATION	a→b
ORGANISATION NAME	a→b
ADDRESS	✓
ELECTRONIC COMMUNICATION DETAILS	

DISCHARGE SUMMARY	Obligation blank denotes optional
OTHER RECIPIENT	
PERSON NAME	a→b
ORGANISATION NAME	a→b
ADDRESS	
ELECTRONIC COMMUNICATION DETAILS	
T/T010 Relationship to Subject of Care	✓
PROBLEMS/DIAGNOSES THIS VISIT	!
PRINCIPAL PROBLEM/DIAGNOSIS	!
T/T010 Problem/Diagnosis Description	!
Date Problem Started	✓
T Problem/Diagnosis Note	
Problem/Diagnosis Awareness	↷✓
✓✗ Is Aware	!
T/T010 Relationship to Subject of Care	!
T NON-AWARENESS REASON	✓
SECONDARY PROBLEM/DIAGNOSIS	
T/T010 Problem/Diagnosis Description	!
Date Problem Started	✓
T Problem/Diagnosis Note	
Problem/Diagnosis Awareness	↷✓
✓✗ Is Aware	!
T/T010 Relationship to Subject of Care	!
T NON-AWARENESS REASON	✓
COMPLICATIONS	
T/T010 Problem/Diagnosis Description	!
Date Problem Started	✓
T Problem/Diagnosis Note	
Problem/Diagnosis Awareness	↷
✓✗ Is Aware	!
T/T010 Relationship to Subject of Care	!

DISCHARGE SUMMARY	Obligation (blank denotes optional)
T NON-AWARENESS REASON	✓
S= ASSOCIATED PROBLEMS	
T/T010 Problem/Diagnosis Description	!
Date Problem Started	✓
T Problem/Diagnosis Note	
Problem/Diagnosis Awareness	↷
✓✗ Is Aware	!
T/T010 Relationship to Subject of Care	!
T Non-awareness Reason	✓
S= COMORBIDITIES	
T/T010 Problem/Diagnosis Description	!
Date Problem Started	✓
T Problem/Diagnosis Note	
Problem/Diagnosis Awareness	↷
✓✗ Is Aware	!
T/T010 Relationship to Subject of Care	!
T Non-awareness Reason	✓
S= PROCEDURES PERFORMED THIS VISIT	✓
CLINICAL INTERVENTION	!
T/T010 Clinical Intervention Description	!
DateTime Performed	✓
T Clinical Intervention Note	
CLINICAL INTERVENTION AWARENESS	✓
✓✗ Is Aware	!
T/T010 Person Category	!
T Non-awareness Reason	✓
S= DISCHARGE MEDICATIONS	!
MEDICATION ITEM DETAILS	↷ !
T/T010 Product Description	C a→b

DISCHARGE SUMMARY		Obligation (blank denotes optional)
T010	Abstract Product	C a→b
T010	Trade Family	C a→b
T010	Formulation Name	C a→b
T010	Form	!
A/B	Strength	!
123/A/B	Dose	!
T/T010	Frequency	!
T/T010	Frequency Qualifier	
	Medication Duration	!
	Quantity	!
T010	Route	!
T/T010	Reason For Medication	✓
T010	Status	!
T/T010	Change Description	✓
T/T010	Reason For Change	a→b
T/T010	Subject of Care Instructions	
MEDICATIONS CEASED THIS VISIT		!
MEDICATION ITEM DETAILS		↻ !
T/T010	Product Description	C a→b
T010	Abstract Product (Generic Name)	C a→b
T010	Trade Family	C a→b
T010	Formulation Name	C a→b
T010	Form	!
A/B	Strength	!
123/A/B	Dose	✓
T/T010	Frequency	✓
T/T010	Frequency Qualifier	
	Medication Duration	!
	Quantity	!
T010	Route	✓

DISCHARGE SUMMARY	Obligation (blank denotes optional)
T/T010 Reason For Medication	✓
T010 Status	!
T/T010 Change Description	✓
T/T010 Reason For Change	a→b
T/T010 Subject of Care Instructions	
KNOWN ADVERSE REACTIONS AND ALERTS	!
ADVERSE REACTIONS	!
ADVERSE REACTION	!
T/T010 Agent Description	!
REACTION DETAILS	!
Onset	✓
T/T010 Adverse Reaction Description	!
FINDING SITE	↻ a→b
T/T010 Finding Site Description	!
T/T010 Finding Site Qualifier	
T Adverse Reaction Note	
ALERTS	!
ALERT	↻ !
Start DateTime	✓
T/T010 Alert Description	!
T/T010 Alert Note	
CLINICAL MANAGEMENT	✓
T Clinical Synopsis Comment	!
FOLLOW-UP	✓
REQUESTED SERVICE	↻ !
REFERREE	!
HEALTHCARE PROVIDER IDENTIFIER - INDIVIDUAL	a→b
PERSON NAME	a→b
HEALTHCARE PROVIDER IDENTIFIER - ORGANISATION	a→b
ORGANISATION NAME	a→b
ADDRESS	✓

DISCHARGE SUMMARY	Obligation blank denotes optional
ELECTRONIC COMMUNICATION DETAILS	↷ ✓
T/T010 Provider Occupation Category	
T/T010 Requested Service Description	!
T Reason for Service	!
Service Commencement Window	!
T/T010 Subject of Care Instruction	!
RECOMMENDATIONS TO GENERAL PRACTITIONER	
T Recommendation to Provider	!
INVESTIGATIONS: DETAILED REPORT	✓
PATHOLOGY	!
PATHOLOGY TEST	↷ !
TEST REQUESTER	
HEALTHCARE PROVIDER IDENTIFIER - INDIVIDUAL	✓
PERSON NAME	!
REPORTING PATHOLOGIST	
HEALTHCARE PROVIDER IDENTIFIER - INDIVIDUAL	✓
PERSON NAME	!
T/T010 Test Name	!
DateTime Specimen Collected	!
T/T010 Specimen Type	a→b
T/T010 Result Status	!
STRUCTURED ATOMIC RESULT	↷ !
T/T010 Atomic Result Name	!
123/T Result Value	!
T/T010 Result Units	!
123/T Reference Range	!
T/T010 Out of Range Indicator	a→b
T Test Method	✓
T/T010 Additional Finding	↷
Verbatim Report	!

DISCHARGE SUMMARY	Obligation (blank denotes optional)
Interpretive Note	
DIAGNOSTIC IMAGING	
DIAGNOSTIC IMAGING TEST	↻ !
Imaging Requester	
HEALTHCARE PROVIDER IDENTIFIER - INDIVIDUAL	✓
PERSON NAME	!
REPORTING RADIOLOGIST	
HEALTHCARE PROVIDER IDENTIFIER - INDIVIDUAL	✓
PERSON NAME	!
DateTime Performed	!
Report Status	!
Investigation Name	!
Imaging Report	!
Diagnostic Imaging Note	
OTHER INVESTIGATIONS	
OBSERVATION	↻ !
DateTime of Observation	!
Observation Description	!
Observation Result	!
Observation Abnormal Flag	a→b
Observation Note	

3 Usage

Conditions of Use	Sent by a provider or organization to notify other provider(s)/relevant parties about the discharge of a subject of care from a provider's/organization's care. The notification contains relevant clinical information about the events with additional information including information/advice to GP and subject of care
Conditions of Use Source	
Misuse	Using discharge summary for referral to other provider(s)/relevant parties

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice

Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Child

Data Type	Name	Version	Obligation	Condition	Occurrence
	VERSION TRACKING	1.0	Essential		Single
	HEALTH EVENT CONTEXT	1.0	Essential		Single
	ORIGINAL REFERRAL (display name = Referral & Services Requested)	1.0	Conditional	Required if admission/ health event is result of a referral by a referer who may be healthcare provider or other participant	Single
	DISCHARGE	1.0	Essential		Single
	USUAL GENERAL PRACTIONER	1.0	Conditional	Essential if summary recipient is not GP - but acknowledge that not all patient has a GP	Single
	DISCHARGE SUMMARY RECIPIENTS	1.0	Essential		Single
	PROBLEMS/DIAGNOSES THIS VISIT (display name [for admitted patients] = PROBLEMS/DIAGNOSES: This Admission)	1.0	Essential		Single
	ASSOCIATED PROBLEMS	1.0	Optional	Optional for recipients (other than GP). Essential for hospital auditing and statistical requirements and for GP	Single
	PROCEDURES PERFORMED THIS VISIT (alternate display name = PROCEDURE PERFORMED: This Admission)	1.0	Essential		Single
	DISCHARGE MEDICATIONS (alternate display name = Admission & Discharge Medications)	1.0	Essential		Single
	MEDICATIONS CEASED THIS VISIT (alternate display name = MEDICATIONS CEASED:This Admission)	1.0	Essential		Single
	KNOWN ADVERSE REACTIONS AND ALERTS (alternate display name = Known Allergies, Adverse Reactions and Alerts)	1.0	Essential		Single
	CLINICAL MANAGEMENT	1.0	Desirable		Single
	FOLLOW-UP	1.0	Desirable	Required if follow-up has been arranged. (not all discharges have follow-up arrangements)	Single
	RECOMMENDATIONS TO GENERAL PRACTITIONER	1.0	Optional		Single
	INVESTIGATIONS: DETAILED REPORT	1.0	Desirable		Single

VERSION TRACKING

1. Identification

Name	VERSION TRACKING	
Meta-data Type	Data Group	
Identifier	DG-20101	*External Identifier*
Version	1.0	

2. Definition

Definition	A data group that holds versioning information (version identification and tracking information) about discharge summaries that belong to the same logical set, i.e. that are related to the same healthcare encounter or event.
Definition Source	NEHTA
Synonymous Names	
Context	Used in the healthcare settings for correct identification and tracking of different versions of discharge summaries that belong to the same logical set.
Context Source	NEHTA
Assumptions	It is anticipated that the contents of discharge summary may evolve over time after its initial creation. For example, new contents may be added as new information (such as diagnostic test results) become available, or clinical judgement about the subject of care's condition may change. There may also be a need to amend information in previously compiled discharge summary when discrepancies between the documented contents and facts are discovered. When a new version of the discharge summary is generated, it needs to be correctly linked to the previous version(s) and the related summaries correctly grouped into a logical set. The version tracking and set grouping function is provided by six member data elements of this data group: Discharge Summary Instance Identifier - machine generated unique identifier which is not intended for human use Set Identifier- manual or machine generated unqiue identifier, for grouping of all referral documents from the same set together Version Number - manual or machine generated unique numeric value, for uniquely identifying each version of the referral Referral document within the same set Discharge Summary Status DateTime Authored; and DateTime Issued The name of this data group will not appear in a Discharge Summary document.

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	Discharge Summary	1.0	Essential	Essential	Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
ID	Discharge Summary Instance Identifier	1.0	Essential		Single
ID	Set Identifier	1.0	Essential		Single
ID	Version Number	1.0	Essential		Single
T/T$_{010}$	Discharge Summary Status	1.0	Essential		Single
	DateTime Authored	1.0	Essential		Single
	DateTime Issued	1.0	Essential		Single

Discharge Summary Instance Identifier

1. Identification

Name	Discharge Summary Instance Identifier	
Meta-data Type	Data Element	
Identifier	DE-20101	*External Identifier*
Version		

2. Definition

Definition	Unique system identifier of an instance of Discharge Summary being created.
Definition Source	NEHTA
Synonymous Names	Discharge summary instance ID
Context	Required for shared electronic health records/clinical information systems. A Discharge Summary document can have multiple instances as it passes through its life cycle of creation, revisions before it is first sent, and revised versions after it is first sent. The value of this data element enables systems to identify all instances of a discharge summary uniquely, thus enabling efficient storage, query and audit trail of discharge information about a subject of care. Note - this data element is intended for machine/system use only and hence need not be displayed on discharge summary documents For use in the healthcare setting. It is recommended that the Discharge Summary Instance Identifier value should be globally unique. The global uniqueness value of this Identifier can be achieved by: System ID + Episode ID When nationally unique identifiers (e.g. HPI for providers and IHI for subject of care), the global uniqueness value of this Identifier can be achieved by: System ID + unique provider facility ID (HPI) + unique subject of care ID
Context Source	NEHTA
Assumptions	The identifier is generated and is available for use within an electronic system. It is not intended for clinical use and will be transparent to clinicians authoring discharge summaries
Data Type	UniqueIdentifier
Value Domain	

3. Usage

Conditions of Use	To be used for system identification of discharge summary instances.
Conditions of Use Source	NEHTA
Examples	Example 1: VJ9TW2K.7.63286.123456.009 (where VJ9TW2K = system generated unique ID for the instance of the discharge summary 7.63286.123456.009 = Episode_ID value in which 7 = state_id value, 63286 = facility_id value; 123456 = person_id value; 009 = episode_num value for subject of care Jean Doe [MRN 123456] at Royal Gold Coast Hospital [Facility ID = 63286] in Queensland [State ID = 7])
Misuse	use of identifier for any other purposes.

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	VERSION TRACKING	1.0	Essential		Single

Set Identifier

1. Identification

Name	Set Identifier	
Meta-data Type	Data Element	
Identifier	DE-20102	*External Identifier*
Version	1.0	

2. Definition

Definition	Unique identifier of a Set of inter-related discharge summaries when successive changes to the discharge summaries belonging to a single healthcare encounter or episode resulted in different versions of the discharge summaries being created.
Definition Source	NEHTA
Synonymous Names	
Context	Used in healthcare setting. Different versions of discharge summary belonging to a single healthcare encounter or episode may be generated after the discharge of the patient. For example, new information (such as test results) may be added or contents may be changed (for example, diagnosis, or care plan revisions) after a discharge summary has been sent on patient's discharge. The Set Identifier value allows different versions of the discharge summary that belong to the same healthcare encounter/eipsode to be logically grouped together as an integral set. For the purpose of discharge summary, jurisdiction consultations reflected a strong preference in using the Episode ID as Set Identifier. The value of Episode ID uniquely identifies a specific health encounter (episode) such that all information pertinent to that healthcare encounter can be logically grouped. In the context of discharge summary, the Episode ID is used to logically group all different versions of discharge summary pertinent to a specific healthcare encounter (episode). Information from Tasmania as at March 2006 indicated that the format for Episode ID is made up of patient's URN (unique medical record number) + n where n = a numeric value denoting the sequence number of a patient's encounter with the healthcare facility/hospital. For example, the second visit/encounter of a patient with a URN value of 123456 will be 123456-2. As the URN value is only unique within each PMI (patient master index), there can be two identical Episode ID value from two PMI refering to the same or different patients. Information from Queensland as at March 2006 indicated that the format for Episode ID also comprises patient's URN + visit/encounter number (similar to Tasmania). To ensure global (national and statewide) uniqueness, Queensland uses the following format: state_id:facility_id:urn:episode_num. Therefore, the suggested format of the Episode ID is to be based on the Queensland model: state_id + facility_id + person_id + episode_num where the person_id is urn or mrn at present until it is replaced by IHI when available)
Context Source	NEHTA

Assumptions	The value of "Episode ID" must be unique at least for all patients within a healthcare facility, i.e. the same "Episode ID" value cannot be assigned to different patients. It is desirable that the Episode ID should be globally unique (within Australia). Episode is used synomynously with Encounter. A visit to the emergency department is considered an encounter. A second visit to the emergency department, although for the same (unresolved) problem is considered another encounter. An admission to the hospital (from admission to discharge) is considered an encounter. A re-admission to the hospital for the unresolved problem(s) from the previous admission should be considered as another encounter. This is especially important for management of patient with chronic illness such as hypertension, chronic respiratory diseases, etc where multiple emergency department visits, admission or GP visits can occur. Information from jurisdiction consultation also indicates that about 5% of admitted patients may experience "administrative discharge", e.g. a surgical patient may be "administratively discharged" to the care of the palliative care team but states in the hospital, and likely to stay in the same ward and same bed. Such patients will have two episode ID assigned for the single admission. However, only one discharge summary will be generated for the patient, i.e. at the time of physical discharge from the hopsital. Jurisdiction advisor recommends that the 2nd episode ID value to be used such cases where the patient is assigned two episode ID values during one single encounter.
Data Type	UniqueIdentifier
Value Domain	

3. Usage

Conditions of Use	To be used for identification of discharge summary instances that belong to one and the same healthcare event/visit.
Conditions of Use Source	
Examples	Example 1) Episode ID = 2000x.26790.123456.2 (where 2000x = state id value for NSW, for example; 26790 = facility id value for Royal Prince Alfred Hospital, for example; 123456 = urn for patient John Doe, for example; and 2 = episode number value for John Doe at Royal Prince Alfred Hospital) Example 2) Episode ID = 3000k.63286.123456.9 (where 3000k = state id value for Tasmania, for example; 63286 = facility id value for Royal Hobart Hospital, for example; 123456 = urn for patient Jean Doe, for example; and 9 = episdoe number value for Jean Doe at Royal Hobart Hospital)
Misuse	use of identifier for any other purposes.

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	VERSION TRACKING	1.0	Essential		Single

Version Number

1. Identification

Name	Version Number	
Meta-data Type	Data Element	
Identifier	DE-20103	*External Identifier*
Version	1.0	

2. Definition

Definition	Unique identifier of a version of Discharge Summary from other versions within the same discharge summary set.
Definition Source	NEHTA
Synonymous Names	Discharge Summary Version Number
Context	It is common that different versions of discharge summaries about one and the same healthcare event/visit are authored and released. For example, at the time of discharge a discharge summary is authored by the intern (and released) which can be subsequently edited by the registrar/RMO and later by the specialist/ consultant. The Set Identifier allows different versions of discharge summaries that belong to the one and the same healthcare event/visit to be linked together for tracking and medico-legal purposes. The Version Number is used to uniquely identify each version of the discharge summary document that belongs to the same set. Required for shared electronic health records/clinical information systems, which enables systems to identify and link together a set of discharge summaries that belong to one and the same healthcare event, thus enabling efficient storage, query and audit trail of discharge information about a subject of care. Value of the (discharge summary) Version Number is generated manually or automatically by algorithimc process, and is available for use within manual and/or an electronic system. Each Discharge Summary while undergoing authoring and editing processes before being released will retain the same Set Identifier and Version Number values. The Discharge Summary Version Number value should be unique within each discharge summary set. The openEHR Foundation publication (http://www.openEHR.org) - the openEHR Common Information Model Release 1.0 Revision 2.0 (published in Feb 2006) Section 6, and the openEHR Support Information Model Release 1.0 Release 1.5 (published in Feb 2006) Section - provide useful guidelines which can be used to guide the generation and mantainenance of Discharge Summary Set and Version Identifier.
Context Source	NEHTA
Assumptions	
Data Type	Number
Value Domain	

3. Usage

Conditions of Use	To be used for identification of versions of released discharge summary that belong to one and the same healthcare event/visit (i.e. same document set with same Set Identifier value).
Conditions of Use Source	NEHTA

Examples	Example 1) Version No = 001 Example 2) Version No = 012 If the two documents belong to the same discharge summary set (i.e. belong to the same encounter for the same patient), then Version 012 is a later version of Version 001
Misuse	use of identifier for any other purposes.

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	VERSION TRACKING	1.0	Essential		Single

Discharge Summary Status

1. Identification

Name	Discharge Summary Status	
Meta-data Type	Data Element	
Identifier	DE-20104	*External Identifier*
Version	1.0	

2. Definition

Definition	The status of a discharge summary in relation itself and to other discharge summaries within the same discharge summary set.
Definition Source	NEHTA
Synonymous Names	Summary Status
Context	A document/package of information may assume different status values during and after the process of creation. In the context of discharge summary, its status in relation to previously created discharge summaries within the same discharge summary set has critical clinical and medico-legal importance. For example, if when a discharge summary is first created and sent after patient is discharge, it has a status value = new as there is no preceding discharge summary version in the same set. When new information (e.g. diagnostic test results) becomes available and a healthcare provider sents out a new version of the discharge summary, this can be done in two ways: (a) only the new clinical information is included in the new version of the discharge summary and this new version is to be appended to the previously sent version, the discharge summary status value of the new version = append, i.e. it is intended to compliment the previous version and its contents must be read in conjunction to the previous version. (b) the new information is added to the previously written discharge summary and the new version that contains both previously authored information and the addition information is then sent. The revised discharge summary will have a status value = replace, i.e. it completely replaces the previous version.
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	Discharge Summary Status Values AS4007.6 Version 2.4 specification code value (for RF1-1 Referral Status): I = interim F = final C = correction

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	VERSION TRACKING	1.0	Essential		Single

Discharge Summary Status Values

1. Identification

Name	Discharge Summary Status Values
Meta-data Type	Value Domain
Identifier	VD-20104
Version	1.0

2. Definition

Definition	
Definition Source	NEHTA

3. Value Domain

Source	
Version Number	
Permissible Values	*to be determined*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	Discharge Summary Status	1.0	Essential		Single

DateTime Authored

1. Identification

Name	DateTime Authored	
Meta-data Type	Data Element	
Identifier	DE-20105	*External Identifier*
Version	1.0	

2. Definition

Definition	The date or date and time that authoring of the discharge summary by the authoring healthcare provider is started or done.
Definition Source	NEHTA
Synonymous Names	DateTime Discharge Summary Created DateTime Created DateTime Issued
Context	For use by system and discharge summary authoring application. Note: This data element is intended for machine/system use only hence it need not be displayed on discharge summary. However, this data element should be displayed on the discharge summary authoring application to inform case manager/clinician of the discharge summary creation date and time.
Context Source	
Assumptions	The DateTime Recorded value may or may not be the same as the DateTime Sent value. The Discharge Summary may be created by a final year medical student or an intern and awaits to be authorised for release by more senior clinician. Or the authoring clinician may need to wait for additional information, e.g. pathology/radiology results, or further inputs from specialist, etc before releasing.
Data Type	DateTime
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) 31/03/2004 Example 2) 03/2004 Example 3) 2004 Example 4) 31/03/2004 13:10
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	VERSION TRACKING	1.0	Essential		Single

DateTime Issued

1. Identification

Name	DateTime Issued	
Meta-data Type	Data Element	
Identifier	DE-20106	*External Identifier*
Version	1.0	

2. Definition

Definition	The date or date and time that the discharge summary was sent/electronically transmitted by authorized healthcare provider who may or may not be the authoring provider/clinician.
Definition Source	NEHTA
Synonymous Names	Date Sent; DateTime Discharged Summary Sent; DateTime Discharged Summary Transmitted
Context	For use in the healthcare setting. Captures the date and time value when the discharge summary is sent by the authoring provider to the discharge summary recipients. In the electronic environment, it captures the date and time when the discharge summary is transmitted (by authorisation of the authoring provider) from the discharge summary authoring application in one facility to the discharge summary receiving application in another facility.
Context Source	
Assumptions	The DateTime Discharge Summary Sent value may or may not be the same as the DateTime Created value. The Discharge Summary may be created by a final year medical student or an intern and awaits to be authorised for release by more senior clinician. Or the authoring clinician may need to wait for additional information, e.g. pathology/radiology results, or further inputs from specialist, etc before releasing.
Data Type	DateTime
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) 31/03/2004 Example 3) 2004 Example 4) 2004-03-31 13:10
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	VERSION TRACKING	1.0	Essential		Single

HEALTH EVENT CONTEXT

1 Identification

Name	HEALTH EVENT CONTEXT	
Meta-data Type	Data Group	
Identifier	DG-20102	*External Identifier*:
Version	1.0	

2 Definition

Definition	A data group that associates context specific information about a healthcare event/encounter or clinical interaction that describes the participant(s) in the event, including the nature of the clinical event/interaction, and the date and time of the event
Definition Source	NEHTA
Synonymous Names	Visit Context; Encounter Context
Context	NOTE: The data group was formerly known as CLINICAL CONTEXT. Data elements/groups included within this data group provides mainly information about the subject of care and provider identification which is specific to the context of a healthcare event/visit. They are not intended to carry clinical information. Using the label/name CLINICAL CONTEXT can give rise to confusion. This is a data group for grouping contextually related data groups/elements that are displayed within the beginning (header) sections of the discharge summary. This data group name is not intended for display on discharge summary. It is used as a grouper in this specification template.
Context Source	NEHTA
Assumptions	

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	Details of clinical information about a subject of care specific to a particular healthcare event/encounter

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parent

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY	1.0	Essential	Essential	Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	SUBJECT OF CARE	1.0	Essential		Single
	FACILITY	1.0	Essential		Single
T/T010	Care Setting	1.0	Essential		Single
	SPECIALIST	1.0	Essential		Single
	REGISTRAR	1.0	Essential		Single
	DISCHARGE SUMMARY AUTHOR	1.0	Essential		Single
	Admission/Encounter DateTime	1.0	Essential		Single
	REASON FOR ENCOUNTER	1.0	Essential		Single

SUBJECT OF CARE

1. Identification

Name	SUBJECT OF CARE
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20103 *External Identifier* AS 5017-2006
Version	1.0

2. Definition

Definition	Details pertaining to the identification of the healthcare client (subject of care) about whom the healthcare event/visit information has been captured and/or interchanged.
Definition Source	NEHTA
Synonymous Names	Patient Details; Subject of Care Identification
Scope	For use in the healthcare setting. Captures identification information about the subject of care. Based on stakeholder feedbacks, the following Healthcare Client Identification data elements should be included: Individual Healthcare Identifier: Individual Healthcare Identifier Name - Obligation = Essential; Individual Healthcare Identifier Designation - Obligation = Desirable Person Name (First name, middle name/initial, Family name) - Obligation = Essential Address - Obligation = Essential Date of Birth - Obligation = Essential Age - Obligation = Desirable Sex - Obligation = Essential
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	HEALTH EVENT CONTEXT	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	INDIVIDUAL HEALTHCARE IDENTIFIER	1.0	Essential		Single
	PERSON NAME	1.0	Essential		Single
	ADDRESS	1.0	Essential		Single
	Sex	1.0	Essential		Single
	Date of Birth	1.0	Essential		Single
	Age	1.0	Essential		Single

FACILITY

1. Identification

Name	FACILITY
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20107 *External Identifier*
Version	1.0

2. Definition

Definition	Details pertaining to the identification of a Healthcare Organisation/Facility which is involved in or associated with the delivery of the healthcare services to the subject of care, or caring for his/her wellbeing.
Definition Source	NEHTA
Synonymous Names	Healthcare Organisation Identification; Healthcare Facility; Facility Details
Scope	For use in the healthcare setting. Captures identification of Healthcare Provider Organisation/ Facility. Based on stakeholder feedback, the following Healthcare Provider Identification data elements should be included in the Discharge Summary: (i) Organisation name - Obligation = Essential (ii) Healthcare Provider Identifier - Organisation: HPI - Obligation = Desirable (iii) Address - Obligation = Essential (iv) Phone number - Obligation = Essential; or (v) Fax - Obligation = Essential (vi) email address - Obligation = Optional (Vii) Department Name - Obglication = Optional (Viii) Care Setting - Obligation = Essential
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

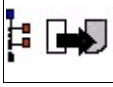
Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	HEALTH EVENT CONTEXT	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROVIDER ORGANISATION IDENTIFICATION	1.0	Desirable		Single
	ORGANISATION NAME	1.0	Essential		Single
	DEPARTMENT/UNIT	1.0	Essential		Single
	ADDRESS	1.0	Essential		Single
	ELECTRONIC COMMUNICATION DETAILS (display name = Telephone and Fax/Email)	1.0	Optional		Single

Care Setting

1. Identification

Name	Care Setting	
Meta-data Type	Data Element	
Identifier	DE-20111	*External Identifier*
Version	1.0	

2. Definition

Definition	An agreed statement of the type(s) of care setting within which healthcare services have been provided to the subject of care.
Definition Source	NEHTA
Synonymous Names	
Scope	
Scope Source	
Assumptions	
Data Type	CodeableText
Value Domain	Care Setting Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Accident and Emergency Example 2) Admitted-patient
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	HEALTH EVENT CONTEXT	1.0	Essential		Single

Care Setting Values

1. Identification

Name	Care Setting Values
Meta-data Type	Value Domain
Identifier	VD-20111
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Care Setting	1.0	Essential		Single

SPECIALIST

1. Identification

Name	Specialist
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20112 *External Identifier*
Version	1.0

2. Definition

Definition	Details pertaining to the identification of the Consultant/Specialist of the clinical facility/ department who was responsible for taking charge of care given to the subject/patient during the healthcare event/encounter.
Definition Source	NEHTA
Synonymous Names	Consultant
Scope	For use in the healthcare setting. Captures identification information on the Healthcare Provider Person in charge of delivery of care to the subject of care. Based on stakeholder feedbacks, the following Healthcare Client and Provider Identification data elements should be included as Registrar details: Person Name (First name, middle name/initial, Family name) - Obligation = Essential Healthcare Provider Identifier - Individual (HPI-I) - Obligation = Desirable Telephone/Pager - Obligation = Optional Fax/Email - Obligation = Optional
Scope Source	
Assumptions	
Examples	

3. Usage

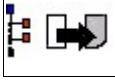
Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

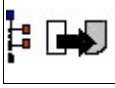
Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	HEALTH EVENT CONTEXT	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	SPECIALISTS IDENTIFIER	1.0	Essential		Single
	SPECIALISTS NAME	1.0	Essential		Single

REGISTRAR

1. Identification

Name	REGISTRAR
Meta-data Type	Externally sourced Data Group specification
Identifier	*External Identifier*
Version	1.0

2. Definition

Definition	Details pertaining to the identification of the Registrar of the clinical facility/department who was responsible for providing care to the subject/patient during the healthcare event/ encounter; and the resident medical officer (RMO) who is responsible for authoring the discharge summary.
Definition Source	NEHTA
Synonymous Names	Registrar (display name used in Discharge Summary Mockup document)
Scope	For use in the healthcare setting. Captures identification information on the Healthcare Provider Person. Based on stakeholder feedbacks, the following Healthcare Client and Provider Identification data elements should be included as Registrar details: Person Name (First name, middle name/initial, Family name) - Obligation = Essential Healthcare Provider Identifier - Individual (HPI-I) : Obligation = Desirable Telephone/Pager - Obligation = Essential Fax/Email - Obligation = Optional
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

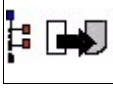
Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	HEALTH EVENT CONTEXT	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	REGISTRARS IDENTIFIER	1.0	Essential		Single
	REGISTRARS NAME	1.0	Essential		Single
	ELECTRONIC COMMUNICATION DETAILS	1.0	Essential - for Phone or Pager; Optional - for Fax and email		Single

DISCHARGE SUMMARY AUTHOR

1. Identification

Name	DISCHARGE SUMMARY AUTHOR
Meta-data Type	Externally sourced Data Group specification
Identifier	*External Identifier*
Version	1.0

2. Definition

Definition	Details pertaining to the identification of the healthcare provider who is a participant of a healthcare event. In this case, it refers to the healthcare provider who is the main author of the discharge summary.
Definition Source	NEHTA
Synonymous Names	Discharge Summary Author (display name used in Discharge Summary Mockup document) Author
Scope	For use in the healthcare setting. Captures identification information on the Healthcare Provider Person. Based on stakeholder feedbacks, the following Healthcare Client and Provider Identification data elements should be included as Registrar details: Person Name (First name, middle name/initial, Family name) - Obligation = Essential Healthcare Provider Identifier - Individual (HPI-I) : Obligation = Desirable Telephone/Pager - Obligation = Optional Fax/Email - Obligation = Optional
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

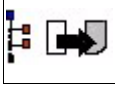
Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	HEALTH EVENT CONTEXT	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	AUTHORS IDENTIFIER	1.0	Essential		Single
	AUTHORS NAME	1.0	Essential		Single

Admission/Encounter DateTime

1. Identification

Name	Admission/Encounter DateTime	
Meta-data Type	Data Element	
Identifier	DE-20122	*External Identifier*
Version	1.0	

2. Definition

Definition	The date or date and time at which the subject of care is admitted to the healthcare facility; or date/date and time at which the healthcare event/encounter experienced by the subject of care at the healthcare facility occurred.
Definition Source	NEHTA
Synonymous Names	Admission Date or Admission Date and Time (Display name used in Discharge Summary mock-up document) - if Care Setting value = in-patient) Encounter Date or Admission Date and Time (Display name for discharge summary - if Care Setting value = emergency department) Visit Date or Visit Date and Time (display name for for discharge summary - if Care Setting value = emergency department)
Scope	For use at the healthcare setting. Used to denote the date or date and time at which the subject of care experienced the healthcare event which might be an admission, or an encounter at the healthcare facility such as emergency department, outpatient clinic, or GP/ Specialist clinic, etc.
Scope Source	
Assumptions	
Data Type	DateTime
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) 31/03/2004 Example 2) 03/2004 Example 3) 2004 Example 4) 31/03/2004 13:10
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	HEALTH EVENT CONTEXT	1.0	Essential		Single

REASON FOR ENCOUNTER

1. Identification

Name	REASON FOR ENCOUNTER
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20122 *External Identifier*
Version	1.0

2. Definition

Definition	An agreed statement of the reason(s) why a person enters the healthcare system, representing the demand for care/service by that subject of care
Definition Source	NEHTA
Synonymous Names	Reason for Admission Problem on Admission
Scope	For use in healthcare setting. Used to identify the reason for either emergency department encounter or in-patient admission/healthcare event. NOTE - The data group contains two data elements: - Reason for Encounter Description - Reason for Encounter Note This data group name which can be considered as eqivlaent to the Reason for Encounter section in the discharge summary is not displayed on the discharge summary to avoid repetition. Rather the displayed items include Admission Reason and/or Encounter Reason.
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	Used to identify symptoms, issues, problems or diagnosis requiring subject of care attendance at the healthcare facility.
Conditions of Use Source	
Misuse	Used to specify services/procedures requested or performed at the healthcare facility.

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	HEALTH EVENT CONTEXT	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Reason for Encounter Description	1.0	Essential		Single
T	Reason for Encounter Note	1.0	Optional		Single

Reason for Encounter Description

1. Identification

Name	Reason for Encounter Description	
Meta-data Type	Data Element	
Identifier	DE-20113	*External Identifier*
Version	1.0	

2. Definition

Definition	An agreed statement of the reason(s) why a person enters the healthcare system. *This takes the form of a description of the diagnosis, problem (or condition, or issue) resulting in the subject of care requring the healthcare services identified in the discharge summary.*
Definition Source	NEHTA
Synonymous Names	Admission Reason; Reason for Visit; Presenting Problem
Scope	For use in healthcare setting. Used to describe the symptoms/complaints, condition, issue, problem or diagnosis requiring either emergency department or in-patient encounter/healthcare event.
Scope Source	
Assumptions	
Data Type	CodeableText
Value Domain	Reason for Encounter Description Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	acopia (as example of Condition/Problem statement) instability/unsteady gait/repeated falls severe dizziness/severe hypotension uncontrolled high blood pressure acute exacerbation of congestive heart failure (as example of Diagnosis)
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	REASON FOR ENCOUNTER	1.0	Essential		Single

Reason for Encounter Description Values

1. Identification

Name	REASON FOR ENCOUNTER DESCRIPTION VALUES
Meta-data Type	Value Domain
Identifier	VD-20113
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	REASON FOR ENCOUNTER DESCRIPTION	1.0	Essential		Single

Reason for Encounter Note

1. Identification

Name	Reason for Encounter Note	
Meta-data Type	Data Element	
Identifier	DE-20114	*External Identifier*
Version	1.0	

2. Definition

Definition	Free text comments provding additonal information relevant to the reason(s) why a person enters the healthcare system.
Definition Source	NEHTA
Synonymous Names	Admission Reason Note
Scope	For use in the healthcare setting. Used to provide additional information (not captured by Reason for Encounter Description) about the subject of care's condition/problem/diagnosis which led to either emergency department or in-patient encounter/healthcare event.
Scope Source	
Assumptions	
Data Type	Text
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	REASON FOR ENCOUNTER	1.0	Optional		Single

ORIGINAL REFERRAL

1 Identification

Name	ORIGINAL REFERRAL	
Meta-data Type	Data Group	
Identifier	DG-20125	*External Identifier*:
Version	1.0	

2 Definition

Definition	Details pertaining to any initiating referral, including referrer details and any services requested in the original referral by the Referring Healthcare Provider or referring person/ organisation. It does not include medication prescriptions requests.
Definition Source	NEHTA
Synonymous Names	Referral & Services Requested (*display Name used in discharge summary mockup*)
Scope	The data group contains data which identify the original referrer, services requested and reasons for request: - Referral Initiators (either Healthcare Provider Person/Organisation or Other participant) - [[Requested Service Description]] (displayed as Requested Service or Service Description) data element - [[Referral Reason]] data element This data group name may not be displayed in the Discharge Summary document. If displayed, the display name may be Referral & Services Requested.
Scope Source	
Assumptions	

3 Usage

Conditions of Use	For use in HEALTH EVENT CONTEXT. The healthcare event (i.e. emergency department encounter or in-hospital/admission encounter) may be the result of a referral from the subject's GP, private specialist, aged care facility. In a discharge summary, this data group is used to group together information about the referral which **initiated the hospital encounter**. It is possible that the subject of care is admitted to the hospital without a referral, e.g. through the Emergency Department. In such case, there may not be a referrer and reasons for referral, etc information may not be available. The use of this data group in the Discharge Summary template is hence considered conditional upon the presence of a referrer in the healthcare event/encounter. See also Reason for Encounter If the patient has been referred to the hospital by a referrer, e.g. healthcare provider such as GP, referrer information is essential.
Conditions of Use Source	NEHTA
Misuse	This data group should not be used to specify medication prescriptions or diagnostic test requests.This data group should NOT be used to carry referral information from the hospital to the subject's GP or other providers within or outside the hospital.

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parent

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY	1.0	Conditional	Required if Healthcare Event/Encounter is initiated by a referral initiator	Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROVIDER REFERRER	1.0	Essential	If referral initiator is a healthcare provider, e.g. GP.	Single
	ALTERNATIVE REFERRER	1.0	Conditional	If referral initiator is Participant other than Healthcare Provider	Single
	Requested Service Description (display name = Service Requested or Service Description)	1.0	Desirable		Single
	Reason for Referral	1.0	Essential		Single

PROVIDER REFERRER

1. Identification

Name	PROVIDER REFERRER
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20126 *External Identifier* AS4846 -2006
Version	1.0

2. Definition

Definition	Details pertaining to the identification of the party (provider person or organisation) who made the orginal request for service provision.
Definition Source	NEHTA
Synonymous Names	Original Referrer
Scope	
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	ORIGINAL REFERRAL	1.0	Desirable		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	REFERRER IDENTIFIER	1.0	Desirable		Single
	REFERRERS NAME	1.0	Essential	If referral/request is initiated by a Healthcare Provider	Single

	REFERRER ORGANISATION	1.0	Conditional	Required if Provider person details not populated	Single
	ORGANISATION NAME	1.0	Conditional	Required if Provider person data not populated	Single
	ELECTRONIC COMMUNICATION DETAILS	1.0	Desirable (Telephone) / Optional (Fax/ Email)		Single

REFERRER IDENTIFIER

1. Identification

Name	REFERRER IDENTIFIER
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20127 *External Identifier* AS 4846 - 2006
Version	1.0

2. Definition

Definition	A unique number or code issued for the purpose of identifying a healthcare provider Individual (person). *The combination of any Healthcare Provider Individual Identifier Designation, Healthcare Provider Identifier Issuer and Healthcare Provider Identifier Type should uniquely identify an individual Healthcare Provider.*
Definition Source	Standards Australia AS 4846 - 2006 (Healthcare Provider Identification)
Synonymous Names	Healthcare Provider Identifier - Individual Individual Healthcare Provider Index Individual Healthcare Provider Identifier HPI-I
Scope	Used in healthcare setting. Captures the Unqiue Healthcare Provider Person/Individual Identification Number value assigned to the person as a participant (provider) in the healthcare event or within the healthcare system. The healthcare provider person identification number is unique within the organisation, establishment or agency at present. It is intended that this identifier will be nationally unique when NEHTA has completed the design of the national identifier systems. In the Discharge Summary, this data group name (HEALTHCARE PROVIDER IDENTIFER - INDIVIDUAL) is not generally displayed. Instead, the Healthcare Provider Individual Identifier Type data element value is displayed: e.g. HPI-I (display name) - is used in the Referral. Standards Australia AS 4846 - 2006 (Healthcare Provider Identification) document specifies that currently a number of identifier systems can be used to identify a healthcare provider (person): (i) Staff ID Code/Employee Number. (ii) Identifiers assigned by regulatory bodies for professional registration (e.g. an identifier assigned to an individual general practitioner by a State/Territory Medical Registration Board). (iii) Identifiers assigned by government agencies or other regulatory bodies for restricted purposes only e.g. Medicare Provider Number(s), Medicare Prescriber Number(s). (iv) Professional Organization Membership Number (e.g. Medical Directory Australia number [MDA number], Physiotherapy Association of Australia Registration Number). (v) Australian Business Number or Licience Number (for provider organisations/facility). A unique national health provider identifier can be issued by NEHTA to each healthcare provider person or facility. Section 2, P.17 of AS 4846 - 2006 defines a three-data element Healthcare Provider Identifier for individual provider (person): (a) Healthcare Provider Identifier Designation (the number or alpha numeric code assigned to a Healthcare Provider person) (b) Healthcare Provider Identifer Type (e.g. HPI-I, Staff ID) (c) Healthcare Provider Identifier Issuer (e.g. Medicare)
Scope Source	NEHTA and Standards Australia
Assumptions	
Examples	

3. Usage

Conditions of Use	Used to uniquely identify a Provider (person) of care within a local organisation, establishment or agency.

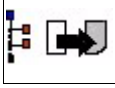
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	PROVIDER REFERRER	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	HEALTHCARE PROVIDER INDIVIDUAL IDENTIFIER TYPE (e.g. HPI) (see external reference for full specification AS 4846 - 2007)	1.0	Essential		Single
	HEALTHCARE PROVIDER INDIVIDUAL IDENTIFIER DESIGNATION (see external reference for full specification AS 4846 - 2006: Healthcare Provider Identifier Designation)	1.0	Essential		Single
	HEALTHCARE PROVIDER INDIVIDUAL IDENTIFIER ISSUER (see external reference for full specification AS 4846 - 2006: Healthcare Provider Identifier Issurer)	1.0	Essential		Single

See PROVIDER ORGANISATION IDENTIFICATION

REFERRERS NAME

1. Identification

Name	REFERRERS NAME
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20128 *External Identifier* AS4846 - 2006
Version	1.0

2. Definition

Definition	An appellationname by which an individual (person) is called within a social context.
Definition Source	Adapted from NEHTA and Standards Australia AS 5017 - 2006 (Healthcare Client Identification) and AS 4846 - 2006 (Healthcare Provider Identification) and AS 5017 - 2006 (Healthcare Client Identification) documents
Synonymous Names	
Scope	Used in the Healthcare setting. Captures the name details of a person (healthcare client or healthcare provider). The AS 4846 - 2006 Section 3, P.23 defines the Healthcare Provider (person) name, and AS 5017 - 2006 Section 3, P.35 defines the Healthcare Client name as a composit data consisting of the following data elements • Name Title • Name Title Sequence Number • Family Name • Gven Name • Gven Name Sequence Nuimber • Name Suffix • Name Suffix Sequence Number • Name Usage • Name Usage Start Date • Name Usage Start Date Accuracy Indicator • Name Usage End Date • Name Usage End Date Accuracy Indicator • Preferred Name Indicator • Name Conditional Usuage Flag In the context of discharge summary, it is recommended that the following four Person Name data elements are included in the PERSON NAME data group: • Name title • Family name • Given names • Name suffix
Scope Source	
Assumptions	
Examples	

3. Usage

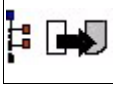
Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	PROVIDER REFERRER	1.0	Essential		Single

Children

See Provider Name

REFERRER ORGANISATION

1. Identification

Name	REFERRER ORGANISATION
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20129 *External Identifier* AS 4846 - 2006
Version	1.0

2. Definition

Definition	A unique number or code issued for the purpose of identifying a healthcare provider organisation entity or facility. *The combination of any Healthcare Provider Organisation Identifier Designation, Healthcare Provider Organisation Identifier Geographic Area, Healthcare Provider Organisation Identifier Issuer and Healthcare Provider Organisation Identifier Type should uniquely identify an individual Healthcare Provider Organisation entity or facility*
Definition Source	Standards Australia AS 4846 - 2006 (Healthcare Provider Identification)
Synonymous Names	Healthcare Organisation Identifier Healthcare Provider Organisation Identifier HPI-O
Scope	Used in healthcare setting. Captures the Unqiue Organization Identification Number value assigned to an Organisation involved in delivery of healthcare services within the healthcare system. In the Discharge Summary, this data group is not generally displayed. Instead, the Healthcare Organisation Identifier Name data element value is displayed.
Scope Source	NEHTA and Standards Australia
Assumptions	

3. Usage

Conditions of Use	Used to uniquely identify a subject of care within a local organisation, establishment or agency.
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROVIDER REFERRER	1.0	Conditional	If referrer is a healthcare provider organisation; and if unique identifier is available	Single

Children

See HEALTHCARE PROVIDER IDENTIFIER - ORGANISATION

ALTERNATIVE REFERRER

1. Identification

Name	ALTERNATIVE REFERRER
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20132 *External Identifier*
Version	1.0

2. Definition

Definition	Details pertaining to the identification of party other than Healthcare Provider or Healthcare Provider Facility/Organisation who/which is making a request for service provision.
Definition Source	NEHTA
Synonymous Names	Referred by (display name - used in Discharge Summary mock-up document) Other Referrer Other Referring Party
Scope	For use in the healthcare setting. Captures identification information on the non- Healthcare Provider Person/Facility who/which initiated a service provision (e.g. referral) request.
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	Referrals are generally considered to be initiated by a qualified medical practitioner. However, patients may be "referred" to a hospital by social workers, courts of law, carers and other categories. These alternative referrers will be unlikely to be registered with a national health provider identifier
Conditions of Use Source	
Misuse	

4. Data Flow

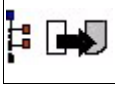
Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	ORIGINAL REFERRAL	1.0	Conditional	If referral or service request is made by non-healthcare provider or organisation	Single

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	REFERRERS NAME	1.0	Essential	If referral/request is initiated by a Healthcare Provider	Single

	ORGANISATION NAME	1.0	Conditional	Required if initaitor person data not populated	Single
	ELECTRONIC COMMUNICATION DETAILS (display name = Telephone and Fax/ Email)	1.0	Desirable for Telephone number. Optional for Fax/Email.	Optional (Telephone); Optional (Fax/ Email)	Single
	Relationship to Subject of Care (display name = Relationship)	1.0	Desirable		Single

Relationship to Subject of Care

1. Identification

Name	Relationship to Subject of Care	
Meta-data Type	Data Element	
Identifier	DE-20116	*External Identifier*
Version	1.0	

2. Definition

Definition	Descriptor that specifies the relationship of a participant to the subject of care
Definition Source	NEHTA
Synonymous Names	Relationship to Consumer Relationship to Patient Relationship
Context	
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	Relationship to Subject of Care Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Carer
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	ALTERNATIVE REFERRER	1.0	Essential		Single

Relationship to Subject of Care Values

1. Identification

Name	Relationship to Subject of Care Values
Meta-data Type	Value Domain
Identifier	
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Relationship to Subject of Care	1.0	Essential		Single

Requested Service Description

1. Identification

Name	Requested Service Description	
Meta-data Type	Data Element	
Identifier	DE-20117	*External Identifier*
Version	1.0	

2. Definition

Definition	An agreed statement of the type(s) of service requested for, or provided to, the subject of care.
Definition Source	NEHTA
Synonymous Names	Service Requested (display name in dischagre summary mockup document)
Scope	For use in healthcare setting. Used to identify diagnostic, clinical procedures or clinical management requested by the healthcare provider to be undertaken on/provided to the subject of care.
Scope Source	
Assumptions	
Data Type	CodeableText
Value Domain	Requested Service Description Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Dialysis Example 2) Adjustment of heart failure/hypertensive medications Example 3) Adjust INR to therapeutic range, etc
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	ORIGINAL REFERRAL	1.0	Desirable		Single
	REQUESTED SERVICE	1.0	Essential		Single

Requested Service Description Values

1. Identification

Name	Requested Service Description Values
Meta-data Type	Value Domain
Identifier	VD-20117
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Requested Service Description	1.0	Essential		Single

Reason for Referral

1. Identification

Name	Reason for Referral	
Meta-data Type	Data Element	
Identifier	DE-20118	*External Identifier*
Version	1.0	

2. Definition

Definition	A clinical description of reason(s) a service is being requested or received.
Definition Source	NEHTA
Synonymous Names	Reason for Referral Reason for Requesting Service
Scope	For use in healthcare setting. In the context of discharge summary, this data element captures information about problems/ issues experienced by the subject of care as identified by the referral initiator. It may be used to communicate/describe to the hospital the reason(s) why the patient was referred.
Scope Source	
Assumptions	
Data Type	CodeableText
Value Domain	Reason for Referral Values

3. Usage

Conditions of Use	See also Reason for Encounter
Conditions of Use Source	
Examples	Example 1) To rule out ischaemic heart disease Example 2) To rule out organic brain lesions
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	ORIGINAL REFERRAL	1.0	Desirable		Single

Reason for Referral Values

1. Identification

Name	Reason for Referral Values
Meta-data Type	Value Domain
Identifier	VD-20118
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Reason for Referral	1.0	Essential		Single

DISCHARGE

1 Identification

Name	DISCHARGE	
Meta-data Type	Data Group	
Identifier	DG-20136	*External Identifier*:
Version	1.0	

2 Definition

Definition	Details relevant to the discharge of a subject of care from a healthcare organisation.
Definition Source	NEHTA
Synonymous Names	Separation
Scope	For use in healthcare setting. Captures details about the discharge of patient from the healthcare facility at conclusion of the healthcare event or encounter. NOTE - The data group contains the following data group/elements: • DateTime End (display name = Discharge DateTime) • Discharge Reason • Discharge Destination • Discharge to Address This data group which can be considered as equivlaent to a Discharge Context section in the discharge summary is not display on the discharge summary to avoid repetition. Rather the Discharge Date, Discharge Reason, Discharge Destination, and Address (if discharge address is different from patient's residential address) are displayed.
Scope Source	
Assumptions	

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	Used to specify medication prescriptions or diagnostic test requests.

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parent

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY	1.0	Essential		Multiple

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	DateTime Discharged	1.0	Essential		Single
	Discharge Reason	1.0	Essential		Single
	Discharge Destination	1.0	Essential		Single
	Discharge To Address	1.0	Optional	Required if Discharge to Address is different from patient's home address	Single

DateTime Discharged

1. Identification

Name	DateTime Discharged	
Meta-data Type	Data Element	
Identifier	DE-20120	*External Identifier*
Version	1.0	

2. Definition

Definition	The date or date and time at which the subject of care is discharged/released from the healthcare facility; or date/time at which the healthcare event/encounter in question ceased.
Definition Source	NEHTA
Synonymous Names	Discharge Date Discharge Date and Time
Scope	For use at the healthcare setting. Used to denote the date or date and time at which the subject of care is released/discharged from the healthcare facility at completion of a healthcare event/encounter.
Scope Source	
Assumptions	
Data Type	DateTime
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) 31/03/2004 Example 2) 03/2004 Example 3) 2004 Example 4) 31/03/2004 13:10
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	DISCHARGE	1.0	Essential		Single

Discharge Reason

1. Identification

Name	Discharge Reason	
Meta-data Type	Data Element	
Identifier	DE-20121	*External Identifier*
Version	1.0	

2. Definition

Definition	The status at separation of a person (subject of care) from an organisation.
Definition Source	NEHTA
Synonymous Names	reason for discharge
Scope	
Scope Source	
Assumptions	
Data Type	CodeableText
Value Domain	Discharge Reason Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	routine discharge discharge against medical advise
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	DISCHARGE	1.0	Essential		Single

Discharge Reason Values

1. Identification

Name	Discharge Reason Values
Meta-data Type	Value Domain
Identifier	VD-20121
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Discharge Reason	1.0	Essential		Single

Discharge Destination

1. Identification

Name	DISCHARGE DESTINATION	
Meta-data Type	Data Element	
Identifier	DE-20122	*External Identifier*
Version	1.0	

2. Definition

Definition	A description of the type and/or name of destination/location to which the subject of care is discharge at the end of the healthcare event/visit.
Definition Source	NEHTA
Synonymous Names	Discharge Location Type
Scope	
Scope Source	
Assumptions	
Data Type	CodeableText
Value Domain	Discharge Destination Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Home, self Example 1) Home, care of others Example 1) Reahbilitation Facility Example 1) Age Care Facility
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	DISCHARGE	1.0	Essential		Single

Discharge Destination Values

1. Identification

Name	Discharge Destination Values
Meta-data Type	Value Domain
Identifier	VD-20122
Version	1.0

2. Definition

Definition	Values to describe the type and/or name of destination/location to which the subject of care is discharge at the end of the healthcare event/visit.
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Discharge Destination	1.0	Essential		Single

Discharge To Address

1. Identification

Name	Discharge To Address	
Meta-data Type	Externally sourced Data Group specification	
Identifier	DG-20137	*External Identifier*
Version	1.0	

2. Definition

Definition	The referential description of a location where an entity (person or organisation) is located or can be otherwise reached or found.
Definition Source	
Synonymous Names	Discharge to address
Scope	Used in the healthcare setting. Captures detail information on the address to which the subject of care is discharged to. Use in the event that the "discharged to" address may often be different from the subject of care's address of usual residence. For example, the subject of care might be discharged to an aged care facility, or to a relative or carer's place of residence for continual care. A personal (Healthcare Client) Address is a composite data element that is captured through the combination of nine data elements. These nine data elements are set out in Table 9 and Figure 8 of Standards Australia AS5017 - 2006: • Address line (Buidling/Complex Sub-Unit Type - Abbreviation; Building/Complex Sub-Unit Number; Building/Property Name; Floor/Level Number; Floor/Level Type; House/Property Number; Lot/Section Number; Street Name; Street Type Code; Street Suffix Code) • Suburb/Town/Locality • Australian State/Territory Identifier - Postal • Non-Australian State/Province • Postcode - Australia • Postcode - International • Delivery Point Identifier • Country Identifier • Address Type (Address Type Start Date + Date Accuracy Indicator; Address Type End Date + Date Accuracy Indicator) A Healthcare Provider Address is a composite data element that is captured through the combination of eleven data elements as set out in Table 8 and Figure 5 of Standards Australia AS 4846 - 2006. Nine data elements are identical as Address components for Healthcare Client. Two additional data elements include: • Healthcare Provider Identifier Linkage Key • Healthcare Provider Organisation Identifier Linkage Key In the context of discharge summary, it is recommended that the following Address data elements from AS5017, AS4846 are included in this data group: • Address Line • Suburb/Town/Locality • Non-Australian State/Province • Postcode - Australia / Postcode - International • Country Identifier • Country (Country Name)
Scope Source	
Assumptions	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	DISCHARGE	1.0	Optional	Required if Discharged to Address is not the same as patient's residential address	Single

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	AUSTRALIAN ADDRESS LINE (see external reference for full sepcification: AS 5017 - 2006; AS 4846 - 2006)	1.0	Essential		Single
	AUSTRALIAN SUBURB/TOWN/LOCALITY (see external reference for full sepcification: AS 5017 - 2006;AS 4846 - 2006)	1.0	Essential		Single
	AUSTRALIAN STATE/PROVINCE (see external reference for full sepcification: AS 5017 - 2006; AS 4846 - 2006)	1.0	Optional		Single
	AUSTRALIAN POSTCODE (see external reference for full sepcification: AS 5017 - 2006; AS 4846 - 2006)	1.0	Optional	Essential/Desirable for Australian addresses	Single
	INTERNATIONAL ADDRESS LINE (see external reference for full sepcification: AS 5017 - 2006; AS 4846 - 2006)	1.0	Conditional	If Subject of Care has international address	Single
	INTERNATIONAL SUBURB/TOWN/LOCALITY (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	If Subject of Care has international address	Single
	INTERNATIONAL STATE/PROVINCE (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	If Subject of Care has international address	Single
	INTERNATIONAL POSTCODE (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	If Subject of Care has international address	Single
	COUNTRY IDENTIFIER (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	If Subject of Care has international address	Single
	COUNTRY (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	Essential for International addresses	Single

USUAL GENERAL PRACTIONER

1 Identification

Name	USUAL GENERAL PRACTIONER	
Meta-data Type	Event Summary Section	
Identifier	S-20102	*External Identifier*
Version	1.0	

2 Definition

Definition	A section that groups together identification details of the usual general practitioner responsible for the providing health services to the subject of care. It includes identification details of the general practitioner and his/her organisation details.
Definition Source	NEHTA
Synonymous Names	Patient's Usual General Practitioner (Display name)
Scope	
Scope Source	
Assumptions	

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY	1.0	Desirable	Required if subject of care has/has nominated a GP	Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	HEALTHCARE PROVIDER IDENTIFICATION: USUAL GENERAL PRACTITIONER	1.0	Essential		Single

HEALTHCARE PROVIDER IDENTIFICATION: USUAL GENERAL PRACTITIONER

1. Identification

Name	HEALTHCARE PROVIDER IDENTIFICATION: USUAL GENERAL PRACTITIONER
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20138 *External Identifier*
Version	1.0

2. Definition

Definition	Details pertaining to the identification of the healthcare provider person or organisation who/ that is assocaited with the delivery of healthcare to a client/subject of care. In this case, it refers to the General Practitioner provider and/or the General Practitioner clinic/facility.
Definition Source	NEHTA
Synonymous Names	Usual General Practitioner Usual GP
Scope	For use in the healthcare setting. Captures identification information on the Healthcare Provider (General Practitioner) Person and/or Facility. NOTE - This data group name is used as a grouper to hold together General Practitioner details. It is not displayed on Discharge Summary. Instead, its data element members are displayed. Based on stakeholder feedbacks, the following Healthcare Client and Provider Identification data elements should be included as Registrar details: Person Name (First name, middle name/initial, Family name) - Obligation = Essential Healthcare Provider Identifier - Individual (HPI-I) : Obligation = Desirable Organisation Name - Obligation = Conditional (if patient is under care of the GP clinic instead of GP) Healthcare Provider Identifier - Organisation (HPI-O) : Obligation = Conditional (if patient is under care of GP Clinic and HPI available) Address (can be GP or Organisation address) - Obligation = Desirable/Conditional Telephone - Obligation = Desirable Fax/Email - Oblgiation = Optional
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	USUAL GENERAL PRACTIONER	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	HEALTHCARE PROVIDER IDENTIFIER - INDIVIDUAL	1.0	Desirable	Required if available	Single
	Provider Name	1.0	Essential		Single
	PROVIDER ORGANISATION IDENTIFICATION	1.0	Conditional	If the primary care provider is a GP practice instead of a provider person.	Single
	ORGANISATION NAME	1.0	Conditional	'If the primary care provider is a GP practice instead of a provider person.	Single
	ADDRESS	1.0	Desirable		Single
	ELECTRONIC COMMUNICATION DETAILS (display name = Telephone and Fax/Email)	1.0	Desirable	Desirable (Telephone). Optional (Fax/Email).	Single

DISCHARGE SUMMARY RECIPIENTS

1 Identification

Name	DISCHARGE SUMMARY RECIPIENTS	
Meta-data Type	Event Summary Section	
Identifier	S-20103	*External Identifier*
Version	1.0	

2 Definition

Definition	A section that groups information about person and/organisation recipients of the discharge summary.
Definition Source	NEHTA
Synonymous Names	
Scope	For use in healthcare setting. Captures details of Discharge Summary Recipients who/which can be: • Healthcare Provider person and/or organisations (including patient's GP) • Other participants who/which are non-healthcare professionals (persons or organisations) but are involved in the care of or has/have an interest in the well being of the patient • The subject of care As each copy of the Discharge Summary is sent to one recipient, only one set of recipient details will appear on each discharge summary.
Scope Source	NEHTA
Assumptions	

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	Details of clinical information about a subject of care specific to a particular healthcare event/visit

4 Data Flow

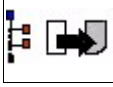
Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	SUBJECT OF CARE RECIPIENT (non displayed data group name. Patient/ Healthcare Client recipient of discharge summary)	1.0	Desirable		Single
	PROVIDER RECIPIENT (non displayed data group name)	1.0	Essential		Multiple
	OTHER RECIPIENT (non displayed data group name)	1.0	Optional		Multiple

SUBJECT OF CARE RECIPIENT

1. Identification

Name	SUBJECT OF CARE RECIPIENT
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20139 *External Identifier* AS 5017-2006
Version	1.0

2. Definition

Definition	Details pertaining to the identification of the healthcare client (subject of care) about whom the healthcare event/visit information has been captured and/or interchanged, and who is designated as a recipient of a copy of the discharge summary.
Definition Source	NEHTA
Synonymous Names	Subject of Care Recipient
Scope	For use in the healthcare setting. Captures identification information about the subject of care who is also the recipient of a copy of the discharge summary. Based on stakeholder feedback, the following Healthcare Client Identification data elements should be included: • Person Identifiers: Person Identifier Name - Obligation = Essential; Person Identifier Designation - Obligation = Desirable • Person Name (First name, middle name/initial, Family name) - Obligation = Essential • Address - Obligation = Essential • Date of Birth - Obligation = Essential • Age - Obligation = Desirable • Sex - Obligation = Essential Given that the Subject of Care details are captured within the HEALTH EVENT CONTEXT data group, only the name of the Subject of Care needs to be included to identify the person as the recipient of a copy of discharge summary.
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
S	DISCHARGE SUMMARY RECIPIENTS	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	PERSON NAME	1.0	Essential		Single

PROVIDER RECIPIENT

1. Identification

Name	PROVIDER RECIPIENT
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20149 *External Identifier*
Version	1.0

2. Definition

Definition	Details pertaining to the identification of an individual or organisation who/which is involved in or associated with the delivery of healthcare to a client, or caring for client well being; and is designated as a recipient of a copy of the discharge summary to continue the care of the subject.
Definition Source	NEHTA
Synonymous Names	Discharge Summary Recipient
Scope	For use in the healthcare setting. Captures identification information on the Healthcare Provider Person or Organisation. NOTE - This data group name is used as a grouper to hold together details of the healthcare provider who receives a copy of the discharge summary. It is not displayed on Discharge Summary. Instead, its data element members are displayed. In the context of discharge summary, these include the recipient of the discharge summary.
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

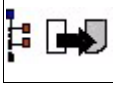
Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY RECIPIENTS	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	HEALTHCARE PROVIDER IDENTIFIER - INDIVIDUAL	1.0	Desirable	Required if available	Single
	PERSON NAME	1.0	Essential		Single
	HEALTHCARE PROVIDER IDENTIFIER - ORGANISATION	1.0	Conditional	Required if Provider person details not populated (i.e. Organisation provider is the recipient)	Single
	ORGANISATION NAME	1.0	Conditional	Required if Provider person data not populated	Single
	ADDRESS	1.0	Desirable		Single
	ELECTRONIC COMMUNICATION DETAILS (display name = Telephone and Fax/Email)	1.0	Optional (telephone), Optional (Fax/ Email).		Single

Other Recipient

1. Identification

Name	OTHER RECIPIENT
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20141 *External Identifier*
Version	1.0

2. Definition

Definition	Details pertaining to the identification of an individual or organisation associated with a potential or actual subject of care, who is designated to receive a copy of the discharge summary.
Definition Source	NEHTA
Synonymous Names	Other Recipient Discharge Summary Recipient: Other Party Recipient of Discharge Summary Recipient
Scope	For use in the healthcare setting. Captures identification information on the non- Healthcare Provider Person/Facility who/which receives a copy of the discharge summary because the person or facility is associated with provision of care/service to the subject of care. NOTE - This data group name is used as a grouper to hold together details of the non-healthcare provider who initiated the referral. It is not displayed on Discharge Summary. Instead, its data element members are displayed.
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY RECIPIENTS	1.0	Optional		Multiple

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	PERSON NAME	1.0	Essential	If discharge recipient is initiated by a Healthcare Provider	Single
	ORGANISATION NAME	1.0	Conditional	Required if recipient person is associated with an organisation; or the recipient is a non-health provider organisation	Single
	ADDRESS	1.0	Desirable		Single
	ELECTRONIC COMMUNICATION DETAILS (display name = Telephone and Fax/ Email)	1.0	Optional	Optional (Telephone); Optional (Fax/ Email)	Single
	Relationship to Subject of Care (display name = Relationship)	1.0	Desirable		Single

Relationship to Subject of Care

1. Identification

Name	Relationship to Subject of Care	
Meta-data Type	Data Element	
Identifier	DE-20125	*External Identifier*
Version	1.0	

2. Definition

Definition	Descriptor that specifies the relationship of a participant to the subject of care
Definition Source	NEHTA
Synonymous Names	Relationship to Consumer Relationship to Patient Relationship
Context	
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	Relationship to Subject of Care Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	ALTERNATIVE REFERRER	1.0	Essential		Single
	OTHER RECIPIENT	1.0	Essential		Single

Relationship to Subject of Care Values

1. Identification

Name	Relationship to Subject of Care Values
Meta-data Type	Value Domain
Identifier	VD-20125
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Relationship to Subject of Care	1.0	Essential		Single

PROBLEMS/DIAGNOSES THIS VISIT

1 Identification

Name	PROBLEMS/DIAGNOSES THIS VISIT	
Meta-data Type	Event Summary Section	
Identifier	S-20104	*External Identifier*
Version	1.0	

2 Definition

Definition	A section that groups together the diagnostic labels or problem statements assigned by the healthcare provider to describe the principal and secondary diagnoses, health/medical problems pertaining to the subject of care during a healthcare event/visit, and complications that the subject of care might have sufferred during the same healthcare event/visit.
Definition Source	NEHTA
Synonymous Names	Problems/Diagnoses:This Admission Problems/Diagnoses During This Visit Problems/Diagnosis During This Admission
Scope	For use in healthcare setting. NOTE: the Section label Problems/Diagnoses This Visit is intended for use in a discharge summary both for an **Admitted Patient** or **ED Visit.** Therefore the generic term **This Visit** is used. For **Admitted Patient**, a more specific section display name of **PROBLEMS/DIAGNOSES: This Admission** may be used in the Discharge Summary.
Scope Source	NEHTA
Assumptions	

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	PRINCIPAL PROBLEM/DIAGNOSIS	1.0	Essential		Single

	SECONDARY PROBLEM/DIAGNOSIS	1.0	Optional		Single
	ASSOCIATED PROBLEMS	1.0	Optional		Single
	COMORBIDITIES	1.0	Optional		Single
	COMPLICATIONS	1.0	Optional		Single

PRINCIPAL PROBLEM/DIAGNOSIS

1 Identification

Name	PRINCIPAL PROBLEM/DIAGNOSIS	
Meta-data Type	Event Summary Section	
Identifier	S-20105	*External Identifier*
Version		

2 Definition

Definition	A grouping describing a diagnostic label or problem statement assigned by the healthcare provider to describe the principal diagnosis or health/medical problem pertaining to the subject of care during a healthcare event/visit. **Diagnosis:** a concise technical description of medical condition/problem or situation pertaining to a subject of care. The decision to apply the diagnositc label or problem description/ statement by the healthcare provider is based on his/her assessment and interpretation of the cause, nature, or manifestation of the subject of care's medical/health condition(s). A diagnosis represents the nature and identification of a disease. **Problem:** a description of a subject of care's condition for which a specific diagnosis has not yet been identified.
Definition Source	NEHTA
Synonymous Names	Chief Complaint
Scope	For use in the healthcare setting. Used to identify the diagnosis/clinical problem(s) pertaining to a subject of care. Based on stakeholder feedbacks, the following Participant Identification data elements should be included: • Diagnosis Description - Obligation = Essential • DateTime:Start - Obligation = Desirable • Problem/Diagnosis Note = Optional • Problem/Diagnosis Awareness (of Subject of Care, Provider, and/or Other Participants) = Desirable Within the context of discharge summary, the ~Problem/Diagnosis data group is used to carry information about: • - Principal diagnosis • - Secondary diagnosis • - Complication • - Associated diagnosis/comorbidity NOTE - this data group name is used as a grouper for all data elements relevant to Clinical/ Health Problems or Diagnoses. In discharge sumary, this data group contains the following data elements/group: • Problem/Diagnosis Description • DateTiem Start • Problem/Diagnosis Note • Problem/Diagnosis Awareness The data group name PROBLEM/DIAGNOSIS is not displayed in discharge summary. What is displayed is the display name of Problem/Diagnosis Description (which is Problem/Diagnosis).
Scope Source	NEHTA
Assumptions	

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice

Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	PROBLEMS/DIAGNOSES THIS VISIT	1.0	Optional		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS	1.0	Desirable		Multiple

SECONDARY PROBLEM/DIAGNOSIS

1 Identification

Name	SECONDARY PROBLEM/DIAGNOSIS	
Meta-data Type	Event Summary Section	
Identifier	S-20106	*External Identifier*
Version		

2 Definition

Definition	A grouping describing a diagnostic label or problem statement assigned by the healthcare provider to describe the principal diagnosis or health/medical problem pertaining to the subject of care during a healthcare event/visit. **Diagnosis:** a concise technical description of medical condition/problem or situation pertaining to a subject of care. The decision to apply the diagnositc label or problem description/ statement by the healthcare provider is based on his/her assessment and interpretation of the cause, nature, or manifestation of the subject of care's medical/health condition(s). A diagnosis represents the nature and identification of a disease. **Problem:** a description of a subject of care's condition for which a specific diagnosis has not yet been identified.
Definition Source	NEHTA
Synonymous Names	Chief Complaint
Scope	For use in the healthcare setting. Used to identify the diagnosis/clinical problem(s) pertaining to a subject of care. Based on stakeholder feedbacks, the following Participant Identification data elements should be included: • Diagnosis Description - Obligation = Essential • DateTime:Start - Obligation = Desirable • Problem/Diagnosis Note = Optional • Problem/Diagnosis Awareness (of Subject of Care, Provider, and/or Other Participants) = Desirable Within the context of discharge summary, the ~Problem/Diagnosis data group is used to carry information about: • - Principal diagnosis • - Secondary diagnosis • - Complication • - Associated diagnosis/comorbidity NOTE - this data group name is used as a grouper for all data elements relevant to Clinical/ Health Problems or Diagnoses. In discharge sumary, this data group contains the following data elements/group: • Problem/Diagnosis Description • DateTiem Start • Problem/Diagnosis Note • Problem/Diagnosis Awareness The data group name PROBLEM/DIAGNOSIS is not displayed in discharge summary. What is displayed is the display name of Problem/Diagnosis Description (which is Problem/Diagnosis).
Scope Source	NEHTA
Assumptions	

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	PROBLEMS/DIAGNOSES THIS VISIT	1.0	Optional		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS	1.0	Desirable		Multiple

ASSOCIATED PROBLEMS

1 Identification

Name	ASSOCIATED PROBLEMS	
Meta-data Type	Event Summary Section	
Identifier	S-20108	*External Identifier*
Version		

2 Definition

Definition	A section that groups together the diagnostic labels or problem statements assigned by the healthcare provider to describe the diagnoses, health/medical problems or comorbidities pertaining to the subject of care, which were considered to be of clinical/health interest but might have little or no impact on the management or care of the subject during a healthcare event/visit.
Definition Source	NEHTA
Synonymous Names	
Scope	
Scope Source	
Assumptions	

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	PROBLEMS/DIAGNOSES THIS VISIT	1.0	Optional		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS	1.0	Desirable		Multiple

COMORBIDITIES

1 Identification

Name	COMORBIDITIES	
Meta-data Type	Event Summary Section	
Identifier	S-20108	*External Identifier*
Version		

2 Definition

Definition	A section that groups together the diagnostic labels or problem statements assigned by the healthcare provider to describe the diagnoses, health/medical problems or comorbidities pertaining to the subject of care, which were considered to be of clinical/health interest but might have little or no impact on the management or care of the subject during a healthcare event/visit.
Definition Source	NEHTA
Synonymous Names	
Scope	
Scope Source	
Assumptions	

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	PROBLEMS/DIAGNOSES THIS VISIT	1.0	Optional		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS	1.0	Essential		Multiple

COMPLICATIONS

1 Identification

Name	Complications	
Meta-data Type	Event Summary Section	
Identifier	S-20107	*External Identifier*
Version		

2 Definition

Definition	A grouping describing a diagnostic label or problem statement assigned by the healthcare provider to describe the principal diagnosis or health/medical problem pertaining to the subject of care during a healthcare event/visit. **Diagnosis:** a concise technical description of medical condition/problem or situation pertaining to a subject of care. The decision to apply the diagnositc label or problem description/ statement by the healthcare provider is based on his/her assessment and interpretation of the cause, nature, or manifestation of the subject of care's medical/health condition(s). A diagnosis represents the nature and identification of a disease. **Problem:** a description of a subject of care's condition for which a specific diagnosis has not yet been identified.
Definition Source	NEHTA
Synonymous Names	Chief Complaint
Scope	For use in the healthcare setting. Used to identify the diagnosis/clinical problem(s) pertaining to a subject of care. Based on stakeholder feedbacks, the following Participant Identification data elements should be included: • Diagnosis Description - Obligation = Essential • DateTime:Start - Obligation = Desirable • Problem/Diagnosis Note = Optional • Problem/Diagnosis Awareness (of Subject of Care, Provider, and/or Other Participants) = Desirable Within the context of discharge summary, the ~Problem/Diagnosis data group is used to carry information about: • - Principal diagnosis • - Secondary diagnosis • - Complication • - Associated diagnosis/comorbidity NOTE - this data group name is used as a grouper for all data elements relevant to Clinical/ Health Problems or Diagnoses. In discharge sumary, this data group contains the following data elements/group: • Problem/Diagnosis Description • DateTiem Start • Problem/Diagnosis Note • Problem/Diagnosis Awareness The data group name PROBLEM/DIAGNOSIS is not displayed in discharge summary. What is displayed is the display name of Problem/Diagnosis Description (which is Problem/Diagnosis).
Scope Source	NEHTA
Assumptions	

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	PROBLEMS/DIAGNOSES THIS VISIT	1.0	Optional		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS	1.0	Desirable		Multiple

PROBLEM/DIAGNOSIS

1 Identification

Name	Problem/Diagnosis	
Meta-data Type	Event Summary Section	
Identifier	DG-20146	*External Identifier*
Version		

2 Definition

Definition	A grouping describing a diagnostic label or problem statement assigned by the healthcare provider to describe the principal diagnosis or health/medical problem pertaining to the subject of care during a healthcare event/visit. **Diagnosis:** a concise technical description of medical condition/problem or situation pertaining to a subject of care. The decision to apply the diagnositc label or problem description/ statement by the healthcare provider is based on his/her assessment and interpretation of the cause, nature, or manifestation of the subject of care's medical/health condition(s). A diagnosis represents the nature and identification of a disease. **Problem:** a description of a subject of care's condition for which a specific diagnosis has not yet been identified.
Definition Source	NEHTA
Synonymous Names	Chief Complaint
Scope	For use in the healthcare setting. Used to identify the diagnosis/clinical problem(s) pertaining to a subject of care. Based on stakeholder feedbacks, the following Participant Identification data elements should be included: • Diagnosis Description - Obligation = Essential • DateTime:Start - Obligation = Desirable • Problem/Diagnosis Note = Optional • Problem/Diagnosis Awareness (of Subject of Care, Provider, and/or Other Participants) = Desirable Within the context of discharge summary, the ~Problem/Diagnosis data group is used to carry information about: • - Principal diagnosis • - Secondary diagnosis • - Complication • - Associated diagnosis/comorbidity NOTE - this data group name is used as a grouper for all data elements relevant to Clinical/ Health Problems or Diagnoses. In discharge sumary, this data group contains the following data elements/group: • Problem/Diagnosis Description • DateTime Start • Problem/Diagnosis Note • Problem/Diagnosis Awareness The data group name PROBLEM/DIAGNOSIS is not displayed in discharge summary. What is displayed is the display name of Problem/Diagnosis Description (which is Problem/Diagnosis).
Scope Source	NEHTA
Assumptions	

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	PRINCIPAL PROBLEM/DIAGNOSIS	1.0	Essential		Single
	SECONDARY PROBLEM/DIAGNOSIS	1.0	Essential		Single
	ASSOCIATED PROBLEMS	1.0	Essential		Single
	COMORBIDITIES	1.0	Essential		Single
	COMPLICATIONS	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	Problem/Diagnosis Description	1.0	Essential		Single
	Date Problem Started	1.0	Desirable		Single
	Problem/Diagnosis Note	1.0	Optional		Single
	Problem/Diagnosis Awareness	1.0	Desirable		Multiple

Problem/Diagnosis Description

1. Identification

Name	Problem/Diagnosis Description	
Meta-data Type	Data Element	
Identifier	DE-20126	*External Identifier*
Version	1.0	

2. Definition

Definition	A concise technical description or statement of problem/diagnosis or situation pertaining to the subject of care. The decision to apply the diagnositc label or problem description/statement by the healthcare provider is based on his/her assessment and interpretation of the cause, nature, or manifestation of the subject of care's medical/health condition(s). A diagnosis: represents the nature and identification of a disease. Problem: a description of a subject of care's condition for which a specific diagnosis has not yet been identified.
Definition Source	NEHTA
Synonymous Names	
Scope	
Scope Source	
Assumptions	
Data Type	CodeableText
Value Domain	Problem/Diagnosis Description Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	- Appendicitis - Acute myocardial infarction - Measle - Recurrent headaches - Acute abdominal pain - Acopia
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	PROBLEM/DIAGNOSIS	1.0	Essential		Single

Problem/Diagnosis Description Values

1. Identification

Name	Problem/Diagnosis Description Values
Meta-data Type	Value Domain
Identifier	VD-20126
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	Problem/Diagnosis Description	1.0	Essential		Single

Date Problem Started

1. Identification

Name	Date Problem Started	
Meta-data Type	Data Element	
Identifier	DE-20127	*External Identifier*
Version	1.0	

2. Definition

Definition	The start date or data and time that a subject of care's problem commenced.
Definition Source	NEHTA
Synonymous Names	
Scope	For use in the healthcare setting. Captures the date or the date and time values of - a diagnosis/problem or or adverse events (e.g. complication, adverse reaction, alert) experienced by the subject of care
Scope Source	
Assumptions	
Data Type	DateTime
Value Domain	

3. Usage

Conditions of Use	Often, an exact date is not possible to identify.
Conditions of Use Source	
Examples	Example 1) 31/03/2004 Example 2) 03/2004 Example 3) 2004 Example 4) 31/03/2004 13:10
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS	1.0	Optional		Single

Problem/Diagnosis Note

1. Identification

Name	Problem/Diagnosis Note	
Meta-data Type	Data Element	
Identifier	DE-20128	*External Identifier*
Version	1.0	

2. Definition

Definition	Free text comments provding additonal information relevant to the diagnoses/problems in question.
Definition Source	NEHTA
Synonymous Names	
Scope	Used in the healthcare setting. Captures additional information about the diagnoses/problems in question.
Scope Source	
Assumptions	
Data Type	Text
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS	1.0	Optional		Single

PROBLEM/DIAGNOSIS AWARENESS

1. Identification

Name	PROBLEM/DIAGNOSIS AWARENESS	
Meta-data Type	Data Group	
Identifier	DG-20147	*External Identifier*
Version	1.0	

2. Definition

Definition	An indication/specification of whether a person (which may be a subject of care or his/her relative or family member) is aware of a clinical diagnosis or health problem, or complications in question.
Definition Source	NEHTA
Synonymous Names	
Scope	For use in the healthcare setting. Captures detailed information about a subject's (healthcare provider, subject of care or persons related to the subject of care) awareness of a clinical diagnosis or health problem, or complications arising from the health event/encounter. NOTE - this data group name itself may not be displayed within the PROBLEM/DIAGNOSIS data group in the discharge summary. Instead, its data element members might be displayed: • Is Aware (displayed as Awareness) • Subject (displayed as Person) • Reason
Scope Source	NEHTA
Assumptions	

3. Usage

Conditions of Use	Recording a subject's awareness of clinical diagnosis or problem in question.
Conditions of Use Source	NEHTA
Examples	
Misuse	Recording of counselling or education details.

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS	1.0	Optional		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	Is Aware	1.0	Essential		Single

T/T010	Person Category	1.0	Essential		Single
T	Non-awareness Reason	1.0	Desirable		Single

Is Aware

1. Identification

Name	Is Aware	
Meta-data Type	Data Element	
Identifier	DE-20129	*External Identifier*
Version	1.0	

2. Definition

Definition	Denotes whether or not a subject is aware of the health/clinical problem or issue in question.
Definition Source	NEHTA
Synonymous Names	Awareness
Context	
Context Source	
Assumptions	
Data Type	Boolean
Value Domain	yes/no

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS AWARENESS	1.0	Optional		Single

Person Category

1. Identification

Name	Person Category	
Meta-data Type	Data Element	
Identifier	DE-20130	*External Identifier*
Version	1.0	

2. Definition

Definition	The category of a person that is associated with one or more healthcare event(s)/encounter(s).
Definition Source	NEHTA
Synonymous Names	Person (display name used in discharge summary mock-up document)
Context	In this case, the data element describes the relationship of a carer or agent of the subject of care in order to record whether the subject of care or the carer has an awareness of a condition.
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	Person Category Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1: Subject of Care Example 2: Spouse Example 3: Partner Example 4: Child Example 5: Grand child Example 6: Parent Example 7: Grand parent
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS AWARENESS	1.0	Optional		Single

Person Category Values

1. Identification

Name	Person Category Values
Meta-data Type	Value Domain
Identifier	VD-20130
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Person Category	1.0	Essential		Single

Non-awareness Reason

1. Identification

Name	Non-awareness Reason	
Meta-data Type	Data Element	
Identifier	DE-20131	*External Identifier*
Version	1.0	

2. Definition

Definition	The reason(s) certain actions have/have not been taken.
Definition Source	NEHTA
Synonymous Names	Reason for not being aware Reason (display name in discharge summary mockup document)
Context	In the context of situation awareness, the description provides the reason(s) the subject is or is not aware of the health/clinical problems, issues, procedures, etc in question.
Context Source	
Assumptions	
Data Type	Text
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1: Subject not informed at request of spouse Example 2: Family in opinion that patient is unable to cope with the impact/poor prognosis of diagnosis Example 3: Subject informed at request of patient/subject of care
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS AWARENESS	1.0	Optional		Single

PROCEDURES PERFORMED THIS VISIT

1 Identification

Name	PROCEDURES PERFORMED THIS VISIT	
Meta-data Type	Event Summary Section	
Identifier	S-20109	*External Identifier*
Version		

2 Definition

Definition	A section that groups together information about clinical procedures (excluding diagnostic procedures) or interventions performed on the subject of care during a healthcare visit/ encountered.
Definition Source	NEHTA
Synonymous Names	Procedure Performed:This Admission *(alternate display name - for use with "Admitted Patient", i.e. patient discharged after an ED encounter without admission to hospital)*
Scope	For use in healthcare settings. NOTE: This section label uses a generic term **This Visit** as the section label is intended for use in discharge summary for either **Admitted Patients** or **ED** Visits (for which the encounter is not considered as admission). For **Admitted Patient** this section label can be replaced with a more specific label, e.g. **PROCEDURES PERFORMED: This Admission.**
Scope Source	NEHTA
Assumptions	

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	Used to describe diagnostic procedures performed during visit/encounter.

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY	1.0	Desirable	Required if clinical procedure(s) was/were performed on the subject of care during the healthcare event/episode.	Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	CLINICAL INTERVENTION	1.0	Essential		Multiple

CLINICAL INTERVENTION

1. Identification

Name	CLINICAL INTERVENTION	
Meta-data Type	Data Group	
Identifier	DG-20150	*External Identifier*
Version	1.0	

2. Definition

Definition	An intervention carried out by a healthcare provider to improve, maintain or assess the health of a subject of care, in a clinical situation. Clinical interventions include invasive and non-invasive procedures, and cognitive interventions
Definition Source	METeOR glossary
Synonymous Names	Diagnostic intervention, Therapeutic intervention, Diagnostic procedure, Therapeutic procedure, Treatment, Procedure, Counselling, Advising
Scope	Used in healthcare setting. Captures detail information on past and present clinical interventions, as performed by a healthcare provider. In the context of Discharge Summary, it is used to capture information on therapeutic/ treatment proceudres during the healthcare visit/encounter and excluses diagnostic procedures . NOTE - This data group name is used as a grouper to associate data elements relevant to clinical procedures. It is not displayed in discharge summary. Instead, one of its data element members - Clinical Intervention Description is displayed and assumes the display name as Procedure.
Scope Source	NEHTA
Assumptions	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Creation of Arterio-venous shunt for heamodialysis Example 2) Peritoneal Dialysis
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	PROCEDURES PERFORMED THIS VISIT	1.0	Essential		Multiple

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	Clinical Intervention Description (display name = Procedure)	1.0	Essential		Single
	DateTime Performed	1.0	Desirable		Single
	Clinical Intervention Note (display name = Note)	1.0	Optional		Single
	CLINICAL INTERVENTION AWARENESS	1.0	Desirable		Multiple

Clinical Intervention Description

1. Identification

Name	Clinical Intervention Description	
Meta-data Type	Data Element	
Identifier	DE-20132	*External Identifier*
Version	1.0	

2. Definition

Definition	A description of the clinical procedure (diagnostic or interventional/therapeutic) undertaken on or provided to the subject of care. Used in healthcare setting. Captures information on past and present clinical interventions, as performed by a healthcare provider. In the context of Discharge Summary, it specifies therapeutic/treatment procedures performed during the healthcare visit/encounter (but excludes diagnostic procedures).
Definition Source	METeOR glossary
Synonymous Names	Diagnostic intervention, Therapeutic intervention, Diagnostic procedure, Therapeutic procedure, Treatment, Procedure, Counselling, Advising
Scope	For use in the healthcare setting.
Scope Source	NEHTA
Assumptions	
Value Domain	Clinical Intervention Description Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Creation of Arterio-venous shunt for heamodialysis Example 2) Peritoneal Dialysis
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	CLINICAL INTERVENTION	1.0	Essential		Single

Clinical Intervention Description Values

1. Identification

Name	Clinical Intervention Description Values
Meta-data Type	Value Domain
Identifier	VD-20132
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	Clinical Intervention Description	1.0	Essential		Single

DateTime Performed

1. Identification

Name	DateTime Performed	
Meta-data Type	Data Element	
Identifier	DE-20133	*External Identifier*
Version	1.0	

2. Definition

Definition	The Date or Date and Time a clinical intervention (i.e. clinical procedure such as dialysis, endoscopy, etc) is performed on the subject of care.
Definition Source	NEHTA
Synonymous Names	Date Performed Date and Time Performed Date Procedure Performed Date and Time Procedure Performed Date Test Performed Date and Time Test Performed
Scope	For use in the healthcare setting. Captures the date or the date and time values of a procedure or diagnostic test being performed.
Scope Source	
Assumptions	
Data Type	DateTime
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) 31/03/2004 Example 2) 03/2004 Example 3) 2004 Example 4) 31/03/2004 13:10
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	CLINICAL INTERVENTION	1.0	Desirable		Single

Clinical Intervention Note

1. Identification

Name	Clinical Intervention Note	
Meta-data Type	Data Element	
Identifier	DE-20134	*External Identifier*
Version	1.0	

2. Definition

Definition	Free text comments provding additonal information relevant to clinical procedures/ interventions in question.
Definition Source	NEHTA
Synonymous Names	
Scope	
Scope Source	
Assumptions	
Data Type	Text
Value Domain	

3. Usage

Conditions of Use	Used to provide additional information about the clinical procedure/intervention in question.
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	CLINICAL INTERVENTION	1.0	Optional		Single

CLINICAL INTERVENTION AWARENESS

1. Identification

Name	CLINICAL INTERVENTION AWARENESS	
Meta-data Type	Data Group	
Identifier	DG-20151	*External Identifier*
Version	1.0	

2. Definition

Definition	An indication/specification of whether a person (who may be the subject of care or his/her relative/family member) is aware of a clinical diagnosis or health problem, or complications in question.
Definition Source	NEHTA
Synonymous Names	Awareness of Procedure Performed Procedure Performed Awareness
Context	For use in the healthcare setting. Captures detailed information about a person's (healthcare provider, subject of care or persons related to the subject of care) awareness of clinical procedure(s) [excluding diagnostic procedures] performed during current healthcare event/ encounter.
Context Source	
Scope	NOTE - this data group name is also not displayed within the PROBLEM/DIAGNOSIS data group in the discharge summary. Instead, its data element members are displayed: - Is Aware (displayed as Awareness) - Subject (displayed as Person) - Reason
Scope Source	NEHTA
Assumptions	

3. Usage

Conditions of Use	Recording a subject's awareness of clinical diagnosis or problem in question.
Conditions of Use Source	NEHTA
Examples	
Misuse	Recording of counselling or education details.

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	CLINICAL INTERVENTION	1.0	Optional		Multiple

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	Is Aware	1.0	Essential		Single
	Person Category	1.0	Essential		Single
	Non-awareness Reason	1.0	Desirable		Single

Is Aware

1. Identification

Name	Is Aware	
Meta-data Type	Data Element	
Identifier	DE-20135	*External Identifier*
Version	1.0	

2. Definition

Definition	Denotes whether or not a subject is aware of the health/clinical problem or issue in question.
Definition Source	NEHTA
Synonymous Names	Awareness
Context	
Context Source	
Assumptions	
Data Type	Boolean
Value Domain	yes/no

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS AWARENESS	1.0	Essential		Single
	CLINICAL INTERVENTION	1.0	Essential		Single

Person Category

1. Identification

Name	Person Category	
Meta-data Type	Data Element	
Identifier	DE-20136	*External Identifier*
Version	1.0	

2. Definition

Definition	The relationship of the person whose awareness of a procedure is being assessed, to the subject of care.
Definition Source	NEHTA
Synonymous Names	Person (display name used in discharge summary mock-up document)
Context	
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	Person Category Values

3. Usage

Conditions of Use	In some cases of mental, cognitive or sensory impairment, the subject of care may not be the person being assessed for a level of awareness of a proposed intervention. This data element allows for the recording of the fact that a carer or agent was aware that a procedure or intervention has been undertaken on the subject of care.
Conditions of Use Source	
Examples	Example 1) Subject of Care Example 2) Spouse Example 3) Partner Example 4) Child Example 5) Grand child Example 6) Parent Example 7) Grand parent
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence

	PROBLEM/DIAGNOSIS AWARENESS	1.0	Essential		Single
	CLINICAL INTERVENTION	1.0	Essential		Single

Person Category Values

1. Identification

Name	Person Category Values
Meta-data Type	Value Domain
Identifier	VD-20136
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Person Category	1.0	Essential		Single

Non-awareness Reason

1. Identification

Name	Non-awareness Reason	
Meta-data Type	Data Element	
Identifier	DE-20137	*External Identifier*
Version	1.0	

2. Definition

Definition	Free text description of the reason(s) certain actions have/have not been taken.
Definition Source	NEHTA
Synonymous Names	Reason for not being aware Reason (display name in discharge summary mockup document)
Context	In the context of situation awareness, the description provides the reason(s) the subject is or is not aware of the health/clinical problems, issues, procedures, etc in question.
Context Source	
Assumptions	
Data Type	Text
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	- Subject not informed at request of spouse - Family in opinion that patient is unable to cope with the impact/poor prognosis of diagnosis - Subject informed at request of patient/subject of care
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS AWARENESS	1.0	Desirable		Single
	CLINICAL INTERVENTION	1.0	Essential		Single

DISCHARGE MEDICATIONS

1. Identification

Name	DISCHARGE MEDICATIONS	
Meta-data Type	Event Summary Section	
Identifier	S-20110	*External Identifier*
Version	1.0	

2. Definition

Definition	A section that groups together information about all medications prescribed to the subject of care as assessed at the time of discharge from a hospital. *Medication is defined as "a therapeutic good that is designed to achieve, or likely to achieve, its principal intended action by pharmacological, chemical, immunological or metabolic means in or on the body of subject of care".*
Definition Source	NEHTA
Synonymous Names	Discharge Medications; Medications on Discharge
Scope	The DISCHARGE MEDICATIONS section in a discharge summary includes: • Admission Medications - i.e. medications known on admission which are continued on discharge and • medications prescribed during encounter/admission which are continued on discharge. The "Admission Medications" included in this section include both those that are continued unchanged on discharge or continued with some changes on discharge.
Scope Source	NEHTA
Assumptions	

3. Usage

Conditions of Use	*see* Scope and *see also* MEDICATIONS CEASED THIS VISIT
Conditions of Use Source	
Misuse	Should not be used to list medications given to patient during the healthcare event/visit or to record medication history.

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	MEDICATION ITEM DETAILS	1.0	Essential		Multiple

MEDICATION ITEM DETAILS

1. Identification

Name	MEDICATION ITEM DETAILS
Meta-data Type	Data Group
Identifier	DG-20152 *External Identifier*
Version	1.0

2. Definition

Definition	Detailed description of a single, unique therapeutic good that may be listed within a prescription or dispensing medications, and may also appear within the current medications list and/or prescribing history of a subject of care.
Definition Source	NEHTA
Synonymous Names	Medication
Scope	Used in healthcare setting. Captures detail information on medications that were one or more of the following criteria:- • were prescribed or being taken at the time of admission; • were ceased or altered during the hospital encounter; • were prescribed during the hospital encounter and expected to be taken after discharge. NOTE - This data element name is used as a grouper to group together data elements relevant to capturing of medication item information. It is not displayed in discharge summary. Within the scope of Discharge Summary and Referral templates, the Medication Item will contain a subset of data items/elements from NEHTA's Medication Item Details superset. The chosen data elements were selected based on feedback from stakeholder consultation and will be displayed in any screen or paper rendition of the discharge summary: • Medication Product: Trade Product Name; Virtual Substance Name (Generic Name); Form; Strength • Medication Formulation: Formulation Name; Form • Dose • Frequency • Duration • Quantity • Route • Status • Change Description • Reason for Change • Subject of Care Instructions
Scope Source	
Assumptions	

3. Usage

Conditions of Use	This data group is repeated for every instance of a medication item being recorded.
Conditions of Use Source	NEHTA
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE MEDICATIONS	1.0	Essential		Multiple
	MEDICATIONS CEASED THIS VISIT		Essential		Multiple

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	Prescription Record Identifier (non displayed data element name)	1.0	Essential	Essential for Discharged Medication; Required for Ceased Medication only if the medication was prescribed during current healthcare event/encounter	Single
	Product Description	1.0	Conditional	Required if Abstract Prdouct, Trade Family and Forumation Name not populated. Not required if medication is a Formulation.	Single
	Abstract Product (display name = Generic Name)	1.0	Conditional	Required if Trade Family and Forumation Name not populated. Not required if medication is a Formulation.	Single
	Trade Family	1.0	Essential	Not required if Product Description, Abstract Product or Formulation Name is populated.	Single
	Formulation Name	1.0	Conditional	Required if prescribed medication is of Forumlation Medication category	Single
	Form	1.0	Essential		Single
	Strength	1.0	Essential	Essential for Discharged Medication; Diserable for Ceased Medications	Single
	Dose	1.0	Essential/ Desirable	Essential for Discharged Medication; Desirable for Ceased Medication	Single
	Frequency	1.0	Essential/ Desirable	Essential for Discharged Medication; Desirable for Ceased Medication	Single
	Frequency Qualifier	1.0	Optional		Single
	Medication Duration	1.0	Essential/ Conditional	Essential for Discharge Medication. Required for Ceased Medication if Quantity (of previously consumed/ administered (and now ceased) medication) is not populated.	Single

	Quantity	1.0	Essential/ Conditional	Essential for Discharge Medication. Required for Ceased Medication if Medication Duration (of previously consumed/ administered (and now ceased) medication) not populated.	Single
	Route	1.0	Essential/ Desirable	Essential for Discharge Medication. Desirable for Ceased Medication.	Single
	Reason For Medication	1.0	Desirable	Not required for Ceased Medication	Single
	Status	1.0	Desirable	Not required for Ceased Medications	Single
	Change Description	1.0	Desirable	Not required for Ceased Medications	Single
	Reason For Change	1.0	Conditional /Essential	Essential for any admission medication that has been changed during current admission or encounter that forms a member of discharge medications. Also Essential for all ceased medications	Single
	Subject of Care Instructions	1.0	Optional		Single

Prescription Record Identifier

1. Identification

Name	Prescription Record Identifier
Meta-data Type	Data Element
Identifier	DE-201140 *External Identifier*
Version	

2. Definition

Definition	Unique system identifier of the prescription record or instance of a prescription.
Definition Source	NEHTA
Synonymous Names	Prescription record identification prescription instance identifier prescription instance identification.
Context	Require for linking the discharge medication item (or precribed medication item ceased during current healthcare event) to the electronic prescription instance, which enables systems to uniquely identify the prescription to which the discharge medication item is associated, thus enabling query and audit trail of the medication item contained in the discharge medication list. NOTE: This data element will not be displayed in the discharge summary document.
Context Source	NEHTA
Assumptions	The identifier is generated and is available for use within an electronic system.
Data Type	UniqueIdentifier
Value Domain	

3. Usage

Conditions of Use	To be used on authorised prescription of legal substances.
Conditions of Use Source	NEHTA
Examples	Example 1) MFR (Medication Form Reference)
Misuse	Unauthorised and/or illegal substance use.

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Essential		Single
	CHILDREN	1.0	Conditional	Required only if ceased medication item is prescribed during current healthcare encounter/ event	Single

Product Description

1. Identification

Name	Product Description	
Meta-data Type	Data Element	
Identifier	DE-20141	*External Identifier*
Version	1.0	

2. Definition

Definition	The name of the medication as described by a prescriber or pharmacist. This name often includes the dose form and the strength of the dose form, concatenated into a single string, depending upon the specific level of prescribing. This name could include either the abstract (non-proprietary) name as is often used in hospital prescribing, or a specific trade name.
Definition Source	NEHTA
Synonymous Names	drug name; medication; qualified name
Context	When providers are describing a medication, they may do so at differing levels of specificity, depending upon the clinical context, the healthcare setting, the type of medication being prescribed, their knowledge of specific drugs, the functionality of their prescribing sytem and other factors. This data element is designed to cater for a range of prescribing contexts, such that it can be populated by a value representing an abstract product (diazepam), versus a trade family (valium) and whether the strength and form and pack are included in the description. There are separate data elements that can capture the specific atomic parts of a concatenated description - for details see: Abstract Product, Trade Family, Form, Strength Per Dose Unit. A link to an entry in the Australian Medicines Terminology can be made directly through the code/term combination available with these data elements. For example, if the Product Description in a prescribing entry contained "Valium 5mg tablet", there may also be corresponding medication item detail entries: • Abstract Product: Diazepam • Trade Family: Valium • Strength Per Dose Unit: 5mg • Form: tablet • Route: oral There could be a corresponding set of entries resulting from a pharmacist dispensing: • Trade Family: Antenex • Strength Per Dose Unit: 5mg • Form: tablet
Context Source	NEHTA
Assumptions	
Data Type	CodedText
Value Domain	Product Description Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) "Valium 5mg tablet" Example 2) "Antenex 5 tablet bottle" Example 3) "Diazepam 5mg, tablet"
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice

Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Conditional	Essential if Abstract Product and Trade Family are not populated. Not required if medication is a Formulation.	Single

Product Description Values

1. Identification

Name	Product Description Values
Meta-data Type	Value Domain
Identifier	VD-20141
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	
Version Number	
Permissible Values	*to be determined*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	Product Description	1.0	Essential		Single

Abstract Product

1. Identification

Name	Abstract Product	
Meta-data Type	Data Element	
Identifier	DE-20142	*External Identifier*
Version	1.0	

2. Definition

Definition	The abstract representation of the active ingredient(s) or substance(s), which when formulated as a medicinal product, is intended by an authorising healthcare provider for use in the treatment of the subject of care.
Definition Source	Australian Medicines Terminology (modified)
Synonymous Names	Generic name, Generic substance, Therapeutic intent agent, Therapeutic intent substance, Therapeutic intent ingredient, Therapeutic ingredient, Virtual Therapeutic Moiety [UK dm+d], Virtual Therapeutic Intent (Active ingredient) [Australian Medicines and Devices Terminology].
Context	The standard/approved name of the medication ordered/dispensed/given to the subject of care. The virtual therapeutic intent is usually the shorthand for the medication's chemical name, structure, or formula. The virtual therapeutic intent generally has the following meanings: (1) A term referring to the chemical makeup of a medication rather than to the advertised trade name under which the drug is sold; and (2) A term referring to any medication marketed under its chemical name without advertising.
Context Source	NEHTA
Assumptions	
Data Type	CodedText
Value Domain	Abstract Product Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) "Diazepam" - the Abstract Product name of a sedative, which is marketed by some companies under Trade Family names such as Valium or Vazepam. Example 2) "Diclofenac" - the Abstract Product name for the commonly known Trade Family name Voltaren 50.
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Conditional	Essential if Product Description and Trade Family are not populated. Not required if medication is a Formulation.	Single

Abstract Product Values

1. Identification

Name	Abstract Product Values
Meta-data Type	Value Domain
Identifier	VD-20142
Version	1.0

2. Definition

Definition	Set of allowable values for the abstract representation of the active ingredient(s) or substance(s), which when formulated as a medicinal product, is intended by an authorising healthcare provider for use in the treatment of the subject of care.
Definition Source	Australian Medicines and Devices Terminology (modified). These names are being harmonised by the Therapeutic Goods Administration to be consistent with international names sourced from the WHO, SNOMED CT®, the British Approved Name and other sources.

3. Value Domain

Source	Australian Medicines and Devices Terminology
Version Number	
Permissible Values	*to be determined*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T010	Abstract Product	1.0	Essential		Single

Trade Family

1. Identification

Name	Trade Family	
Meta-data Type	Data Element	
Identifier	DE-20143	*External Identifier*
Version	1.0	

2. Definition

Definition	The trade or proprietory name under which the medication product is marketed.
Definition Source	NEHTA
Synonymous Names	Trade name, brand name, brand family name, BFN, proprietory name.
Context	
Context Source	
Assumptions	
Data Type	CodedText
Value Domain	Trade Family Values

3. Usage

Conditions of Use	The Trade product name may differ between what was prescribed and what actually is dispensed depending on whether or not brand substitution is allowed. The trade product name prescribed can be obtained at any point in time by retrieving the source PRESCRIPTION and viewing the details of the PRESCRIBED MEDICATION ITEM. The Trade Family name can be given alone or in conjunction with Abstract Product in discharge summary depending on organisational and/or jurisdiction policy.
Conditions of Use Source	NEHTA
Examples	Example 1) "Valium" and "Vazepam" are Trade Family names for the Abstract Product - Diazepam. Example 2) "Voltaren 50" is a Trade Family name for its Abstract Product - Diclofenac.
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Essential	Not required if Product Description and Abstract Product are populated. Also not required if medication is a Formulation.	Single

Trade Family Values

1. Identification

Name	Trade Family Values
Meta-data Type	Value Domain
Identifier	VD-20143
Version	1.0

2. Definition

Definition	Set of allowable values for the trade or proprietory name under which the medication is marketed.
Definition Source	NEHTA

3. Value Domain

Source	Australian Medicines and Devices Terminology
Version Number	
Permissible Values	*to be determined*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T O10	Trade Family	1.0	Essential		Single

Formulation Name

1. Identification

Name	Formulation Name	
Meta-data Type	Data Element	
Identifier	DE-20144	*External Identifier*
Version	1.0	

2. Definition

Definition	The identifying name of the formulated medication.
Definition Source	NEHTA
Synonymous Names	Formulated medication name, formulated pharmaceutical substance name, pharmaceutical preparation name.
Context	
Context Source	
Assumptions	
Data Type	CodableText
Value Domain	Formulation Name Values To be imported from the Australian Medicine and Device Terminology repository

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Conditional	Essential if medication item is a formualtion product	Single
	CHILDREN	1.0	Conditional	Essential if medication is a formulation product	Single

Formulation Name Values

1. Identification

Name	Formulation Name Values
Meta-data Type	Value Domain
Identifier	VD-20144
Version	1.0

2. Definition

Definition	Set of allowable values for the identifying name of the formulated medication.
Definition Source	NEHTA

3. Value Domain

Source	Australian Medicines and Devices Terminology
Version Number	
Permissible Values	*To be determined.*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T010	Formulation Name	1.0	Essential		Single

Form

1. Identification

Name	Form	
Meta-data Type	Data Element	
Identifier	DE-20145	*External Identifier*
Version	1.0	

2. Definition

Definition	The physical manifestation of the medication for dispensing/administering.
Definition Source	NEHTA
Synonymous Names	
Context	
Context Source	
Assumptions	
Data Type	CodedText
Value Domain	Form Values To be imported from Australian Medicine and Device Terminology repository

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Tablet Example 2) Capsule Example 3) Suppository Example 4) Insufflation
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Essential		Single
	CHILDREN	1.0	Essential		Single

Form Values

1. Identification

Name	Form Values
Meta-data Type	Value Domain
Identifier	VD-20145
Version	1.0

2. Definition

Definition	Set of allowable values for the total physical manifestation of the medication for dispensing/ administering.
Definition Source	NEHTA

3. Value Domain

Source	potentially SNOMED CT®
Version Number	1.0
Permissible Values	Blister Cachet Caplet Capsule Cement Chewable tablet Coated tablet Collodion Concentrate for cutaneous solution Cutaneous AND/OR transdermal dosage form Dental dosage form Dialysis dosage form Disc Dispersible tablet Drug aerosol Drug dressing Drug lotion Drug paste Drug pledget Drug powder Drug preparation Drug suppository Dual dose sachet Effervescent granules Effervescent tablet Endocervical dosage form Endotracheopulmonary instillation suspension Film-coated tablet Gastro-resistant capsule Gastro-resistant granules Gastro-resistant tablet Gastroenteral dosage form Gel Granules Granules for oral solution Granules for oral suspension Granules for syrup Hard capsule Herbal tea Implant dosage form Impregnated dressing Impregnated pad Infusion concentrate Inhalation dosage form Intrauterine device Intravenous infusion Intravesical AND/OR urethral dosage form Liquid and semi-solid oral dosage form Lozenge Medicated nail laquer Modified-release capsule Modified-release granules Modified-release tablet Ocular AND otic AND nasal dosage form Ointment Oral dosage form Oral drops Oral drops emulsion Oral drops solution Oral drops suspension Oral drug preparation Oral elixir Oral emulsion Oral gel Oral gum Oral liquid Oral lyophilisate Oral paste Oral powder Oral solution Oral suspension Oromucosal AND/OR gingival dosage form Otic dosage form Parenteral form dosage form Pessary Pill Pillule Powder and solvent for endocervical gel Powder and solvent for endotracheopulmonary instillation solution Powder and solvent for eye drops solution Powder and solvent for eye drops suspension Powder and solvent for infusion Powder and solvent for injection solution Powder and solvent for injection suspension Powder and solvent for oral solution Powder and solvent for oral suspension Prolonged-release capsule Prolonged-release granules Prolonged-release tablet Radionuclide generator Radiopharmaceutical dosage form Rectal dosage form Sachet Sealant Shampoo Soft capsule Solid oral dosage form Soluble tablet Solvent for eye drops reconstitution Solvent for eye lotion reconstitution Solvent for parenteral use Stomach irrigation Sublingual spray Suppository Syrup Tablet Time-release capsule Toothpaste Tracheopulmonary dosage form Types of contrast medium Vaginal dosage form Wound stick

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	Form	1.0	Essential		Single

Strength

1. Identification

Name	Strength	
Meta-data Type	Data Element	
Identifier	DE-20146	*External Identifier*
Version	1.0	

2. Definition

Definition	The representation of the amount of the medication's active ingredient present in a single dose unit for dispensing/administering.
Definition Source	NEHTA
Synonymous Names	Strength per Dose Unit; Dose Strength
Context	
Context Source	
Assumptions	
Data Type	Quantity or Ratio
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Weight / unit volume (for liquids) Example 2) Percentage by volume Example 3) Ratio (for solid combination dose forms) Example 4) Mass
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Essential		Single

Dose

1. Identification

Name	Dose	
Meta-data Type	Data Element	
Identifier	DE-20147	*External Identifier*
Version	1.0	

2. Definition

Definition	The amount of medication to be taken/administered at one time.
Definition Source	NEHTA
Synonymous Names	
Context	
Context Source	
Assumptions	
Data Type	Number/Quantity/QuantityRange
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Essential		Single

Frequency

1. Identification

Name	Frequency	
Meta-data Type	Data Element	
Identifier	DE-20148	*External Identifier*
Version	1.0	

2. Definition

Definition	How often the medication has to be taken/administered.
Definition Source	NEHTA
Synonymous Names	
Context	
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	Frequency Values To be imported from the Australian Medicine and Device Terminology repository

3. Usage

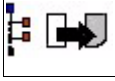
Conditions of Use	
Conditions of Use Source	
Examples	Example 1) per hour/hourly; per two hour/2 hourly; per 6 hour/6 hourly; per 8 hour/8 hourly; per 12 hour/12 hourly Example 2) daily Example 3) every other day Example 4) twice a day Example 5) three times a day Example 6) immediately / STAT Example 7) PRN
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Essential		Single

Frequency Values

1. Identification

Name	Frequency Values
Meta-data Type	Value Domain
Identifier	VD-20148
Version	1.0

2. Definition

Definition	Set of allowable values for describing how often the medication has to be taken/administered.
Definition Source	NEHTA

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	Frequency	1.0	Essential		Single

Frequency Qualifier

1. Identification

Name	Frequency Qualifier	
Meta-data Type	Data Element	
Identifier	DE-20149	*External Identifier*
Version	1.0	

2. Definition

Definition	Information provided in addition to the frequency that provides more detail or guidance about the administration of the medication.
Definition Source	NEHTA
Synonymous Names	
Context	
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	Frequency Qualifier Values To be imported from the Australian Medicine and Device Terminology repository

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) after meals Example 2) before meals Example 3) before bed Example 4) in the morning Example 5) at night
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Optional		Single

Frequency Qualifier Values

1. Identification

Name	Frequency Qualifier Values
Meta-data Type	Value Domain
Identifier	VD-20149
Version	1.0

2. Definition

Definition	Set of allowable values for the information provided in addition to the frequency that provides more detail or guidance about the administration of the medication.
Definition Source	NEHTA

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	FREQUENCY QUALIFIER	1.0	Essential		Single

Medication Duration

1. Identification

Name	Medication Duration	
Meta-data Type	Data Element	
Identifier	DE-20150	*External Identifier*
Version	1.0	

2. Definition

Definition	The length of time the medication course should continue.
Definition Source	NEHTA
Synonymous Names	Duration (display name in Discharge Summary mockup document)
Context	Used particularly when medication information is captured retrospectively (e.g. Medical history) and the start date and/or cease date cannot be recalled. May also be used in medication prescription where specification of the start date is impractical or impossible and the quantity of medication not specified.
Context Source	
Assumptions	
Data Type	Duration
Value Domain	

3. Usage

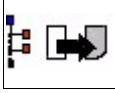
Conditions of Use	
Conditions of Use Source	
Examples	Example 1) 6 days Example 2) 3 months Example 3) 1 year
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Essential		Single

Quantity

1. Identification

Name	Quantity	
Meta-data Type	Data Element	
Identifier	DE-20151	*External Identifier*
Version	1.0	

2. Definition

Definition	The number of doses and/or physical amount of medication that has been prescribed or dispensed for the subject of care, or administered to/by the subject of care.
Definition Source	NEHTA
Synonymous Names	
Context	
Context Source	
Assumptions	
Data Type	Quantity
Value Domain	

3. Usage

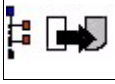
Conditions of Use	
Conditions of Use Source	
Examples	Loratidine 10 mg daily X 90 tables Amoxicllin 500 mg/capsule X 9 doses/capsules
Misuse	

4.Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Essential		Single

Route

1. Identification

Name	Route	
Meta-data Type	Data Element	
Identifier	DE-20152	*External Identifier*
Version	1.0	

2. Definition

Definition	The way through which a medication is administered.
Definition Source	NEHTA
Synonymous Names	
Context	
Context Source	
Assumptions	
Data Type	CodedText
Value Domain	Route Values To be imported from the Australian Medicine and Device Terminology repository

3. Usage

Conditions of Use	Use "Unknown" only for retrospective data collection.
Conditions of Use Source	NEHTA
Examples	Example 1) Oral Example 2) Subcutaneous injection Example 3) Epidural Example 4) Unknown
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Essential		Single

Route Values

1. Identification

Name	Route Values
Meta-data Type	Value Domain
Identifier	VD-20152
Version	1.0

2. Definition

Definition	Set of allowable values to describe the way through which a medication is administered to/by the subject of care.
Definition Source	NEHTA

3. Value Domain

Source	
Version Number	

Permissible Values

By inhalation	Intralesional route	Nasogastric route
By irrigation	Intraluminal route	Nasojejunal route
Caudal route	Intralymphatic route	Oesophagostomy route
Dental route	Intramedullary route	Ophthalmic route
Endocervical route	Intramuscular route	Oral route
Endosinusial route	Intramyometrial route	Orogastric route
Endotracheopulmonary route	Intraosseous route	Oromucosal route
Epidural route	Intraovarian route	Oropharyngeal route
External route	Intraperitoneal route	Otic route
Extra-amniotic route	Intrapleural route	Paracervical route
Extraluminal route	Intraprostatic route	Paravertebral route
Fistula route	Intrapulmonary route	Periarticular route
Gastro-intestinal stoma route	Intrasinal route	Pericardial route
Gastroenteral route	Intraspinal route	Perineural route
Gastrostomy route	Intrasternal route	Periosteal route
Intra-arterial route	Intrasynovial route	Peritendinous route
Intra-articular route	Intratendinous route	Periurethral route
Intra-osseous route	Intratesticular route	Rectal route
Intraabdominal route	Intrathecal route	Skin route
Intraamniotic route	Intrathoracic route	Subcutaneous route
Intrabiliary route	Intratracheal route	Subgingival route
Intrabronchial route	Intratympanic route	Submucosal route
Intrabursal route	Intrauterine route	Subtendinous route
Intracardiac route	Intravenous route	Surgical cavity route
Intracartilaginous route	Intravenous central route	Surgical drain route
Intracavernous route	Intravenous peripheral route	Topical route
Intracerebral ventricle route	Intravenous piggyback	Transcervical route
Intracervical route	Intravenous push route	Transdermal route
Intracisternal route	Intraventricular route	Transluminal route
Intracoronal route	Intravesical route	Transmucosal route
Intracoronary route	Intravitreal route	Transurethral route
Intracranial route	Iontophoresis route	Tumour cavity route
Intradermal route	Jejunostomy route	Ureteral route
Intradiscal route	Laryngeal route	Urethral route
Intraductal route	Mucous fistula route	Urostomy route
Intraduodenal route	Nasal route	Vaginal route
Intraepithelial route	Nasoduodenal route	

4. Usage

Default Value	
Conditions of Use	The value domain options are mutually exclusive and cannot be used in conjunction with each other.
Conditions of Use Source	
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	Route	1.0	Essential		Single

Reason For Medication

1. Identification

Name	Reason For Medication	
Meta-data Type	Data Element	
Identifier	DE-20153	*External Identifier*
Version	1.0	

2. Definition

Definition	The clinical justification (esp. specific therapeutic effect intended) for use of the medication.
Definition Source	NEHTA
Synonymous Names	
Context	For use in clinical setting. This is a Queensland Discharge Summary data requirement. Information is consider critical for patient education and safe medication management.
Context Source	
Assumptions	
Data Type	CodableText
Value Domain	Reason for Medication Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Optional		Single

Reason for Medication Values

1. Identification

Name	Reason for Medication Values
Meta-data Type	Value Domain
Identifier	VD-20153
Version	1.0

2. Definition

Definition	Set of allowable values for recording the clinical justification (esp. specific therapeutic effect intended) for the subject of care's use of the medication.
Definition Source	NEHTA

3. Value Domain

Source	potentially SNOMED CT®
Version Number	*to be determined*
Permissible Values	*to be determined*

4. Usage

Default Value	
Conditions of Use	The value domain options are mutually exclusive and cannot be used in conjunction with each other. Although any number and combination of these order methods may have been used to communicate during the course of the entire ordering process which includes initiation, confirmation, delivery, etc - the method used by the ordering person(s) to initiate the order should only be recorded.
Conditions of Use Source	
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	Reason For Medication	1.0	Essential		Single

Status

1. Identification

Name	Status	
Meta-data Type	Data Element	
Identifier	DE-20154	*External Identifier*
Version	1.0	

2. Definition

Definition	The status of the medication item within the subject of care's medications list as a result of the current review being conducted, which may or may not have altered depending on the reviewer's assessment. *It is assumed that the medication list would be reviewed by the treating physician prior to discharge of patient at the end of the healthcare event/encounter.*
Definition Source	NEHTA
Synonymous Names	Order Status
Context	
Context Source	
Assumptions	
Data Type	CodedText
Value Domain	Status Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Newly prescribed Example 2) Newly reported Example 3) Existing - unaltered Example 4) Existing - altered Example 5) Ceased
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Optional		Single

Status Values

1. Identification

Name	Status Values
Meta-data Type	Value Domain
Identifier	VD-20154
Version	1.0

2. Definition

Definition	Set of allowable values for defining the current status of the medication item within its general 'lifecycle' from prescribed/ordered through to it being dispensed, administered, reviewed, completed (full length of medication duration)/suspended/cancelled/re-prescribed.
Definition Source	NEHTA

3. Value Domain

Source	NEHTA
Version Number	1.0
Permissible Values	Prescribed Dispensed Administered Cancelled administration Cancelled prescription Suspended dispensing Suspended administration Suspended re-order Reviewed Completed Re-prescribed

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T010	STATUS	1.0	Essential		Single

Change Description

1. Identification

Name	Change Description	
Meta-data Type	Data Element	
Identifier	DE-20155	*External Identifier*
Version	1.0	

2. Definition

Definition	Description of the change in the subject of care's medication item information.
Definition Source	NEHTA
Synonymous Names	
Context	
Context Source	
Assumptions	
Data Type	CodableText
Value Domain	Change Description Values

3. Usage

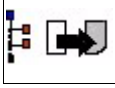
Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Correction of prescription error Example 2) Cessation of medication Example 3) Change of dose Example 4) Addition of drug Example 5) Substitution of drug
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Optional		Single

Change Description Values

1. Identification

Name	Change Description Values
Meta-data Type	Value Domain
Identifier	VD-20155
Version	1.0

2. Definition

Definition	Set of allowable values to describe the type of change made to a subject of care's medication item by an authorised healthcare provider.
Definition Source	NEHTA

3. Value Domain

Source	WiniFRED (Windows Fast Reliable Easy Dispense) Electronic Dispensing System - (PCA NU Systems Pty Ltd) - modified
Version Number	1.0
Permissible Values	Correction of prescription error Cessation of medication Change of dose Addition of drug Substitution of drug Change frequency of administration Change of route of administration Change time of administration Therapeutic drug monitoring Monitoring of toxicity/efficacy Therapeutic consultation Other Unknown

4. Usage

Default Value	
Conditions of Use	Use "Unknown" only for retrospective data collection. Use "Other" for values that are not currently listed within this value domain. The change description should be recorded using free text when "Other" is chosen.
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	Change Description	1.0	Essential		Single

Reason For Change

1. Identification

Name	Reason For Change	
Meta-data Type	Data Element	
Identifier	DE-20156	*External Identifier*
Version	1.0	

2. Definition

Definition	The reason(s) for which a clinical intervention, medication prescription/dispensing or administration status, diagnosis or prognosis has been changed.
Definition Source	NEHTA
Synonymous Names	
Context	
Context Source	
Assumptions	
Data Type	CodableText
Value Domain	Reason for Change Values

3. Usage

Conditions of Use	Use "Unknown" only for retrospective data collection.
Conditions of Use Source	NEHTA
Examples	For Medication Prescription, Dispensing or Administration, example Reason for Change values are: Example 1) 1 = Life saving Example 2) 2 = Prevent major toxicity Example 3) 3 = Optimise drug therapy Example 4) 4 = Patient request - untolerable side effect of dizziness/diarrhoea Example 5) 5 = costing Example 6) 6 = due to exisiting complication (e.g. bleeding after surgical/ diagnostic procedure)
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	CHILDREN	1.0	Conditional	Essential for any admission medication that has been changed during current admission/encounter that is also a member of the discharge medications	Single

Reason for Change Values

1. Identification

Name	Reason for Change Values
Meta-data Type	Value Domain
Identifier	VD-20156
Version	1.0

2. Definition

Definition	Set of allowable values for recording the clinical justification (esp. specific therapeutic effect intended) for the subject of care's use of the medication.
Definition Source	NEHTA

3. Value Domain

Source	potentially SNOMED CT®
Version Number	*to be determined*
Permissible Values	*to be determined*

4. Usage

Default Value	
Conditions of Use	The value domain options are mutually exclusive and cannot be used in conjunction with each other. Although any number and combination of these order methods may have been used to communicate during the course of the entire ordering process which includes initiation, confirmation, delivery, etc - the method used by the ordering person(s) to initiate the order should only be recorded.
Conditions of Use Source	
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	Reason For Change	1.0	Essential		Single

Subject of Care Instructions

1. Identification

Name	Subject of Care Instructions	
Meta-data Type	Data Element	
Identifier	DE-20157	*External Identifier*
Version	1.0	

2. Definition

Definition	Details of the instructions/advice and information that have been given to the subject of care from a healthcare provider.
Definition Source	NEHTA
Synonymous Names	Advice to Patient
Scope	In the context of discharge summary, the information includes instructions about medications on discharge, arranged and planned services, etc. NOTE - This data element name is not displayed in the Discharge Summary. It is represented by a text box containing all relevant patient instruction information.
Scope Source	
Assumptions	
Data Type	CodableText
Value Domain	Subject of Care Instruction Values

3. Usage

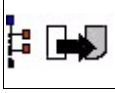
Conditions of Use	
Conditions of Use Source	
Examples	Example: Go for a blood test at the community diagnostic medical laboratory on next wednesday after discharge. Then see GP on thursday.
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	MEDICATION ITEM DETAILS	1.0	Essential		Single

Subject of Care Instruction Values

1. Identification

Name	Subject of Care Instruction Values
Meta-data Type	Value Domain
Identifier	VD-20157
Version	1.0

2. Definition

Definition	
Definition Source	NEHTA

3. Value Domain

Source	
Version Number	*to be determined*
Permissible Values	*to be determined*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	Subject of Care Instructions	1.0	Essential		Single

MEDICATIONS CEASED THIS VISIT

1. Identification

Name	MEDICATIONS CEASED THIS VISIT	
Meta-data Type	Event Summary Section	
Identifier	S-20111	*External Identifier*
Version	1.0	

2. Definition

Definition	A section that groups together information about a subject of care's medication(s) that had been given before or during the healthcare encounter but was/were stopped on discharge. *Medication is defined as "a therapeutic good that is designed to achieve, or likely to achieve, its principal intended action by pharmacological, chemical, immunological or metabolic means in or on the body of subject of care".*
Definition Source	NEHTA
Synonymous Names	Medications ceased this admission
Scope	For use in healthcare settings. NOTE - the generic term "Medication Ceased This Visit" is used in this Template and in the Mock-up document. It is intended for covering both "Admitted Patient" and patient discharged after an "ED encounter" (i.e. discharged from ED without an admission to the hospital). For patients discharged after an in-patient encounter, the alternate display name "Medication Ceased This Admission" may be used. The "Admission Medications" included in this section include both those that are continued unchanged on discharge or continued with some changes on discharge.
Scope Source	NEHTA
Assumptions	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	Used to list discharge medications.

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	MEDICATION ITEM DETAILS	1.0	Essential		Multiple

KNOWN ADVERSE REACTIONS AND ALERTS

1 Identification

Name	KNOWN ADVERSE REACTIONS AND ALERTS	
Meta-data Type	Event Summary Section	
Identifier	S-20112	*External Identifier*
Version	1.0	

2 Definition

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

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	ADVERSE REACTIONS	1.0	Optional		Multiple
	ALERTS	1.0	Optional		Multiple

ADVERSE REACTIONS

1 Identification

Name	ADVERSE REACTIONS	
Meta-data Type	Event Summary Section	
Identifier	S-20113	*External Identifier*
Version	1.0	

2 Definition

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

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	KNOWN ADVERSE REACTIONS AND ALERTS	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	ADVERSE REACTION	1.0	Optional		Multiple

ADVERSE REACTION

1 Identification

Name	Adverse reaction	
Meta-data Type	Externally sourced Data Group	
Identifier	DG-20154	*External Identifier*
Version	1.0	

2) Definition

Definition	A harmful or undesirable response to an agent/substance. *An adverse reaction may occur within a variable timeframe after exposure to an agent/ substance and may range from minor reactions like a skin rash to serious and life-threatening events such as anaphylaxis. Exposure may be by ingestion, inhalation, injection or direct contact.* *An adverse reaction includes allergies, intolerances and sensitivities. An adverse reaction does not include poisoning, medical errors or mishaps that may occur during surgical or medical care, as these are generally classified as an adverse event.*
Definition Source	NEHTA
Synonymous Names	
Scope	NOTE - This data group associates data elements that capture relevant Adverse Reaction details. The data group name is not displayed in the Discharge Summary. It has the following structure/data elements that are displayed in a discharge summary: - Agent Description (Displayed in Discharge Summary as Agent) - Reaction Details (data group which is not displayed) . ----- Adverse Reaction Description (displayed as Reaction) . ----- DateTime:Start (Displayed as Date Start) - Adverse Reaction Note (Dispalyed as Reaction Note)
Scope Source	NEHTA
Assumptions	

Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Diagnostic biopsy of bone marrow (MBS item 30087) Example 2) Comprehensive HACC Assessment Authority (HACC MDS Code 5)
Misuse	

Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	ADVERSE REACTIONS	1.0	Essential		Multiple

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Agent Description	1.0	Essential		Single
	REACTION DETAILS	1.0	Essential		Single
T	Adverse Reaction Note	1.0	Optional		Single

Agent Description

1. Identification

Name	Agent Description	
Meta-data Type	Data Element	
Identifier	DE-20160	*External Identifier*
Version	1.0	

2. Definition

Definition	The agent/substance causing the adverse reaction experienced by the subject of care, as determined by a healthcare provider.
Definition Source	NEHTA
Synonymous Names	Agent
Scope	
Scope Source	
Assumptions	
Value Domain	Agent Description Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Egg Example 2) Penicillin Example 3) Bee sting
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	ADVERSE REACTION	1.0	Essential		Single

Agent Description Values

1. Identification

Name	Agent Description Values
Meta-data Type	Value Domain
Identifier	VD-20160
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	Agent Description	1.0	Essential		Single

REACTION DETAILS

1. Identification

Name	REACTION DETAILS	
Meta-data Type	Externally sourced Data Group	
Identifier	DG-20155	*External Identifier*
Version	1.0	

2. Definition

Definition	Details of one or more reactions (harmful or undesirable responses) to an agent. *An agent can be a substance such as food, drug, animal, etc. or something less tangible, such as sunlight, heights, enclosed spaces.*
Definition Source	NEHTA
Synonymous Names	
Scope	NOTE - This data group name associates data elements that capture details of the adverse reaction (excluding the Agent that caused the reaction). This data group name would not normally be displayed in the discharge summary. It has the following data elements that are displayed in the discharge summary: - Adverse Reaction Description (Displayed as Reaction) - DateTime Start
Scope Source	NEHTA
Assumptions	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	ADVERSE REACTION	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Adverse Reaction Description	1.0	Essential		Single

	FINDING SITE	1.0	Conditional	Required if adverse reaction findings affect certain body site (e.g. papular urticaria on upper right quadrant of abdomen). Not required if adverse reactions not affect body site (e.g. severe diarrhoea)	Single
	Onset (display name = Date Started)	1.0	Desirable		Single

Onset

1. Identification

Name	Onset	
Meta-data Type	Data Element	
Identifier	DE-20161	*External Identifier*
Version	1.0	

2. Definition

Definition	The start date or data and time of a subject of care's Adverse Reaction
Definition Source	NEHTA
Synonymous Names	Date Start (Display name) - used in Discharge Summary Mock-up document Start Date Start Date and Time Onset date
Scope	For use in the healthcare setting. Captures the date or the date and time values of - a diagnosis/problem or or adverse events (e.g. complication, adverse reaction, alert) experienced by the subject of care
Scope Source	
Assumptions	
Data Type	DateTime
Value Domain	

3. Usage

Conditions of Use	Sometimes, the date or age at which a person reacts to an agent is a relevant to understanding a condition, or to determining appropriate treatment. Often, this will be an approximate, self-reported age, date or datetime.
Conditions of Use Source	
Examples	Example 1) 31/03/2004 Example 2) 03/2004 Example 3) 2004 Example 4) 31/03/2004 13:10
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	REACTION DETAILS	1.0	Desirable		Single

Adverse Reaction Description

1. Identification

Name	Adverse Reaction Description	
Meta-data Type	Data Element	
Identifier	DE-20162	*External Identifier*
Version	1.0	

2. Definition

Definition	The symptoms and/or signs experienced or exhibited by the subject of care as a consequence of the adverse reaction to a specific agent/substance, as determined by a healthcare provider
Definition Source	NEHTA
Synonymous Names	Reaction
Scope	
Scope Source	
Assumptions	
Value Domain	Adverse Reaction Description Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Itchy eyes Example 2) Dysphagia Example 3) generalised urticaria/skin rashes
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	ADVERSE REACTION	1.0	Essential		Single

Adverse Reaction Description Values

1. Identification

Name	Adverse Reaction Description Values
Meta-data Type	Value Domain
Identifier	VD-20162
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	Adverse Reaction Description	1.0	Essential		Single

FINDING SITE

1. Identification

Name	FINDING SITE	
Meta-data Type	Externally sourced Data Group	
Identifier	DG-20156	*External Identifier*
Version	1.0	

2. Definition

Definition	Details of the anatomical/body site on which clinical or health related findings (such as signs and symptoms) have been made or described.
Definition Source	NEHTA
Synonymous Names	
Scope	NOTE - This is a non-displayed data group name (i.e. the name of the data group is not displayed in clinical information documents such as discharge summary, referral, etc). It is a structure that groups together data elements used to capture finding information on anatomical/body site/surface. This data group has the following data elements that are displayed in the discharge summary: - Finding Site Description (Dispalyed as Sites or Finding Sites) - Finding Site Qualifier (Displayed as Site Qualifier)
Scope Source	NEHTA
Assumptions	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	REACTION DETAILS	1.0	Conditional	Required if adverse reaction findings affect anatomical/body sites (e.g. skin rash). Not required if findings do not affect specific anatomical/body sites (e.g. diarrhoea)	Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Finding Site Description (display name = Sites or Finding Sites)	1.0	Essential		Single
T/T010	Finding Site Qualifier (display name = Site Qualifier)	1.0	Conditional	Used when further qualification of antomical/body sites is required to improve information precision (e.g. right, left, medial, lateral, etc)	Single

Finding Site Description

1. Identification

Name	Finding Site Description	
Meta-data Type	Data Element	
Identifier	DE-20163	*External Identifier*
Version	1.0	

2. Definition

Definition	The description of anatomical/body site(s) on which the adverse reaction findings have been made.
Definition Source	NEHTA
Synonymous Names	Sites
Scope	Used in healthcare settings.
Scope Source	NEHTA
Assumptions	
Value Domain	Finding Site Description Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Abdominal wall Example 2) Forearm Example 3) Thigh
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	FINDING SITE	1.0	Essential		Single

Finding Site Description Values

1. Identification

Name	Finding Site Description Values
Meta-data Type	Value Domain
Identifier	VD-20163
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	Finding Site Description	1.0	Essential		Single

Finding Site Qualifier

1. Identification

Name	Finding Site Qualifier	
Meta-data Type	Data Element	
Identifier	DE-20164	*External Identifier*
Version	1.0	

2. Definition

Definition	The descriptor used to qualify or further refine anatomical/body site(s) description in order to add clarity and precision to the site description.
Definition Source	NEHTA
Synonymous Names	
Scope	Used in healthcare settings. When used within the Adverse Reaction data group, this data element is used to add clairty or precision to description of the anatomical/body sites on which adverse reaction findings appear.
Scope Source	NEHTA
Assumptions	
Value Domain	Finding Site Qualifier Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) site qualifier value = "right lower quadrant" which improves clarity or adds precision to finding site description value of "Abdominal wall" Example 2) site qualifier value = "right" which improves clarity or adds precision to finding site description value of "forearm" Example 3) site qualifier value = "right upper" which improves clarity or adds precision to finding site description value of "thigh"
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	FINDING SITE	1.0	Optional	Not required for findings that do not affect an antomical/ body site, e.g. diarrhoea, anaphylaxis.	Single

Finding Site Qualifier Values

1. Identification

Name	Finding Site Qualifier Values
Meta-data Type	Value Domain
Identifier	VD-20164
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	Finding Site Qualifier	1.0	Essential		Single

Adverse Reaction Note

1. Identification

Name	Adverse Reaction Note	
Meta-data Type	Data Element	
Identifier	DE-20165	*External Identifier*
Version	1.0	

2. Definition

Definition	Free text comments relevant to the Adverse Reaction in question
Definition Source	NEHTA
Synonymous Names	Reaction Note
Scope	
Scope Source	
Assumptions	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	ADVERSE REACTION	1.0	Essential		Single

ALERTS

1 Identification

Name	ALERTS	
Meta-data Type	Event Summary Section	
Identifier	S-20121	*External Identifier*
Version	1.0	

2 Definition

Definition	A section that groups together alert information about the subject of care that is known to the provider/provider facility during a healthcare visit/encountered.
Definition Source	NEHTA
Synonymous Names	
Scope	
Scope Source	
Assumptions	

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	KNOWN ADVERSE REACTIONS AND ALERTS	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	ALERT	1.0	Optional		Multiple

ALERT

1. Identification

Name	ALERT	
Meta-data Type	Data Group	
Identifier	DG-20157	*External Identifier*
Version	1.0	

2. Definition

Definition	Information pertaining to a subject of care that may: • need special consideration by a healthcare provider before making a decision about his/her actions to avert an unfavourable healthcare event; or • need consideration and/or action by a healthcare provider or facility in relation to the care and safety of the subject of care, staff and/or other individuals; or • notify the healthcare provider of special circumstances that may be relevant in delivering care and/or interacting with the subject of care.
Definition Source	NEHTA
Synonymous Names	
Scope	NOTE - This data group name groups together data element that captures details about Alerts pertainining to the patient. This data element name itself is not displayed in the discharge summary. Instead, the following data element members are displayed: • Alert Description (displayed as Alert Description) • DateTime:Start (Displayed as Date Start) • Alert Note (displayed as Alert Note)
Scope Source	NEHTA
Assumptions	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Animal present at subject of care's home Example 2) Subject of care is a risk to others Example 3) Subject of care speaks no English Example 4) Pacemaker present
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	KNOWN ADVERSE REACTIONS AND ALERTS	1.0	Essential		Multiple

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Alert Description	1.0	Essential		Single
	Start DateTime	1.0	Desirable		Single
T	Alert Note	1.0	Optional		Single

Start DateTime

1. Identification

Name	Start DateTime	
Meta-data Type	Data Element	
Identifier	DE-20166	*External Identifier*
Version	1.0	

2. Definition

Definition	The start date or data and time of a subject of care's Alert
Definition Source	NEHTA
Synonymous Names	Date Started Start Date Start Date and Time
Scope	For use in the healthcare setting. Captures the date or the date and time values of - a diagnosis/problem or or adverse events (e.g. complication, adverse reaction, alert) experienced by the subject of care
Scope Source	
Assumptions	
Data Type	DateTime
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) 31/03/2004 Example 2) 03/2004 Example 3) 2004 Example 4) 31/03/2004 13:10
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	ALERT	1.0	Desirable		Single

Alert Description

1. Identification

Name	Alert Description	
Meta-data Type	Data Element	
Identifier	DE-20167	*External Identifier*
Version	1.0	

2. Definition

Definition	Details of the nature of the alert.
Definition Source	NEHTA
Synonymous Names	
Scope	
Scope Source	
Assumptions	
Data Type	CodeableText
Value Domain	Alert Description Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Animals present at subject of care's home Example 2) Subject of care is a risk to others Example 3) Pacemaker present
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	ALERT	1.0	Essential		Single

Alert Description Values

1. Identification

Name	Alert Description Values
Meta-data Type	Value Domain
Identifier	VD-20176
Version	1.0

2 Definition

Definition	Details of the nature of the alert.
Definition Source	NEHTA

3 Value Domain

Source	NEHTA
Version Number	
Permissible Values	*to be determined*

4 Usage

Default Value	
Conditions of Use	The value domain options are mutually exclusive and cannot be used in conjunction with each other.
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	Alert Description	1.0	Essential		Single

Alert Note

1. Identification

Name	Alert Note	
Meta-data Type	Data Element	
Identifier	DE-20168	*External Identifier*
Version	1.0	

2. Definition

Definition	Free text comments relevant to the Alert in question.
Definition Source	NEHTA
Synonymous Names	
Scope	Used in healthcare setting. Captures detail information about the alert in question that is not otherwise captured in other Alert data elements.
Scope Source	NEHTA
Assumptions	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	ALERT	1.0	Essential		Single

CLINICAL MANAGEMENT

1 Identification

Name	CLINICAL MANAGEMENT	
Meta-data Type	Event Summary Section	
Identifier	S-20114	*External Identifier*
Version	1.0	

2 Definition

Definition	A section that contains summary information/comments on the clinical management of the subject of care, and the prognosis of diagnosis/problems identified during a healthcare event/ visit. It may also include health related information pertinent to the subject of care.
Definition Source	NEHTA
Synonymous Names	Clinical Synopsis Clinical Summary
Scope	
Scope Source	
Assumptions	

Hierarchical Structure

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	Used to list discharge medications.

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY	1.0	Desirable		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
T	Clinical Synopsis Comment	1.0	Essential		Single

Clinical Synopsis Comment

1. Identification

Name	Clinical Synopsis Comment	
Meta-data Type	Data Element	
Identifier	DE-20169	*External Identifier*
Version	1.0	

2. Definition

Definition	A summary/comment on the subject of care's health issues/problems (from the perspective of healthcare provider, carer, subject of care and significant others, or unrelated person). The description include summary of the issues/problems, management strategies, outcomes/ progress and possible prognosis.
Definition Source	NEHTA
Synonymous Names	Clinical Synopsis Description Clinical Summary Description
Scope	NOTE - This data element is represented as a text box in the discharge summary that captures all clincial management/intervention information. The data element name is not displayed in the discharge summary.
Scope Source	
Data Type	Text

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Admitted for elective bronchoscopy for assessment of left lingular and bibasal pneumonia. No focal endobronchial pathology identified. No evidence of malignancy and no pathogens isolated on bronchial brushings and washings. Example 2) 3/52 ago involved in a rear end motor vehicle accident, mid-velocity impact-complaining of neck pain, dizziness, nausea and difficulties concentrating. Disturbed sleep. No spinal cord signs. Treatment = Cx passive mobilisation, upper trapezius stretches and graduated DNF exercise program. After 2/52 analgesia reduced by half, nausea only infrequent, but dizziness ISQ.
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
S	CLINICAL MANAGEMENT	1.0	Essential		Single

FOLLOW-UP

1 Identification

Name	Follow-Up	
Meta-data Type	Event Summary Section	
Identifier	S-20115	*External Identifier*
Version		

2 Definition

Definition	A section that groups together details of clinical referral or services requested for the subject of care. Such activities may include arranged services such as home nursing or community health services, or follow-up management by the GP or specialist(s), but exclude medication prescriptions. This section also includes information on instructions to subject of care regarding the planned or requested services.
Definition Source	NEHTA
Synonymous Names	
Scope	
Scope Source	NEHTA
Assumptions	

Hierarchical Structure

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY	1.0	Desirable		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	REQUESTED SERVICE	1.0	Essential		Multiple

REQUESTED SERVICE

1. Identification

Name	REQUESTED SERVICE	
Meta-data Type	Data Group	
Identifier	DG-20158	*External Identifier*
Version		

2. Definition

Definition	Details of clinical referral or services requests and/or planned for the subject of care before discharged from a healthcare event/visit. It does not include medication prescriptions and/or diagnostic investigation requests.
Definition Source	NEHTA
Synonymous Names	
Scope	
Scope Source	
Assumptions	

3. Usage

Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	Used to specify medication prescriptions or diagnostic test requests.

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	FOLLOW-UP	1.0	Essential		Multiple

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	REFERREE	1.0	Essential		Single
	Requested Service Description	1.0	Essential		Single
	Reason for Service	1.0	Essential		Single
	Service Commencement Window	1.0	Essential		Single

Referree

1. Identification

Name	REFERREE
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20159 *External Identifier*
Version	1.0

2. Definition

Definition	Details pertaining to the identification of provider person or organisation to whom a request has been, or is being made for provision of a service.
Definition Source	NEHTA
Synonymous Names	Healthcare Provider Identification:Referred To Referred To Provider Referred To (display name)
Scope	For use in the healthcare setting. In the context of discharge summary, this data group captures identification information on the Healthcare Provider Person or Organisation who/which is requested to (i.e. the Referred To party) provide a service after discharge of patient from the healthcare facility at which the healthcare event/encounter has completed.
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	REQUESTED SERVICE	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	HEALTHCARE PROVIDER IDENTIFIER - INDIVIDUAL	1.0	Desirable/ Essential	Required if HPI available	Single

	PERSON NAME	1.0	Essential	If referral/request is initiated by a Healthcare Provider	Single
	HEALTHCARE PROVIDER IDENTIFIER - ORGANISATION	1.0	Conditional	Required if Referred To party is an organisation, and unique organisation identifier is available	Single
	ORGANISATION NAME		Conditional	Required if Referred to party is an organisation	Single
	ADDRESS		Desirable		Single
	ELECTRONIC COMMUNICATION DETAILS (display name = Telephone and Fax/Email)		Desirable (Telephone). Optional (Fax/ Email)		Single
	Provider Occupation Category		Optional		Single

Requested Service Description

1. Identification

Name	Requested Service Description	
Meta-data Type	Data Element	
Identifier	DE-20171	*External Identifier*
Version	1.0	

2. Definition

Definition	An agreed statement of the type(s) of service requested for, or provided to, the subject of care.
Definition Source	NEHTA
Synonymous Names	Service Requested (display name in dischagre summary mockup document)
Scope	For use in healthcare setting. Used to identify diagnostic, clinical procedures or clinical management requested by the healthcare provider to be undertaken on/provided to the subject of care.
Scope Source	
Assumptions	
Data Type	CodeableText
Value Domain	Requested Service Description Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Dialysis Adjustment of heart failure/hypertensive medications Adjust INR to therapeutic range, etc
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	ORIGINAL REFERRAL	1.0	Desirable		Single
	REQUESTED SERVICE	1.0	Essential		Single

Requested Service Description Values

1. Identification

Name	Requested Service Description Values
Meta-data Type	Value Domain
Identifier	VD-20171
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Requested Service Description	1.0	Essential		Single

Reason for Service

1. Identification

Name	Reason for Service	
Meta-data Type	Data Element	
Identifier	DE-20172	*External Identifier*
Version	1.0	

2. Definition

Definition	A clinical description of reason(s) a service is being requested or received.
Definition Source	NEHTA
Synonymous Names	Reason for Requesting Service; Service Reason
Scope	For use in healthcare setting. In the context of discharge summary, this data element captures information about reasons for requesting services (by the healthcare provider) to be provided to the subject of care after discharge from the healthcare facility.
Scope Source	
Assumptions	
Data Type	Text
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	REQUESTED SERVICE	1.0	Essential		Single

Service Commencement Window

1. Identification

Name	Service Commencement Window	
Meta-data Type	Data Element	
Identifier	DE-20173	*External Identifier*
Version	1.0	

2. Definition

Definition	An interval of how soon or the latest that the requesting healthcare provider would like the subject of care to receive the requested service(s).
Definition Source	NEHTA
Synonymous Names	Service Commences
Scope	For use in the healthcare settings. This data element is used to specify the range of time within which the requesting provider would like the requested service(s) to be provided to the subject of care.
Scope Source	
Assumptions	
Data Type	Date and Time
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) 31/03/2006 - 15/04/2006
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	REQUESTED SERVICE	1.0	Essential		Single

Subject of Care Instruction

1. Identification

Name	Subject of Care Instruction	
Meta-data Type	Data Element	
Identifier	DE-20174	*External Identifier*
Version	1.0	

2. Definition

Definition	Details of the instructions/advice and information that have been given to the subject of care from a healthcare provider.
Definition Source	NEHTA
Synonymous Names	Advice to Patient
Scope	In the context of discharge summary, the information includes instructions about medications on discharge, arranged and planned services, etc. NOTE - This data element name is not displayed in the Discharge Summary. It is represented by a text box containing all relevant patient instruction information.
Scope Source	NEHTA
Assumptions	
Data Type	CodeableText
Value Domain	Subject of Care Instruction Values

3. Usage

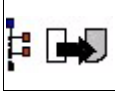
Conditions of Use	
Conditions of Use Source	
Examples	Example: Go for a blood test at the community diagnostic medical laboratory on next wednesday after discharge. Then see GP on thursday.
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	MEDICATION ITEM DETAILS	1.0	Essential		Single
	REQUESTED SERVICE	1.0	Essential		Single

Subject of Care Instruction Values

1. Identification

Name	Subject of Care Instruction Values
Meta-data Type	Value Domain
Identifier	VD-20174
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Subject of Care Instruction	1.0	Essential		Single

RECOMMENDATIONS TO GENERAL PRACTITIONER

1 Identification

Name	RECOMMENDATIONS TO GENERAL PRACTITIONER	
Meta-data Type	Event Summary Section	
Identifier	S-20116	*External Identifier*
Version	1.0	

2 Definition

Definition	A section that contains recommendation information to patient's GP. It may include reminders to GP on special management strategies.
Definition Source	NEHTA
Synonymous Names	Advice to GP
Scope	
Scope Source	
Assumptions	

Hierarchical Structure

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY	1.0	Optional		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	RECOMMENDATION TO PROVIDER	1.0	Essential		Single

Recommendation to Provider

1. Identification

Name	Recommendation to Provider	
Meta-data Type	Data Element	
Identifier	DE-20175	*External Identifier*
Version	1.0	

2. Definition

Definition	Details of the recommendation information given by the healthcare provider(s) from the hospital to the patient's healthcare provider, including the General Practitioner.
Definition Source	NEHTA
Synonymous Names	Advice to Patient
Scope	NOTE - This data element name is not displayed in the Discharge Summary. It is represented by a text box containing all relevant information/recommendation for the subject of care's healthcare provider including GP. The relevant information/recommendation is important for the continuity of care and management of the subject of care after discharge.
Scope Source	NEHTA
Assumptions	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
S	RECOMMENDATIONS TO GENERAL PRACTITIONER	1.0	Optional		Single

INVESTIGATIONS: DETAILED REPORT

1 Identification

Name	Investigations: Detailed Report	
Meta-data Type	Event Summary Section	
Identifier	S-20117	*External Identifier*
Version	1.0	

2 Definition

Definition	A section that groups together results of relevant/significant diagnostic tests (laboratory, histology/cytology, biochemistry, haematology, microbiology and imaging) and specific investigations or examinations undertaken on the subject of care during the healthcare event/visit.
Definition Source	NEHTA
Synonymous Names	
Scope	
Scope Source	NEHTA
Assumptions	

Hierarchical Structure

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	Used to include results of all diagnostic tests performed on the subject of care during a healthcare event/visit.

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY	1.0	Essential	Essential	Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	PATHOLOGY	1.0	Essential		Single
	DIAGNOSTIC IMAGING	1.0	Optional		Single
	OTHER INVESTIGATIONS	1.0	Optional		Single

PATHOLOGY

1. Identification

Name	PATHOLOGY	
Meta-data Type	Event Summary Section	
Identifier	S-20118	*External Identifier*
Version	1.1	

2. Definition

Definition	A subsection that groups together relevant/significant diagnostic tests (microbiology, immunology, histology/cytology, biochemistry, haematology) undertaken on the subject of care during the healthcare event/visit. Information, including test and specimen details and results, pertaining to a single order for diagnostic pathology tests undertaken on a subject of care. *A pathology test is undertaken to determine aspects of a person's health status through examination of specimens such as tissue, fluid or cells. Several tests may be contained within a single order. The tests requested in the order may involve more than one specimen from the subject of care.*
Definition Source	NEHTA
Synonymous Names	
Scope	Pathology is the branch of medicine which is involved in understanding the cause(s) and processes of disease. It does this by looking at changes in the tissues of the body and in blood and other body fluids. Some of these changes show the causes, while others reflect the severity of the disease and are used to follow the effects of treatment. There are several different areas of activity within the Pathology field including Microbiology, Anatomical, Chemical, Genetics, Haematology and Immunology. The Pathology data group incorporates those data elements that deal with information related to pathology tests, covering both requests for service, as well as test results and reports. A single pathology request for service can cover multiple tests. A 'single' pathology test can have multiple components, and thus yield multiple results.
Scope Source	NEHTA
Assumptions	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	Used to include all diagnostic tests performed on the subject of care during a healthcare event/visit.

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5. Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	INVESTIGATIONS: DETAILED REPORT	1.0	Desirable	If any relevant/ significant pathology tests done during healthcare event/visit	Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	PATHOLOGY TEST	1.0	Essential		Multiple

PATHOLOGY TEST

1. Identification

Name	PATHOLOGY TEST	
Meta-data Type	Data Group	
Identifier	DG-20160	*External Identifier*
Version	1.1	

2. Definition

Definition	Information, including results, pertaining to a single diagnostic pathology test undertaken on a subject of care. A pathology test is undertaken to determine an aspect of the health status of a subject of care acquired through examination of specimens such as tissue, fluid or cells.
Definition Source	NEHTA
Synonymous Names	
Scope	Used in healthcare setting. Captures detailed information on Pathology Tests. NOTE - this data group name would not normally appear in Discharge Summary. It is used as a grouper to group all data elements/groups relevant to Pathology Tests. In the discharge summary, the following member data elements/groups of this data group would be displayed: • Requesting Provider (not displayed; instead the Healthcare Provider person name is displayed as the Requesting Provider) • Reporting Provider (not displayed; instead the Healthcare Provider person name is displayed as the Repporting Pathologist) • Test name • Performed Date • Result Status • Structured Result • Report • Interpretive Note
Scope Source	NEHTA
Assumptions	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	Used to include all diagnostic tests performed on the subject of care during a healthcare event/visit.

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5. Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PATHOLOGY	1.0	Essential		Multiple

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	TEST REQUESTER (display name = Requesting Provider)	1.0	Optional		Single
	REPORTING PATHOLOGIST (display name = Reporting Provider or Reporting Pathologist)	1.0	Optional		Single
	Test Name (display name = Test Name)	1.0	Essential		Single
	DateTime Specimen Collected (display name = Performed Date)	1.0	Essential		Single
	Result Status	1.0	Essential		Single
	STRUCTURED ATOMIC RESULT	1.0	Essential		Multiple
	Verbatim Report	1.0	Essential	Essential for cytoloty/histology and microbilogy studies	Single
	Interpretive Note (display name = Note)	1.0	Optional		Single

Test Requester

1. Identification

Name	TEST REQUESTER
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20161 *External Identifier*
Version	1.0

2. Definition

Definition	Details pertaining to the identification of a provider individual or organisation who/which is requesting a healthcare service provision, in this case pathology or diagnostic imaging test(s).
Definition Source	NEHTA
Synonymous Names	Requesting Provider (Display name) Healthcare provider identification:Requester
Scope	For use in the healthcare setting. Captures identification information on the Healthcare Provider Person or Organisation.
Scope Source	
Assumptions	

Hierarchical Structure

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5. Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PATHOLOGY TEST	1.0	Optional		Single

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	HEALTHCARE PROVIDER IDENTIFIER - INDIVIDUAL	1.0	Desirable		Single
	PERSON NAME	1.0	Essential		Single

Test Name

1. Identification

Name	Test Name	
Meta-data Type	Data Element	
Identifier	DE-20176	*External Identifier*
Version	1.1	

2. Definition

Definition	The pathology test requested by the healthcare provider, care team or organisation requested to be performed on the pathology specimen or subject of care. *The test name can refer to a single test (eg HbA1c) or to a test group such as electrolytes, FBC and/or coagulation tests.*
Definition Source	NEHTA
Synonymous Names	Assessment Name; Investigation Name
Context	The assignation of an identification code to a request by the laboratory or diagnostic imaging facility enables tracking of the progress of a request and provides a report reference number.
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	Test Name Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PATHOLOGY TEST	1.0	Essential		Single

Test Name Values

1. Identification

Name	Test Name Values
Meta-data Type	Value Domain
Identifier	VD-20176
Version	1.1

2. Definition

Definition	The name of the pathology test requested by the healthcare provider, care team or organisation requested to be performed on the pathology specimen or subject of care. *The test name can refer to a single test (eg HbA1c) or to a test group such as electrolytes, FBC and/or coagulation tests.*
Definition Source	

3. Value Domain

Source	NEHTA
Version Number	
Permissible Values	*A national test name register which lists perferred terms; synonyms; SNOMED-CT concepts, terms and Identifiers has been developed by NEHTA. This register, or reference set, has been developed with clinician input, analysis of laboratory information systems, the Australian Medical Benefits Schedule, the Royal College of Pathologists of Australasia's manual[a] and the Austpath codes[b]*

a. RCPA manual is available at: http://www.rcpamanual.edu.au/
b. Austpath codes are published and described at: http://www.austpath.uow.edu.au/

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Test Name	1.0	Essential		Single

DateTime Specimen Collected

1. Identification

Name	DateTime Specimen Collected
Meta-data Type	Data Element
Identifier	DE-20177 *External Identifier*
Version	1.0

2. Definition

Definition	The date or date and time a specimen required for pathology test was collected.
Definition Source	NEHTA
Synonymous Names	
Scope	For use in healthcare setting. For Pathology Test (e.g. Troponin T), the DateTime specimen collected value is far more meaningful and clinically relevant than DateTime test performed value.
Scope Source	
Assumptions	
Data Type	DateTime
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) 31/03/2004 Example 2) 03/2004 Example 3) 2004 Example 4) 31/03/2004 13:10
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PATHOLOGY TEST	1.0	Essential		Single

Specimen Type

1. Identification

Name	Specimen Type	
Meta-data Type	Data Element	
Identifier	DE-20178	*External Identifier*
Version	1.1	

2. Definition

Definition	The type of specimen associated with the subject of care and collected for analysis.
Definition Source	NEHTA
Synonymous Names	Laboratory Specimen Type; Microbiology Specimen Type
Context	
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	Specimen Type Values

3. Usage

Conditions of Use	Tests may be undertaken on a sample of tissue, fluid, bone or other material taken from the patient. In some cases, e.g. Electrocardiagrams, are undertaken on the whole patient. Often, such whole body tests may be undertaken by, and at a pathology laboratory. In some circumstances, environmental samples external to the patient may be collected and analysed, e.g. water from air conditioning units tested for the presence of legionella bacteria.
Conditions of Use Source	
Examples	Example 1) Urine Example 2) Peripheral blood - serum Example 3) Wound swab - pus Example 4) Tissue biopsy - liver
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PATHOLOGY TEST	1.0	Essential		Single

Specimen Type Values

1. Identification

Name	Specimen Type Values
Meta-data Type	Value Domain
Identifier	VD-20178
Version	1.1

2. Definition

Definition	Permissable values for the type of biological material sampled for analysis.
Definition Source	

3. Value Domain

Source	NEHTA, SNOMED-CT
Version Number	
Permissible Values	*NEHTA will be providing a reference set for this value domain which will include SNOMED-CT terms and identifiers.*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Specimen Type	1.0	Essential		Single

Result Status

1. Identification

Name	Result Status	
Meta-data Type	Data Element	
Identifier	DE-20179	*External Identifier*
Version	1.0	

2. Definition

Definition	The status of the pathology test results/report as indicated by the performing/reporting provider.
Definition Source	NEHTA
Synonymous Names	
Context	
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	Result Status Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Preliminary Example 2) Interim Example 3) Supplementary Example 4) Final Example 5) Corrected (amended)
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PATHOLOGY TEST	1.0	Essential		Single

Result Status Values

1. Identification

Name	Result Status Values
Meta-data Type	Value Domain
Identifier	VD-20179
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed - but likely to include:* Preliminary; Interim; Supplementary; Final; Corrected (amended)

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Result Status	1.0	Essential		Single

STRUCTURED ATOMIC RESULT

1. Identification

Name	STRUCTURED ATOMIC RESULT	
Meta-data Type	Data Group	
Identifier	DG-20163	*External Identifier*
Version	1.1	

2. Definition

Definition	A set of data elements which specify the result of a diagnostic test.
Definition Source	NEHTA
Synonymous Names	
Scope	Used within the PATHOLOGY TEST data group. Captures detailed information on structured (ususally quantified) test results. NOTE - in discharge summary, this data group is used as a grouper to associate a set of information relevant to a structured test result. The group name itself would not normally be displayed in the discharge summary. Instead, it's data element members are displayed in the discharge summary as follows: - Result Name (Displayed as Result Name) - Result Value (Displayed as Value) - Result Units (Displayed as Unit if required) - Reference Range (Displayed as Reference Range) - Out of Range Indicator (Displayed as Out of Range Indicator)
Scope Source	NEHTA
Assumptions	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	PATHOLOGY TEST	1.0	Essential		Multiple

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Atomic Result Name	1.0	Essential		Single
/A/B/T	Result Value	1.0	Essential		Single
T/T010	Result Units (display name = Unit)	1.0	Essential		Single
123//	Reference Range	1.0	Essential		Single
T/T010	Out of Range Indicator		Conditional		Single
T/T010	Test Method		Desirable		Single

Atomic Result Name

1. Identification

Name	Atomic Result Name	
Meta-data Type	Data Element	
Identifier	DE-20180	*External Identifier*
Version	1.0	

2. Definition

Definition	The name of a single result component/element of a test. *Can refer to a single test result (eg serum sodium) or to one component of a test result group, eg electrolytes.*
Definition Source	NEHTA
Synonymous Names	Assessment Name; Investigation Name
Context	
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	Atomic Result Name Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Sodium Example 2) Haemoglobin Example 3) C-Reactive protein
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	STRUCTURED ATOMIC RESULT	1.0	Essential		Single

Atomic Result Name Values

1. Identification

Name	Atomic Result Name Values
Meta-data Type	Value Domain
Identifier	VD-20180
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	NEHTA
Version Number	
Permissible Values	*A national test name register which lists perferred terms; synonyms; SNOMED-CT concepts, terms and Identifiers has been developed by NEHTA. This register, or reference set, has been developed with clinician input, analysis of laboratory information systems, the Australian Medical Benefits Schedule, the Royal College of Pathologists of Australasia's manual[a] and the Austpath codes[b]*

a. RCPA manual is available at: http://www.rcpamanual.edu.au/
b. Austpath codes are published and described at: http://www.austpath.uow.edu.au/

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Atomic Result Name	1.0	Essential		Single

Result Value

1. Identification

Name	Result Value	
Meta-data Type	Data Element	
Identifier	DE-20181	*External Identifier*
Version	1.0	

2. Definition

Definition	The measured level/magnitude of the test result component
Definition Source	NEHTA
Synonymous Names	
Context	
Context Source	
Assumptions	
Data Type	Text or Quantity or Quantity Range or Ratio
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) 140 Example 2) ++ Example 3) Neg
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PATHOLOGY TEST	1.0	Essential		Single

Result Units

1. Identification

Name	Result Units	
Meta-data Type	Data Element	
Identifier	DE-20182	*External Identifier*
Version	1.0	

2. Definition

Definition	
Definition Source	NEHTA
Synonymous Names	
Context	
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	Result Units Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	STRUCTURED ATOMIC RESULT	1.0	Essential		Single

Result Units Values

1. Identification

Name	Result Units Values
Meta-data Type	Value Domain
Identifier	VD-20182
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined - likely to come from SNOMED-CT or the Unified Code for Units and Measures.*
Version Number	
Permissible Values	*to be developed.*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Result Units	1.0	Essential		Single

Reference Range

1. Identification

Name	Reference Range	
Meta-data Type	Data Element	
Identifier	DE-20183	*External Identifier*
Version	1.0	

2. Definition

Definition	The upper and lower acceptable limits of a test result component as determined from an appropriate relevant reference population. It should be noted that reference ranges are sometimes laboratory specific. The reference range is selected by the laboratory to match the patient's demographics - particularly age and sex.
Definition Source	NEHTA
Synonymous Names	Normal Range
Context	
Context Source	
Assumptions	
Data Type	Quantity Range In some implementations, the reference range may be incorporated into the Quantity datatype used for the result value and units.
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	STRUCTURED ATOMIC RESULT	1.0	Essential		Single

Out of Range Indicator

1. Identification

Name	Out of Range Indicator	
Meta-data Type	Data Element	
Identifier	DE-20184	*External Identifier*
Version	1.1	

2. Definition

Definition	Indicates if the result is within or outside of the reference range. This indicator alos describes the relative amount the result is lower or higher than the reference range limits. *Result values are interpreted as diagnostically significant based upon this indicator in the context of the set of other clinical information available.*
Definition Source	NEHTA
Synonymous Names	Abnormal Result Flag; Abnormal Result Indicator
Context	
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	Out of Range Indicator Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Critically low (markedly below lower limit of reference range) Example 2) Critically high (markedly above upper limit of reference range) Example 3) Low (below lower limit of reference range) Example 4) High (above upper limit of reference range)
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	STRUCTURED ATOMIC RESULT	1.0	Conditional		Single

Out of Range Indicator Values

1. Identification

Name	Out of Range Indicator Values
Meta-data Type	Value Domain
Identifier	VD-20184
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Out of Range Indicator	1.0	Essential		Single

Test Method

1. Identification

Name	Test Method	
Meta-data Type	Data Element	
Identifier	DE-20185	*External Identifier*
Version	1.0	

2. Definition

Definition	A description of the specific method(s) used by the laboratory to perform the analyses and produce the results for the requested test(s). *The method used has a critical impact in the comparability of results. A decision on diagnosis can be affected by the method used based on likelihood of false or true positives and negatives related to sensitivities and specificities of tests.*
Definition Source	NEHTA
Synonymous Names	
Context	Associated with the test name and specimen. Method is chosen by the performing pathologist and / or pathology laboratory.
Context Source	
Assumptions	The specimen material is associated with a single subject of care, or group of people, and is what is to be tested.
Data Type	Text
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) cytogenetics banding techniques applied. Example 2) analysis performed using the XYZ brand kit, using the IJK analysis method.
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	STRUCTURED ATOMIC RESULT	1.0	Essential		Single

Additional Finding

1. Identification

Name	Additional Finding	
Meta-data Type	Data Element	
Identifier	DE-20198	*External Identifier*
Version	1.0	

2. Definition

Definition	Interpretive comments relevant to the requested test(s) carried out as provided by the reporting pathologist.
Definition Source	NEHTA
Synonymous Names	
Context	This interpretive note may be based on one test result or the patterns seen across a range of different tet results for this pathology test episode
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) benign - no malignant cells seen Example 2) Heavy infestation of plasmodium falciparum malaria parasites were seen in thick and thin films Example 3) Calcification signs seen at fracture line suggestive of fracture healing
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PATHOLOGY TEST	1.0	Optional		Multiple

Verbatim Report

1. Identification

Name	Verbatim Report
Meta-data Type	Data Element
Identifier	DE-20186 *External Identifier*
Version	1.0

2. Definition

Definition	The actual pathology (histology/cytology, microbiology) and diagnostic imaging test result returned by the pathologist or radiologist to the requesting provider.
Definition Source	NEHTA
Synonymous Names	
Context	The report is a verbatim copy of the report as issued. The results reported may also, or instead, be supplied in a machine-readable structured form.
Context Source	
Assumptions	
Data Type	Text
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PATHOLOGY TEST	1.0	Essential		Single
	DIAGNOSTIC IMAGING TEST	1.0	Essential		Single

Interpretive Note

1. Identification

Name	Interpretive Note	
Meta-data Type	Data Element	
Identifier	DE-20187	*External Identifier*
Version	1.0	

2. Definition

Definition	Interpretive comments relevant to the requested test(s) carried out as provided by the reporting pathologist.
Definition Source	NEHTA
Synonymous Names	
Context	This interpretive note may be based on one test result or the patterns seen across a range of different tet results for this pathology test episode
Context Source	
Assumptions	
Data Type	Text
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) benign - no malignant cells seen Example 2) Heavy infestation of plasmodium falciparum malaria parasites were seen in thick and thin films Example 3) Calcification signs seen at fracture line suggestive of fracture healing
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PATHOLOGY TEST	1.0	Optional		Single

REPORTING PATHOLOGIST

1. Identification

Name	REPORTING PATHOLOGIST
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20162 *External Identifier*
Version	1.0

2. Definition

Definition	Details pertaining to the identification of a provider individual or organisation who/which is requesting a healthcare service provision, in this case pathology or diagnostic imaging test(s).
Definition Source	NEHTA
Synonymous Names	Requesting Provider (Display name) Healthcare provider identification:Requester
Scope	For use in the healthcare setting. Captures identification information on the Healthcare Provider Person or Organisation.
Scope Source	
Assumptions	

Hierarchical Structure

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5. Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PATHOLOGY TEST	1.0	Optional		Single

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	HEALTHCARE PROVIDER IDENTIFIER - INDIVIDUAL	1.0	Desirable		Single
	PERSON NAME	1.0	Essential		Single

DIAGNOSTIC IMAGING

1 Identification

Name	DIAGNOSTIC IMAGING	
Meta-data Type	Event Summary Section	
Identifier	S-20119	*External Identifier*
Version		

2 Definition

Definition	A subsection that groups together relevant diagnostic imaging procedures (radiology studies such as x-rays, CT scan, MRI; ultrasonic studies, nuclear medicine studies, bone densitometry) undertaken on the subject of care during the healthcare event/visit.
Definition Source	NEHTA
Synonymous Names	Radiology
Scope	
Scope Source	
Assumptions	

Hierarchical Structure

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	Used to include all diagnostic tests performed on the subject of care during a healthcare event/visit.

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	INVESTIGATIONS: DETAILED REPORT	1.0	Desirable	If relevant diagnostic imaging study/studies had been done during healthcare event/visit	Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	DIAGNOSTIC IMAGING TEST	1.0	Essential		Multiple

DIAGNOSTIC IMAGING TEST

1. Identification

Name	DIAGNOSTIC IMAGING TEST	
Meta-data Type	Data Group	
Identifier	DG-20164	*External Identifier*
Version		

2. Definition

Definition	A diagnostic imaging procedure (which can be simple radiographic, CT, MRI, PET, ultrasonic, done densitometric, or nuclear medicine study) undertaken on a subject of care. It is also used to include waveform studies in the context of discharge summary and referral.
Definition Source	NEHTA
Synonymous Names	
Scope	Used in healthcare setting. Captures detail information on Diagnostic Imaging Tests. NOTE - this data group name is not used in Discharge Summary. It is used as a grouper only to group all data elements/groups relevant to Diagnostic Imaging Tests. In the discharge summary, the following member data elements/groups of this data group are displayed: - Requesting Provider (not displayed; instead the Healthcare Provider person name is displayed as the Requesting Provider) - Reporting Provider (not displayed; instead the Healthcare Provider person name is displayed as the Repporting Pathologist) - Performed Date - Result Status - Investigation Name - Report - Diagnostic Imaging Note
Scope Source	NEHTA
Assumptions	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	Used to include all diagnostic studies performed on the subject of care during a healthcare event/visit.

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DIAGNOSTIC IMAGING	1.0	Essential		Multiple

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	IMAGING REQUESTER (display name = Requesting Provider)	1.0	Optional		Single
	REPORTING RADIOLOGIST (display name = Reporting Provider)	1.0	Essential		Single
	DateTime Performed (display name = Performed Date)	1.0	Essential		Single
	Report Status (alternate display name = Result Status)	1.0	Essential		Single
	Investigation Name	1.0	Essential		Single
	Imaging Report	1.0	Optional		Single
	Diagnostic Imaging Note	1.0	Optional		Single

IMAGING REQUESTER

1. Identification

Name	IMAGING REQUESTER
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20165 *External Identifier*
Version	1.0

2. Definition

Definition	Details pertaining to the identification of a provider individual or organisation who/which is requesting a healthcare service provision, in this case pathology or diagnostic imaging test(s).
Definition Source	NEHTA
Synonymous Names	Requesting Provider (Display name) Healthcare provider identification:Requester
Scope	For use in the healthcare setting. Captures identification information on the Healthcare Provider Person or Organisation.
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DIAGNOSTIC IMAGING TEST	1.0	Optional		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	HEALTHCARE PROVIDER IDENTIFIER - INDIVIDUAL	1.0	Desirable		Single
	Provider Name	1.0	Essential		Single

REPORTING RADIOLOGIST

1. Identification

Name	REPORTING RADIOLOGIST
Meta-data Type	Data Group
Identifier	DG-20166 *External Identifier*
Version	1.0

2. Definition

Definition	Details pertaining to the identification of the healthcare provider individual (person) or organisation who/which is reporting diagnostic imaging test result(s).
Definition Source	NEHTA
Synonymous Names	Healthcare provider identification:Reporter Radiologist Reporting Radiologist (Display name) Reporting Provider Reporter
Scope	For use in the healthcare setting. Captures identification information on the Healthcare Provider Person or Organisation.
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

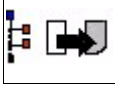
5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DIAGNOSTIC IMAGING TEST	1.0	Optional		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence

	HEALTHCARE PROVIDER IDENTIFIER - INDIVIDUAL	1.0	Desirable		Single
	Provider Name	1.0	Essential		Single

DateTime Performed

1. Identification

Name	DateTime Performed	
Meta-data Type	Data Element	
Identifier	DE-20188	*External Identifier*
Version	1.0	

2. Definition

Definition	The Date or Date and Time a clinical intervention (i.e. clinical procedure such as dialysis, endoscopy, etc) is performed on the subject of care.
Definition Source	NEHTA
Synonymous Names	Date Performed Date and Time Performed Date Procedure Performed Date and Time Procedure Performed Date Test Performed Date and Time Test Performed
Scope	For use in the healthcare setting. Captures the date or the date and time values of a procedure or diagnostic test being performed.
Scope Source	
Assumptions	
Data Type	DateTime
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) 31/03/2004 Example 2) 03/2004 Example 3) 2004 Example 4) 31/03/2004 13:10
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	DIAGNOSTIC IMAGING TEST	1.0	Desirable		Single

Report Status

1. Identification

Name	Report Status	
Meta-data Type	Data Element	
Identifier	DE-20189	*External Identifier*
Version	1.0	

2. Definition

Definition	The status of the diagnostic imaging test report as indicated by the performing/reporting provider.
Definition Source	NEHTA
Synonymous Names	
Context	
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	Report Status Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Preliminary Example 2) Interim Example 3) Supplementary Example 4) Final Example 5) Corrected (amended)
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	DIAGNOSTIC IMAGING TEST	1.0	Essential		Single

Report Status Values

1. Identification

Name	Report Status Values
Meta-data Type	Value Domain
Identifier	VD-20189
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Report Status	1.0	Essential		Single

Investigation Name

1. Identification

Name	Investigation Name	
Meta-data Type	Data Element	
Identifier	DE-20190	*External Identifier*
Version	1.0	

2. Definition

Definition	The diagnostic imaging investigation requested by the healthcare provider, care team or organisation to be performed on the pathology specimen or subject of care.
Definition Source	NEHTA
Synonymous Names	Assessment Name; Investigation Name
Context	The assignation of an identification code to a request by the laboratory or diagnostic imaging facility enables tracking of the progress of a request and provides a report reference number.
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	INVESTIGATION NAME VALUES A set of standard test names is being developed by NEHTA, based on the Austpath codes as recommended in Australian Standard AS4700.2. Part of this development work includes harmonisation with international standards, particularly SNOMED-CT. As at December 2005, NEHTA recommends the use of existing AUSTPATH codes as described in AS4700.2. [AUSTPATH codes were developed by:- , and are copyright …]

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	DIAGNOSTIC IMAGING TEST	1.0	Essential		Single

Investigation Name Values

1. Identification

Name	Investigation Name Values
Meta-data Type	Value Domain
Identifier	VD-20190
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Investigation Name	1.0	Essential		Single

Imaging Report

1. Identification

Name	IMAGING REPORT
Meta-data Type	Data Element
Identifier	DE-20191 *External Identifier*
Version	1.0

2. Definition

Definition	The verbatim diagnostic imaging test report returned by the radiologist to the requesting provider.
Definition Source	NEHTA
Synonymous Names	
Context	The report is a verbatim copy of the report as issued. The results reported may also be augmented by a reference to a machine-readable image.
Context Source	
Assumptions	
Data Type	Text
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	DIAGNOSTIC IMAGING TEST	1.0	Essential		Single

Diagnostic Imaging Note

1. Identification

Name	Diagnostic Imaging Note	
Meta-data Type	Data Element	
Identifier	DE-20192	*External Identifier*
Version	1.0	

2. Definition

Definition	Free text comment relevant to the diagnostic imaging event or report in question.
Definition Source	NEHTA
Synonymous Names	
Context	This interpretive note may be based on one test result or the patterns seen across a range of different tet results for this pathology or diagnostic imaging test episode
Context Source	
Assumptions	
Data Type	Text
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Subject became claustrophobic during the MRI procedure but was able to complete the procedure Example 2) Frail elderly was unable to stand for the erect abdomen X-ray. Sitting AP view of the abdomen was psooible Example 3) Subject was restless during CT procedure and sedation with 10 mg Valium IV was given, the procedure was then completed
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	DIAGNOSTIC IMAGING TEST	1.0	Optional		Single

OTHER INVESTIGATIONS

1 Identification

Name	OTHER INVESTIGATIONS	
Meta-data Type	Event Summary Section	
Identifier	S-20120	*External Identifier*
Version		

2 Definition

Definition	A section that groups together relevant health assessments (other than pathology and diagnostic imaging test) including observation or diagnostic procedures undertaken on the subject of care during the healthcare event/visit.
Definition Source	NEHTA
Synonymous Names	
Scope	For use in healthcare settings. It may also include waveform studies such as ECG, EEC, EMG, etc.
Scope Source	NEHTA
Assumptions	

Hierarchical Structure

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	Used to include all diagnostic tests performed on the subject of care during a healthcare event/visit.

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider, subject of care, carer. Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	INVESTIGATIONS: DETAILED REPORT	1.0	Optional	If relevant health assessments had been done during healthcare event/visit	Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	OBSERVATION	1.0	Essential		Multiple

OBSERVATION

1. Identification

Name	OBSERVATION	
Meta-data Type	Data Group	
Identifier	DG-20167	*External Identifier*
Version		

2. Definition

Definition	Health or physical assessment and/or observation undertaken on the subject of care. The assessment or observation may be subjective, e.g. description of symptoms, appearance; or it may be objective, e.g., body weight, height, heart rate, etc.
Definition Source	NEHTA
Synonymous Names	Health Assessment; Physical Assessment
Scope	Used in healthcare setting. Captures detail information on Other Investtigations (other than Pathology/Laboratory and Diagnostic Imaging tests). NOTE - this data group name is not used in Discharge Summary. It is used as a grouper only to group all data elements/groups relevant to health assessment or investigations other than pathology/laboratory or diagnostic imaging tests. In the discharge summary, the following member data elements/groups of this data group are displayed: - Observation DateTime (Displayed as Date) - Observation Description (Displayed as Description) - Observation Result (Dispalyed as Result) - Result Units (Displayed as Units) - Observation Abormal Flag (Displayed as Abormal Flag) - Observation Note (Displayed as Note)
Scope Source	NEHTA
Assumptions	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	Used to include all diagnostic studies performed on the subject of care during a healthcare event/visit.

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	OTHER INVESTIGATIONS	1.0	Essential		Multiple

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	DateTime of Observation (display name = Date)	1.0	Essential		Single
T/T010	Observation Description (display name = Description)	1.0	Essential		Single
/A/B/T	Observation Result (display name = Result)	1.0	Essential		Single
T/T010	Observation Abnormal Flag (display name = Abnormal Flag)	1.0	Conditional		Single
T	Observation Note (display name = Note)	1.0	Optional		Single

DateTime of Observation

1. Identification

Name	DateTime of Observation	
Meta-data Type	Data Element	
Identifier	DE-20193	*External Identifier*
Version	1.0	

2. Definition

Definition	The date or date and time that the health assessment/observation was performed.
Definition Source	NEHTA
Synonymous Names	
Scope	For use in healthcare setting. Capture the date or date and time the investigation or procedure in question was performed.
Scope Source	
Assumptions	
Data Type	DateTime
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) 31/03/2004 Example 2) 2004-05-19 Example 3) 2004 Example 4) 31/03/2004 13:10
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	OBSERVATION	1.0	Essential		Single

Observation Description

1. Identification

Name	Observation Description	
Meta-data Type	Data Element	
Identifier	DE-20194	*External Identifier*
Version	1.0	

2. Definition

Definition	A description of the type of Observation taken (on the subject of care).
Definition Source	NEHTA
Synonymous Names	
Context	Captures the name of the investigation, or the entity or level of function being observed. For each observation description, there is a corresponding finding or value - see Observation Result. There may also be associated qualifiers such as Observation Abnormal Flag, or Observation Note.
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	Observation Description Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Blood Pressure Example 2) Temperature Example 3) Apgar 1 minute
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	OBSERVATION	1.0	Essential		Single

Observation Description Values

1. Identification

Name	Observation Description Values
Meta-data Type	Value Domain
Identifier	VD-20194
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Observation Description	1.0	Essential		Single

Observation Result

1. Identification

Name	Observation Result	
Meta-data Type	Data Element	
Identifier	DE-20195	*External Identifier*
Version	1.0	

2. Definition

Definition	The outcome of the observation undertaken.
Definition Source	NEHTA
Synonymous Names	
Context	
Context Source	
Assumptions	
Data Type	Text or Quantity or Quantity Range or Ratio
Value Domain	

3. Usage

Conditions of Use	Future versions of this specification may: • support coded or codeable text values • support more complex observation structures • explicitly differentiate between measurable values (e.g. 23 kilogrammes) and qualitative findings (e.g. obese)
Conditions of Use Source	
Examples	Example 1) 120/78 mm Hg (for Blood Pressure) Example 2) 38.6C (for temperature) Example 3) 9 (for Glasgow coma scale)
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	OBSERVATION	1.0	Essential		Single

Observation Abnormal Flag

1. Identification

Name	Observation Abnormal Flag	
Meta-data Type	Data Element	
Identifier	DE-20197	*External Identifier*
Version	1.0	

2. Definition

Definition	A flag indicating the degree of abnormality from the normal limits of the result.
Definition Source	NEHTA
Synonymous Names	Abnormal Flag
Context	
Context Source	
Assumptions	
Data Type	CodeableText
Value Domain	Observation Abnormal Flag Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Abnormal (applies to non numeric result Example 2) critical high (markedly above upper limit of reference range) Example 3) below low normal Example 4) above upper panic limit
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	OBSERVATION	1.0	Conditional		Single

Observation Abnormal Flag Values

1. Identification

Name	Observation Abnormal Flag Values
Meta-data Type	Value Domain
Identifier	VD-20197
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Observation Abnormal Flag	1.0	Essential		Single

Observation Note

1. Identification

Name	Observation Note	
Meta-data Type	Data Element	
Identifier	DE-20198	*External Identifier*
Version	1.0	

2. Definition

Definition	Free text comment relevant to the observation in question.
Definition Source	NEHTA
Synonymous Names	
Context	Used to provide addition information not included in/catered for by the Observation Result data element.
Context Source	
Assumptions	
Data Type	Text
Value Domain	

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) benign - no malignant cells seen Example 2) Heavy infestation of plasmodium falciparum malaria parasites were seen in thick and thin films Example 3) Calcification signs seen at fracture line suggestive of fracture healing
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	OBSERVATION	1.0	Optional		Single

HEALTHCARE PROVIDER

1 Identification

Name	HEALTHCARE PROVIDER		
Meta-data Type	Data Group		
Identifier	DG-10106	*External Identifier*	; AS4846
Version	1.0		

2 Definition

Definition	Details pertaining to a healthcare provider, care team or organisation.
Definition Source	
Synonymous Names	
Scope	The scope of these data elements includes identification of individual and organisation healthcare providers. The data elements also allow for identification of an individual in a healthcare organisation. The definition of healthcare provider is: "any person or organisation who is involved in or associated with the delivery of healthcare to a client, or caring for client wellbeing". The data elements have been defined to enable a common, best practice approach to the way data are captured and stored, to ensure that records relating to a provider will be associated with that individual and/or organisation and no other. The definitions are proposed for clinical and administrative data management purposes. The ability to positively identify healthcare providers and locate their relevant details is an important support to the provision of speedy, safe, high quality, comprehensive and efficient healthcare. Unambiguous identification of individual healthcare providers is necessary for: • Requesting and reporting of orders, tests and results (e.g. pathology, diagnostic imaging) • Other communications and referrals between healthcare providers regarding ongoing care of patients (e.g. a referral from a GP to a specialist, a hospital discharge plan) • Reporting on healthcare provision to statutory authorities (e.g. reporting of hospital patient administration systems data to State/Territory government health agencies) • Payments to providers • Registration of providers • Directories or lists of providers and their service locations for consumer information.
Scope Source	
Assumptions	

Hierarchical Structure

HEALTHCARE PROVIDER IDENTIFICATION (see external reference for full specification ; AS4846)					
	PARTICIPANT DETAILS				
		PERSON NAME (see external reference for full specification ; AS4846; AS5017)			↻
			Name title (see external reference for full specification METeOR ID 270256)		
			Name title sequence number (see external reference for full specification METeOR ID 288263)		
			Given name (see external reference for full specification METeOR ID 270257)		
			Given name sequence number (see external reference for full specification METeOR ID 287595)		
			Family name (see external reference for full specification METeOR ID 270259)		
			Name suffix (see external reference for full specification METeOR ID 270255)		
			Name suffix sequence number (see external reference for full specification METeOR ID 288226)		
			Person name type (see external reference for full specification METeOR ID 270260)		

				Name conditional use flag (see external reference for full specification METeOR ID 287101)	
			PERSON IDENTIFIER (see external reference for full specification ; AS4846; AS5017)		
				Person identifier designation (see external reference for full specification METeOR ID 290046)	
				Person identifier name (see external reference for full specification)	
				Person identifier issuer (see external reference for full specification)	
			ADDRESS (see external reference for full specification ; AS4846; AS5017)		
				Address line (see external reference for full specification METeOR ID 270016)	
				Suburb/town/locality name (see external reference for full specification METeOR ID 270501)	
				Australian State/Territory identifier (see external reference for full specification METeOR ID 270041)	
				Postcode - Australian (see external reference for full specification METeOR ID 270515)	
				Address - country identifier (see external reference for full specification METeOR ID 288091)	
				Non-Australian state/province (see external reference for full specification METeOR ID 288636/288648)	
				Postcode - international (see external reference for full specification METeOR ID 288987)	
				Postal delivery point identifier (see external reference for full specification METeOR ID 270492)	
				Address type (see external reference for full specification METeOR ID 270021)	
			ELECTRONIC COMMUNICATION		
				Electronic communication address (see external reference for full specification METeOR ID 287480/287469)	
				Electronic communication medium (see external reference for full specification METeOR ID 287521/287519)	
				Electronic communication usage code (see external reference for full specification METeOR ID 287579)	
			Sex (see external reference for full specification METeOR ID 287316)		
			Date of birth (see external reference for full specification METeOR ID 270391)		
			Date accuracy indicator (dmy) (see external reference for full specification METeOR ID 289952):Birth date		
			Date of death (see external reference for full specification METeOR ID 287305)		
			Date accuracy indicator (dmy) (see external reference for full specification METeOR ID 289952):Death date		
		ORGANISATION IDENTIFIER (see external reference for full specification ; AS4846)			
			Organisation identifier designation		
			Organisation name		
			Organisation identifier type		
			Organisation name type		
			Organisation start date		
			Organisation end date		
		Provider occupation category (self-identified) (see external reference for full specification METeOR ID 289047)			

		Provider occupation start date (see external reference for full specification METeOR ID 289059)	
		Provider occupation end date (see external reference for full specification METeOR ID 288733)	

3 Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4 Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution

5 Relationships

Parent

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY	1.0	Desirable		Single

HEALTHCARE PROVIDER IDENTIFIER - INDIVIDUAL

1. Identification

Name	HEALTHCARE PROVIDER IDENTIFIER - INDIVIDUAL
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20113 *External Identifier* AS 4846 - 2006
Version	1.0

2. Definition

Definition	A unique number or code issued for the purpose of identifying a healthcare provider Individual (person). The combination of any Healthcare Provider Individual Identifier Designation, Healthcare Provider Identifier Issuer and Healthcare Provider Identifier Type should uniquely identify an individual Healthcare Provider
Definition Source	Standards Australia AS 4846 - 2006 (Healthcare Provider Identification)
Synonymous Names	Healthcare Provider Identifier - Individual Individual Healthcare Provider Index Individual Healthcare Provider Identifier HPI-I
Scope	Used in healthcare setting. Captures the Unqiue Healthcare Provider Person/Individual Identification Number value assigned to the person as a participant (provider) in the healthcare event or within the healthcare system. The healthcare provider person identification number is unique within the organisation, establishment or agency at present. It is intended that this identifier will be nationally unique as part of national infrastructure components being developed by NEHTA. In the Discharge Summary, this data group name (HEALTHCARE PROVIDER IDENTIFER - INDIVIDUAL) is not generally displayed. Instead, the Healthcare Provider Individual Identifier Type data element value is displayed: e.g. HPI-I (display name) - is used in the Referral. Standards Australia AS 4846 - 2006 (Healthcare Provider Identification) document specifies that currently a number of identifier systems can be used to identify a healthcare provider (person): (i) Staff ID Code/Employee Number. (ii) Identifiers assigned by regulatory bodies for professional registration (e.g. an identifier assigned to an individual general practitioner by a State/Territory Medical Registration Board). (iii) Identifiers assigned by government agencies or other regulatory bodies for restricted purposes only e.g. Medicare Provider Number(s), Medicare Prescriber Number(s). (iv) Professional Organization Membership Number (e.g. Medical Directory Australia number [MDA number], Physiotherapy Association of Australia Registration Number). (v) Australian Business Number or Licience Number (for provider organisations/facility). A unique national health provider identifier can be issued by NEHTA to each healthcare provider person or facility. Section 2, P.17 of AS 4846 - 2006 defines a three-data element Healthcare Provider Identifier for individual provider (person): (a) Healthcare Provider Identifier Designation (the number or alpha numeric code assigned to a Healthcare Provider person) (b) Healthcare Provider Identifer Type (e.g. HPI-I, Staff ID) (c) Healthcare Provider Identifier Issuer (e.g. Medicare)
Scope Source	NEHTA and Standards Australia
Assumptions	
Examples	HPI-1234567

3. Usage

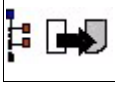
Conditions of Use	Used to uniquely identify a Provider (person) of care within a local organisation, establishment or agency.
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	SPECIALIST	1.0	Desirable	Recommended if unique Provider Identifier available	Single
	REGISTRAR	1.0	Desirable	Recommended if unique Provider Identifier available	Single
	DISCHARGE SUMMARY AUTHOR	1.0	Desirable	Recommended if unique Provider Identifier available	Single
	PROVIDER REFERRER	1.0	Desirable		Single
	HEALTHCARE PROVIDER IDENTIFICATION: USUAL GENERAL PRACTITIONER	1.0	Desirable		Single
	PROVIDER RECIPIENT	1.0	Desirable		Single
	REFERREE	1.0	Desirable		Single
	TEST REQUESTER	1.0	Desirable		Single
	REPORTING PATHOLOGIST	1.0	Desirable		Single
	REPORTING RADIOLOGIST	1.0	Desirable		Single

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	HEALTHCARE PROVIDER INDIVIDUAL IDENTIFIER TYPE (e.g. HPI) (see external reference for full specification AS 4846 - 2007)	1.0	Essential		Single
	HEALTHCARE PROVIDER INDIVIDUAL IDENTIFIER DESIGNATION (see external reference for full specification AS 4846 - 2006: Healthcare Provider Identifier Designation)	1.0	Essential		Single
	HEALTHCARE PROVIDER INDIVIDUAL IDENTIFIER ISSUER (see external reference for full specification AS 4846 - 2006: Healthcare Provider Identifier Issurer)	1.0	Essential		Single

PERSON NAME

1. Identification

Name	PERSON NAME
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20114 *External Identifier*
Version	1.0

2. Definition

Definition	An appellation by which an individual may be identified separately from any other within a social context.
Definition Source	Adapted from NEHTA and Standards Australia AS 5017 - 2006 (Healthcare Client Identification) and AS 4846 - 2006 (Healthcare Provider Identification) and AS 5017 - 2006 (Healthcare Client Identification) documents
Synonymous Names	
Scope	Used in the healthcare setting. Captures the name details of a person (healthcare client or healthcare provider). The AS 4846 - 2006 Section 3, P.23 defines the Healthcare Provider (person) name, and AS 5017 - 2006 Section 3, P.35 defines the Healthcare Client name as a composit data consisting of the following data elements • Name Title • Name Title Sequence Number • Family Name • Gven Name • Gven Name Sequence Nuimber • Name Suffix • Name Suffix Sequence Number • Name Usage • Name Usage Start Date • Name Usage Start Date Accuracy Indicator • Name Usage End Date • Name Usage End Date Accuracy Indicator • Preferred Name Indicator • Name Conditional Usuage Flag In the context of discharge summary, it is recommended that the following four Person Name data elements are included in the PERSON NAME data group: • Name title • Family name • Given names • Name suffix
Scope Source	
Assumptions	

3. Usage

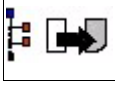
Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	SUBJECT OF CARE	1.0	Essential		Single
	SPECIALIST	1.0	Essential		Single
	REGISTRAR	1.0	Essential		Single
	DISCHARGE SUMMARY AUTHOR	1.0	Essential		Single
	PROVIDER REFERRER	1.0	Essential		Single
	ALTERNATIVE REFERRER	1.0	Essential		Single
	HEALTHCARE PROVIDER IDENTIFICATION: USUAL GENERAL PRACTITIONER	1.0	Essential		Single
	SUBJECT OF CARE RECIPIENT	1.0	Essential		Single
	PROVIDER RECIPIENT	1.0	Essential		Single
	OTHER RECIPIENT	1.0	Essential		Single
	REFERREE	1.0	Essential		Single
	TEST REQUESTER	1.0	Essential		Single
	REPORTING PATHOLOGIST	1.0	Essential		Single
	IMAGING REQUESTER	1.0	Essential		Single
	REPORTING RADIOLOGIST	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	NAME TITLE (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Desirable		Single
	GIVEN NAMES (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Essential		Single
	FAMILY NAME (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Essential		Single
	NAME SUFFIX (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Optional		Single

PROVIDER NAME

1. Identification

Name	Provider Name
Meta-data Type	Externally sourced Data Group specification
Identifier	DG- *External Identifier*
Version	1.0

2. Definition

Definition	An appellation by which an individual (person) is called within a social context.
Definition Source	Adapted from NEHTA and Standards Australia AS 5017 - 2006 (Healthcare Client Identification) and AS 4846 - 2006 (Healthcare Provider Identification) and AS 5017 - 2006 (Healthcare Client Identification) documents
Synonymous Names	
Scope	Used in the healthcare setting. Captures the name details of a person (healthcare client or healthcare provider). The AS 4846 - 2006 Section 3, P.23 defines the Healthcare Provider (person) name, and AS 5017 - 2006 Section 3, P.35 defines the Healthcare Client name as a composit data consisting of the following data elements • Name Title • Name Title Sequence Number • Family Name • Gven Name • Gven Name Sequence Nuimber • Name Suffix • Name Suffix Sequence Number • Name Usage • Name Usage Start Date • Name Usage Start Date Accuracy Indicator • Name Usage End Date • Name Usage End Date Accuracy Indicator • Preferred Name Indicator • Name Conditional Usuage Flag In the context of discharge summary, it is recommended that the following four Person Name data elements are included in the PERSON NAME data group: • Name title • Family name • Given names • Name suffix
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

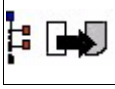
4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice

Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	HEALTHCARE PROVIDER	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	NAME TITLE (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Desirable		Single
	GIVEN NAMES (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Essential		Single
	FAMILY NAME (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Essential		Single
	NAME SUFFIX (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Optional		Single

Provider Occupation Category

1. Identification

Name	Provider Occupation Category	
Meta-data Type	Data Element	
Identifier	DE-20170	*External Identifier*
Version	1.0	

2. Definition

Definition	Descriptor that specifies a healthcare profession or occupation that an individual provider identifies as being one in which he/she provides a significant amount of services
Definition Source	NEHTA
Synonymous Names	Heallth Care Provider Field of Practice (Standards Australia DR06018 Section 7.2.1)
Scope	Used in the healthcare setting. Captures information about the field that an individual Healthcare Provider identifies as being their field of practice i.e. the skill or knowledge in a particular area practised by that provider (Standards AustraliaDR06018 Section 7.2.1).
Scope Source	AS 4846-2006
Assumptions	
Data Type	CodeableText
Value Domain	Provider Occupation Category Values Values to be obtained from Health Provider Identification specification's Provider Occupational Category list

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	- GP - Nurse Practitioner - Nurse Educator - Occupational Therapist - Optometrist - Physiotherapist - Stoma Therapist - Aged/Disabled Person Carer
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	HEALTHCARE PROVIDER	1.0	Optional		Single

Provider Occupation Category Values

1. Identification

Name	Provider Occupation Category Values
Meta-data Type	Value Domain
Identifier	VD-20170
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Provider Occupation Category	1.0	Essential		Single

AUTHORS IDENTIFIER

1. Identification

Name	AUTHORS IDENTIFIER
Meta-data Type	Externally sourced Data Group specification
Identifier	*External Identifier* AS 4846 - 2006
Version	1.0

2. Definition

Definition	A unique number or code issued for the purpose of identifying a healthcare provider Individual (person). The combination of any Healthcare Provider Individual Identifier Designation, Healthcare Provider Identifier Issuer and Healthcare Provider Identifier Type should uniquely identify an individual Healthcare Provider
Definition Source	Standards Australia AS 4846 - 2006 (Healthcare Provider Identification)
Synonymous Names	Healthcare Provider Identifier - Individual Individual Healthcare Provider Index Individual Healthcare Provider Identifier HPI-I
Scope	Used in healthcare setting. Captures the Unqiue Healthcare Provider Person/Individual Identification Number value assigned to the person as a participant (provider) in the healthcare event or within the healthcare system. The healthcare provider person identification number is unique within the organisation, establishment or agency at present. It is intended that this identifier will be nationally unique when NEHTA has completed the design of the national identifier systems. In the Discharge Summary, this data group name (HEALTHCARE PROVIDER IDENTIFER - INDIVIDUAL) is not generally displayed. Instead, the Healthcare Provider Individual Identifier Type data element value is displayed: e.g. HPI-I (display name) - is used in the Referral. Standards Australia AS 4846 - 2006 (Healthcare Provider Identification) document specifies that currently a number of identifier systems can be used to identify a healthcare provider (person): (i) Staff ID Code/Employee Number. (ii) Identifiers assigned by regulatory bodies for professional registration (e.g. an identifier assigned to an individual general practitioner by a State/Territory Medical Registration Board). (iii) Identifiers assigned by government agencies or other regulatory bodies for restricted purposes only e.g. Medicare Provider Number(s), Medicare Prescriber Number(s). (iv) Professional Organization Membership Number (e.g. Medical Directory Australia number [MDA number], Physiotherapy Association of Australia Registration Number). (v) Australian Business Number or Licience Number (for provider organisations/facility). A unique national health provider identifier can be issued by NEHTA to each healthcare provider person or facility. Section 2, P.17 of AS 4846 - 2006 defines a three-data element Healthcare Provider Identifier for individual provider (person): (a) Healthcare Provider Identifier Designation (the number or alpha numeric code assigned to a Healthcare Provider person) (b) Healthcare Provider Identifer Type (e.g. HPI-I, Staff ID) (c) Healthcare Provider Identifier Issuer (e.g. Medicare)
Scope Source	NEHTA and Standards Australia
Assumptions	
Examples	HPI-1234567

3. Usage

Conditions of Use	Used to uniquely identify a Provider (person) of care within a local organisation, establishment or agency.

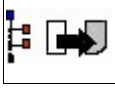
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY AUTHOR	1.0	Desirable	Recommended if unique Provider Identifier available	Single

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	HEALTHCARE PROVIDER INDIVIDUAL IDENTIFIER TYPE (e.g. HPI) (see external reference for full specification AS 4846 - 2007)	1.0	Essential		Single
	HEALTHCARE PROVIDER INDIVIDUAL IDENTIFIER DESIGNATION (see external reference for full specification AS 4846 - 2006: Healthcare Provider Identifier Designation)	1.0	Essential		Single
	HEALTHCARE PROVIDER INDIVIDUAL IDENTIFIER ISSUER (see external reference for full specification AS 4846 - 2006: Healthcare Provider Identifier Issurer)	1.0	Essential		Single

AUTHORS NAME

1. Identification

Name	AUTHORS NAME
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20118 *External Identifier*
Version	1.0

2. Definition

Definition	An appellation by which an individual (person) is called within a social context.
Definition Source	Adapted from NEHTA and Standards Australia AS 5017 - 2006 (Healthcare Client Identification) and AS 4846 - 2006 (Healthcare Provider Identification) and AS 5017 - 2006 (Healthcare Client Identification) documents
Synonymous Names	
Scope	Used in the healthcare setting. Captures the name details of a person (healthcare client or healthcare provider). The AS 4846 - 2006 Section 3, P.23 defines the Healthcare Provider (person) name, and AS 5017 - 2006 Section 3, P.35 defines the Healthcare Client name as composite data consisting of the following data elements • Name Title • Name Title Sequence Number • Family Name • Gven Name • Gven Name Sequence Nuimber • Name Suffix • Name Suffix Sequence Number • Name Usage • Name Usage Start Date • Name Usage Start Date Accuracy Indicator • Name Usage End Date • Name Usage End Date Accuracy Indicator • Preferred Name Indicator • Name Conditional Usuage Flag In the context of discharge summary, it is recommended that the following four Person Name data elements are included in the PERSON NAME data group: • Name title • Family name • Given names • Name suffix
Scope Source	
Assumptions	
Examples	

3. Usage

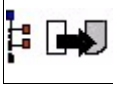
Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	DISCHARGE SUMMARY AUTHOR	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	NAME TITLE (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Desirable		Single
	GIVEN NAMES (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Essential		Single
	FAMILY NAME (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Essential		Single
	NAME SUFFIX (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Optional		Single

REGISTRARS IDENTIFIER

1. Identification

Name	REGISTRARS IDENTIFIER
Meta-data Type	Externally sourced Data Group specification
Identifier	*External Identifier* AS 4846 - 2006
Version	1.0

2. Definition

Definition	A unique number or code issued for the purpose of identifying a healthcare provider Individual (person). The combination of any Healthcare Provider Individual Identifier Designation, Healthcare Provider Identifier Issuer and Healthcare Provider Identifier Type should uniquely identify an individual Healthcare Provider
Definition Source	Standards Australia AS 4846 - 2006 (Healthcare Provider Identification)
Synonymous Names	Healthcare Provider Identifier - Individual Individual Healthcare Provider Index Individual Healthcare Provider Identifier HPI-I
Scope	Used in healthcare setting. Captures the Unqiue Healthcare Provider Person/Individual Identification Number value assigned to the person as a participant (provider) in the healthcare event or within the healthcare system. The healthcare provider person identification number is unique within the organisation, establishment or agency at present. It is intended that this identifier will be nationally unique when NEHTA has completed the design of the national identifier systems. In the Discharge Summary, this data group name (HEALTHCARE PROVIDER IDENTIFER - INDIVIDUAL) is not generally displayed. Instead, the Healthcare Provider Individual Identifier Type data element value is displayed: e.g. HPI-I (display name) - is used in the Referral. Standards Australia AS 4846 - 2006 (Healthcare Provider Identification) document specifies that currently a number of identifier systems can be used to identify a healthcare provider (person): (i) Staff ID Code/Employee Number. (ii) Identifiers assigned by regulatory bodies for professional registration (e.g. an identifier assigned to an individual general practitioner by a State/Territory Medical Registration Board). (iii) Identifiers assigned by government agencies or other regulatory bodies for restricted purposes only e.g. Medicare Provider Number(s), Medicare Prescriber Number(s). (iv) Professional Organization Membership Number (e.g. Medical Directory Australia number [MDA number], Physiotherapy Association of Australia Registration Number). (v) Australian Business Number or Licience Number (for provider organisations/facility). A unique national health provider identifier can be issued by NEHTA to each healthcare provider person or facility. Section 2, P.17 of AS 4846 - 2006 defines a three-data element Healthcare Provider Identifier for individual provider (person): (a) Healthcare Provider Identifier Designation (the number or alpha numeric code assigned to a Healthcare Provider person) (b) Healthcare Provider Identifer Type (e.g. HPI-I, Staff ID) (c) Healthcare Provider Identifier Issuer (e.g. Medicare)
Scope Source	NEHTA and Standards Australia
Assumptions	
Examples	HPI-1234567

3. Usage

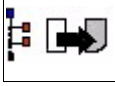
Conditions of Use	Used to uniquely identify a Provider (person) of care within a local organisation, establishment or agency.
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	REGISTRAR	1.0	Desirable	Recommended if unique Provider Identifier available	Single

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	HEALTHCARE PROVIDER INDIVIDUAL IDENTIFIER TYPE (e.g. HPI) (see external reference for full specification AS 4846 - 2007)	1.0	Essential		Single
	HEALTHCARE PROVIDER INDIVIDUAL IDENTIFIER DESIGNATION (see external reference for full specification AS 4846 - 2006: Healthcare Provider Identifier Designation)	1.0	Essential		Single
	HEALTHCARE PROVIDER INDIVIDUAL IDENTIFIER ISSUER (see external reference for full specification AS 4846 - 2006: Healthcare Provider Identifier Issurer)	1.0	Essential		Single

REGISTRARS NAME

1. Identification

Name	REGISTRARS NAME
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-506 (NEHTA data group ID) *External Identifier*
Version	1.0

2. Definition

Definition	An appellation by which an individual (person) is called within a social context.
Definition Source	Adapted from NEHTA and Standards Australia AS 5017 - 2006 (Healthcare Client Identification) and AS 4846 - 2006 (Healthcare Provider Identification) documents
Synonymous Names	
Scope	Used in the healthcare setting. Captures the name details of a person (healthcare client or healthcare provider). The AS 4846 - 2006 Section 3, P.23 defines the Healthcare Provider (person) name, and AS 5017 - 2006 Section 3, P.35 defines the Healthcare Client name as a composit data consisting of the following data elements • Name Title • Name Title Sequence Number • Family Name • Gven Name • Gven Name Sequence Nuimber • Name Suffix • Name Suffix Sequence Number • Name Usage • Name Usage Start Date • Name Usage Start Date Accuracy Indicator • Name Usage End Date • Name Usage End Date Accuracy Indicator • Preferred Name Indicator • Name Conditional Usuage Flag In the context of discharge summary, it is recommended that the following four Person Name data elements are included in the PERSON NAME data group: • Name title • Family name • Given names • Name suffix
Scope Source	
Assumptions	
Examples	

3. Usage

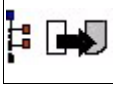
Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	REGISTRAR	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	NAME TITLE (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Desirable		Single
	GIVEN NAMES (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Essential		Single
	FAMILY NAME (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Essential		Single
	NAME SUFFIX (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Optional		Single

SPECIALISTS IDENTIFIER

1. Identification

Name	SPECIALISTS IDENTIFIER
Meta-data Type	Externally sourced Data Group specification (AS 4846 - 2006)
Identifier	*External Identifier*
Version	1.0

2. Definition

Definition	A unique number or code issued for the purpose of identifying a healthcare provider Individual (person). The combination of any Healthcare Provider Individual Identifier Designation, Healthcare Provider Identifier Issuer and Healthcare Provider Identifier Type should uniquely identify an individual Healthcare Provider
Definition Source	Standards Australia AS 4846 - 2006 (Healthcare Provider Identification)
Synonymous Names	Healthcare Provider Identifier - Individual Individual Healthcare Provider Index Individual Healthcare Provider Identifier HPI-I
Scope	Used in healthcare setting. Captures the Unqiue Healthcare Provider Person/Individual Identification Number value assigned to the person as a participant (provider) in the healthcare event or within the healthcare system. The healthcare provider person identification number is unique within the organisation, establishment or agency at present. It is intended that this identifier will be nationally unique when NEHTA has completed the design of the national identifier systems. In the Discharge Summary, this data group name (HEALTHCARE PROVIDER IDENTIFER - INDIVIDUAL) is not generally displayed. Instead, the Healthcare Provider Individual Identifier Type data element value is displayed: e.g. HPI-I (display name) - is used in the Referral. Standards Australia AS 4846 - 2006 (Healthcare Provider Identification) document specifies that currently a number of identifier systems can be used to identify a healthcare provider (person): (i) Staff ID Code/Employee Number. (ii) Identifiers assigned by regulatory bodies for professional registration (e.g. an identifier assigned to an individual general practitioner by a State/Territory Medical Registration Board). (iii) Identifiers assigned by government agencies or other regulatory bodies for restricted purposes only e.g. Medicare Provider Number(s), Medicare Prescriber Number(s). (iv) Professional Organization Membership Number (e.g. Medical Directory Australia number [MDA number], Physiotherapy Association of Australia Registration Number). (v) Australian Business Number or Licience Number (for provider organisations/facility). A unique national health provider identifier can be issued by NEHTA to each healthcare provider person or facility. Section 2, P.17 of AS 4846 - 2006 defines a three-data element Healthcare Provider Identifier for individual provider (person): (a) Healthcare Provider Identifier Designation (the number or alpha numeric code assigned to a Healthcare Provider person) (b) Healthcare Provider Identifer Type (e.g. HPI-I, Staff ID) (c) Healthcare Provider Identifier Issuer (e.g. Medicare)
Scope Source	NEHTA and Standards Australia
Assumptions	
Examples	HPI-1234567

3. Usage

Conditions of Use	Used to uniquely identify a Provider (person) of care within a local organisation, establishment or agency.
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	SPECIALIST	1.0	Desirable	Recommended if unique Provider Identifier available	Single

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	HEALTHCARE PROVIDER INDIVIDUAL IDENTIFIER TYPE (e.g. HPI) (see external reference for full specification AS 4846 - 2007)	1.0	Essential		Single
	HEALTHCARE PROVIDER INDIVIDUAL IDENTIFIER DESIGNATION (see external reference for full specification AS 4846 - 2006: Healthcare Provider Identifier Designation)	1.0	Essential		Single
	HEALTHCARE PROVIDER INDIVIDUAL IDENTIFIER ISSUER (see external reference for full specification AS 4846 - 2006: Healthcare Provider Identifier Issurer)	1.0	Essential		Single

SPECIALISTS NAME

1. Identification

Name	SPECIALISTS NAME
Meta-data Type	Externally sourced Data Group specification
Identifier	DG- *External Identifier*
Version	1.0

2. Definition

Definition	An appellation by which an individual (person) is called within a social context.
Definition Source	Adapted from NEHTA and Standards Australia AS 5017 - 2006 (Healthcare Client Identification) and AS 4846 - 2006 (Healthcare Provider Identification) and AS 5017 - 2006 (Healthcare Client Identification) documents
Synonymous Names	
Scope	Used in the healthcare setting. Captures the name details of a person (healthcare client or healthcare provider). The AS 4846 - 2006 Section 3, P.23 defines the Healthcare Provider (person) name, and AS 5017 - 2006 Section 3, P.35 defines the Healthcare Client name as a composit data consisting of the following data elements • Name Title • Name Title Sequence Number • Family Name • Gven Name • Gven Name Sequence Nuimber • Name Suffix • Name Suffix Sequence Number • Name Usage • Name Usage Start Date • Name Usage Start Date Accuracy Indicator • Name Usage End Date • Name Usage End Date Accuracy Indicator • Preferred Name Indicator • Name Conditional Usuage Flag In the context of discharge summary, it is recommended that the following four Person Name data elements are included in the PERSON NAME data group: • Name title • Family name • Given names • Name suffix
Scope Source	
Assumptions	
Examples	

3. Usage

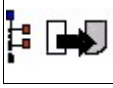
Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	SPECIALIST	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	NAME TITLE (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Desirable		Single
	GIVEN NAMES (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Essential		Single
	FAMILY NAME (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Essential		Single
	NAME SUFFIX (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Optional		Single

PROVIDER ORGANISATION IDENTIFICATION

1. Identification

Name	PROVIDER ORGANISATION IDENTIFICATION
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20108 *External Identifier* AS 4846 - 2006
Version	1.0

2. Definition

Definition	Details, including a unique number or code issued for the purpose of identifying a healthcare provider organisation entity or facility. The combination of any Healthcare Provider Organisation Identifier Designation, Healthcare Provider Organisation Identifier Geographic Area, Healthcare Provider Organisation Identifier Issuer and Healthcare Provider Organisation Identifier Type should uniquely identify an individual Healthcare Provider Organisation entity or facility
Definition Source	Standards Australia AS 4846 - 2006 (Healthcare Provider Identification)
Synonymous Names	HHealthcare Organisation Identifier Healthcare Provider Organisation Identifier HPI-O
Scope	Used in healthcare setting. Captures the Unqiue Organization Identification Number value assigned to an Organisation involved in delivery of healthcare services within the healthcare system. In the Discharge Summary, this data group name (HEALTHCARE PROVIDER IDENTIFER - ORGANISATION) is not generally displayed. Instead, the Healthcare Organisation Identifier Name data element value is displayed: e.g. organisation HPI-O (display name). Standards Australia AS 4846 - 2006 (Section 8, P.93) specifies the following data structure for the Healthcare Provider Organisation Identifier: • Healthcare Provider Organisation Identifier Designation (the code assigned to a provider organisation) • Healthcare Provider Organisation Identifier Geographic Area (e.g. local, state, national) • Healthcare Provider Organisation Identifier Issuer • Healthcare Provider Organisation Identifier Type (e.g. Provider Organisation HPI-O, ABN, etc)
Scope Source	NEHTA and Standards Australia
Assumptions	

3. Usage

Conditions of Use	Used to uniquely identify a subject of care within a local organisation, establishment or agency.
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	FACILITY	1.0	Desirable		Single
	PROVIDER REFERRER	1.0	Conditional	If referrer is a healthcare provider organisation; and if unique identifier is available	Single
	HEALTHCARE PROVIDER IDENTIFICATION: USUAL GENERAL PRACTITIONER	1.0	Desirable		Single
	PROVIDER RECIPIENT	1.0	Conditional	If recipient is a healthcare provider organisation' and if unique identifier is available	Multiple
	REFERREE	1.0	Conditional	If referred to party is a healthcare provider organisation; and if unique identifier is available	Multiple

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	HEALTHCARE PROVIDER ORGANISATION IDENTIFIER TYPE (e.g. ABN; HPI-O) (see external reference for full specification - AS 4846 - 2006)	1.0	Essential		Single
T	HEALTHCARE ORGANISATION IDENTIFIER DESIGNATION (see external reference for full specification - AS 4846 - 2006)	1.0	Essential		Single
T/T010	HEALTHCARE ORGANISATION IDENTIFIER ISSUER (e.g. ATO, NEHTA) (see external reference for full specification - AS 4846 - 2006)	1.0	Essential		Single
T	HEALTHCARE ORGANISATION IDENTIFIER GEOGRAPHIC AREA (e.g. local; regional; state; national) (see external reference for full specification - AS 4846 - 2006)	1.0	Conditional	May not be required if national Identifier is in use nationally	Single

HEALTHCARE PROVIDER IDENTIFIER - ORGANISATION

1. Identification

Name	HEALTHCARE PROVIDER IDENTIFIER - ORGANISATION
Meta-data Type	Externally sourced Data Group specification
Identifier	*External Identifier* AS 4846 - 2006
Version	1.0

2. Definition

Definition	A unique number or code issued for the purpose of identifying a healthcare provider organisation entity or facility. The combination of any Healthcare Provider Organisation Identifier Designation, Healthcare Provider Organisation Identifier Geographic Area, Healthcare Provider Organisation Identifier Issuer and Healthcare Provider Organisation Identifier Type should uniquely identify an individual Healthcare Provider Organisation entity or facility
Definition Source	Standards Australia AS 4846 - 2006 (Healthcare Provider Identification)
Synonymous Names	HHealthcare Organisation Identifier Healthcare Provider Organisation Identifier HPI-O
Scope	Used in healthcare setting. Captures the Unqiue Organization Identification Number value assigned to an Organisation involved in delivery of healthcare services within the healthcare system. In the Discharge Summary, this data group name (HEALTHCARE PROVIDER IDENTIFER - ORGANISATION) is not generally displayed. Instead, the Healthcare Organisation Identifier Name data element value is displayed: e.g. organisation HPI-O (display name) - is used in the Referral. Standards Australia AS 4846 - 2006 (Section 8, P.93) specifies the following data structure for the Healthcare Provider Organisation Identifier: (a) Healthcare Provider Organisation Identifier Designation (the code assigned to a provider organisation) (b) Healthcare Provider Organisation Identifier Geographic Area (e.g. local, state, national) (c) Healthcare Provider Organisation Identifier Issuer (d) Healthcare Provider Organisation Identifier Type (e.g. Provider Organisation HPI-O, ABN, etc)
Scope Source	NEHTA and Standards Australia
Assumptions	

3. Usage

Conditions of Use	Used to uniquely identify a subject of care within a local organisation, establishment or agency.
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	FACILITY	1.0	Desirable		Single
	PROVIDER REFERRER	1.0	Conditional	If referrer is a healthcare provider organisation; and if unique identifier is available	Single
	HEALTHCARE PROVIDER IDENTIFICATION: USUAL GENERAL PRACTITIONER	1.0	Desirable		Single
	PROVIDER RECIPIENT	1.0	Conditional	If recipient is a healthcare provider organisation' and if unique identifier is available	Multiple

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
T/T010	HEALTHCARE PROVIDER ORGANISATION IDENTIFIER TYPE (e.g. ABN; HPI-O) (see external reference for full specification - AS 4846 - 2006)	1.0	Essential		Single
T	HEALTHCARE ORGANISATION IDENTIFIER DESIGNATION (see external reference for full specification - AS 4846 - 2006)	1.0	Essential		Single
T/T010	HEALTHCARE ORGANISATION IDENTIFIER ISSUER (e.g. ATO, NEHTA) (see external reference for full specification - AS 4846 - 2006)	1.0	Essential		Single
T	HEALTHCARE ORGANISATION IDENTIFIER GEOGRAPHIC AREA (e.g. local; regional; state; national) (see external reference for full specification - AS 4846 - 2006)	1.0	Conditional	May not be required if national Identifier is in use nationally	Single

ORGANISATION NAME

1. Identification

Name	ORGANISATION NAME
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20109 *External Identifier*
Version	1.0

2. Definition

Definition	*An appellation/name by which an establishment, agency, facility or organisation can be identified or called.*
Definition Source	
Synonymous Names	Healthcare Provider Organisation Name
Scope	For use in healthcare settings. For correct identification of healthcare organisations. A Healthcare Organisation Name is a composite data element (a combination of nine data elements). These data elements are specified in (Section 9, P.100) Standards Australia Healthcare Provider Identification document (AS 4846 - 2006) . • Healthcare Provider Organisation Name • Healthcare Provider Organisation Name Usage • Healthcare Organisation Name Usage Start Date + Start Date Accuracy Indicator • Healthcare Organization Name Usage End Date + End Date Accuracy Indicator
Scope Source	
Assumptions	In the context of discharge summary, one Provider Organisation Name data elements from AS 4846 - 2006 is used: • Healthcare Provider Organisation Name
Data Type	See external reference for full specification - AS 4846-2006 and AS 5017-2006
Example	Example 1) Royal Adelaide Hospital Example 2) Wakefield Endoscope Clinic

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	PROVIDER REFERRER	1.0	Conditional	Required if referrer is a healthcare provider organisation. Ohterwise, obligation = desirable	Single

ELECTRONIC COMMUNICATION DETAILS

1. Identification

Name	ELECTRONIC COMMUNICATION DETAILS
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20111 *External Identifier* AS4846 - 2006
Version	1.0

2. Definition

Definition	The electronic communication details of an organisation or individual, such as telephone numbers, fax numbers, pager numbers, email addresses and website addresses.
Definition Source	
Synonymous Names	Healthcare Provider Electronic Communication Healthcare Provider Organisation Electronic Communication Telecommunication Telephone Phone Fax Pager Email
Scope	For used in healthcare setting. Captures detail information on electronic communications which include telephone, pager, fax, email or website. An electronic communication is a composite data element that is captured through the combination of three data elements. These three data elements are set out in the Standards Australia Healthcare Client and Healthcare Provider Identification documents • AS 4846 - 2006 Section 6, Healthcare Provider Electronic Communication • AS 4846 - 2006 Section 11, Healthcare Provider Organisation Electronic Communication • AS 5017 - 2006 Section 6, Healthcare Client Electronic Communication The three data elements are: • Electronic Communication Medium (e.g. telephone, facsimile, pager, email) • Electronic Communication Medium Usage Code (e.g. personal, business) • Electronic Communication Details (the phone/fax number or email address) [NEHTA data element name for this item = Electronic Communication Address) In the context of Discharge summary, only the following data elements are used: • Electronic Communication Medium (see external reference for full specification AS 4846 - 2006, and AS 5017 - 2006) • Electronic Communication Details (see external reference for full specification AS 4846 - 2006, and AS 5017 - 2006)
Scope Source	
Assumptions	

3. Usage

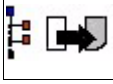
Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	FACILITY	1.0	Essential	Essential (Telephone), Optional (Fax/Email)	Single
	REGISTRAR	1.0	Desirable	usually Pager No is used. May not be used in some facilities/jurisdictions which have concern over giving out patient/client information over telephone enquiry.	Single
	PROVIDER REFERRER	1.0	Desirable	Desirable (Telphone), Optional (Fax/Email)	Single
	ALTERNATIVE REFERRER	1.0	Desirable	Desirable (Telphone), Optional (Fax/Email)	Single
	HEALTHCARE PROVIDER IDENTIFICATION: USUAL GENERAL PRACTITIONER	1.0	Desirable	Desirable (Telphone), Optional (Fax/Email)	Single
	PROVIDER RECIPIENT	1.0	Desirable	Desirable (Telphone), Optional (Fax/Email)	Single
	OTHER RECIPIENT	1.0	Optional		Single
	REFERREE	1.0	Desirable	Desirable (Telphone), Optional (Fax/Email)	Single

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	ELECTRONIC COMMUNICATION MEDIUM (i.e. telephone, Pager, fax or email) (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Essential		Single
	ELECTRONIC COMMUNICATION ADDRESS (i.e. telephone, pager, or fax numbers, email address) (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Essential		Single

Department/Unit

1. Identification

Name	Department/Unit
Meta-data Type	Data Element
Identifier	*External Identifier*
Version	1.0

2. Definition

Definition	Name of the department or unit within a larger organisation.
Definition Source	NEHTA
Synonymous Names	
Scope	
Scope Source	
Assumptions	
Data Type	CodeableText
Value Domain	Department Values

3. Usage

Conditions of Use	This department or unit name may be required where it is not explicitly obtainable by the Organisation Identifier
Conditions of Use Source	
Examples	Example 1) Department of Oncology *(of a some hospital)* Example 2) Chest Clinic Example 3) Ward 8B
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	FACILITY	1.0	Optional		Single

Department Values

1. Identification

Name	Department Values
Meta-data Type	Value Domain
Identifier	
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Department/Unit	1.0	Essential		Single

ADDRESS

1. Identification

Name	ADDRESS
Meta-data Type	Externally sourced Data Group specification
Identifier	DG- *External Identifier*
Version	1.0

2. Definition

Definition	The referential description of a location where an entity (person or organisation) is located or can be otherwise reached or found.
Definition Source	
Synonymous Names	
Scope	Used in the healthcare setting. Captures detail information on the address of: • healthcare client • healthcare provider (person) • healthcare provider organisation • the discharge to address. A Healthcare Client Address is a composite data element (combination of data elements). These data elements are specified in (Section 5, P.69) the Standards Australia Healthcare Client Identification document (AS 5017 - 2006): • Australian Address line (Buidling/Complex Sub-Unit Type - Abbreviation; Building/Complex Sub-Unit Number; Building/Property Name; Floor/Level Number; Floor/Level Type; House/Property Number; Lot/Section Number; Street Name; Street Type Code; Street Suffix Code) • Australian Suburb/Town/Locality • Australian State/Territory Identifier - Postal • Australian Postcode • Healthcare Client International Address.International Address Line • Healthcare Client International Address.International State/Province • Healthcare Client International Address.International Postcode • Healthcare Client International Address.Country Identifier • Address Purpose Details (e.g. Address Purpose, Address Purpose Start Date + Start Date Accuracy Indicator; Address Purpose End Date + End Date Accuracy Indicator) • No fixed address indicator A Healthcare Provider Address is a composite data element (combination of data elements). These data elements are specified in (Section 5, P.51) the Standards Australia Healthcare Client Identification document (AS 4846 - 2006). The data group structure is same as the "Address" data group defined for Healthcare Client. In the context of discharge summary, it is recommended that six Address data elements from AS 5017 - 2006 and AS 4846 - 2006 are included in this data group: • Australian Address Line • Australian Suburb/Town/Locality • Australian Postcode - Australia • International Address Line • International State/Province • International Postcode • Country Identifier • Country (Country Name) [country name is included to provide human readable information as the Country Identifier specified in AS 4846 - 2006 consists only a four-character numeric code] The "Country Identifier" is defined in the Standards Australia Healthcare Client and Provider Identification documents as: "The four character numeric code should be used for data storage and messaging. The full descriptor should be used for data collection or onscreen display (where possible) and all printing or other forms of output." The "Country" data element is added to this specification to facilitate the capturing of the "full descriptor" (country name).
Scope Source	
Assumptions	

3. Usage

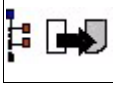
Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	FACILITY	1.0	Essential		Single
	HEALTHCARE PROVIDER IDENTIFICATION: USUAL GENERAL PRACTITIONER	1.0	Desirable		Single
	PROVIDER RECIPIENT	1.0	Desirable		Single
	OTHER RECIPIENT	1.0	Optional		Single
	REFERREE	1.0	Desirable		Single

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	AUSTRALIAN ADDRESS LINE (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Essential		Single
	AUSTRALIAN SUBURB/TOWN/LOCALITY (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Essential		Single
	AUSTRALIAN STATE/PROVINCE (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Optional		Single
	AUSTRALIAN POSTCODE (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Optional	Essential/Desirable for Australian addresses	Single

	INTERNATIONAL ADDRESS LINE (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	If Subject of Care has international address	Single
	INTERNATIONAL SUBURB/TOWN/ LOCALITY (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	If Subject of Care has international address	Single
	INTERNATIONAL STATE/PROVINCE (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	If Subject of Care has international address	Single
	INTERNATIONAL POSTCODE (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	If Subject of Care has international address	Single
	COUNTRY IDENTIFIER (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	If Subject of Care has international address	Single
	COUNTRY (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	Essential for International addresses	Single

SUBJECT OF CARE

1. Identification

Name	SUBJECT OF CARE
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20103 *External Identifier* AS 5017-2006
Version	1.0

2. Definition

Definition	Details pertaining to the identification of the healthcare client (subject of care) about whom the healthcare event/visit information has been captured and/or interchanged.
Definition Source	NEHTA
Synonymous Names	Patient Details; Subject of Care Identification
Scope	For use in the healthcare setting. Captures identification information about the subject of care. Based on stakeholder feedbacks, the following Healthcare Client Identification data elements should be included: Individual Healthcare Identifier: Individual Healthcare Identifier Name - Obligation = Essential; Individual Healthcare Identifier Designation - Obligation = Desirable Person Name (First name, middle name/initial, Family name) - Obligation = Essential Address - Obligation = Essential Date of Birth - Obligation = Essential Age - Obligation = Desirable Sex - Obligation = Essential
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	HEALTH EVENT CONTEXT	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	INDIVIDUAL HEALTHCARE IDENTIFIER	1.0	Essential		Single
	PERSON NAME	1.0	Essential		Single
	ADDRESS	1.0	Essential		Single
	Sex	1.0	Essential		Single
	Date of Birth	1.0	Essential		Single
	Age	1.0	Essential		Single

INDIVIDUAL HEALTHCARE IDENTIFIER

1. Identification

Name	INDIVIDUAL HEALTHCARE IDENTIFIER
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20104 *External Identifier* AS 5017 - 2006
Version	1.0

2. Definition

Definition	A unique number or code issued for the purpose of identifying an individual healthcare client. The combination of any Individual Healthcare Identifier Designation, Individual Healthcare Identifier Geographical Area, Individual Healthcare Identifier Issuer and Individual Healthcare Identifier Type should provide unique identification.
Definition Source	Standards Australia AS 5017 - 2006 (Healthcare Client Identification).
Synonymous Names	IHI; Individual Health Index; National Health Index (NHI); Healthcare Client Identifier; Subject of Care Identifier; Consumer Identifier
Scope	Used in healthcare setting. Captures the Unqiue Person Identification Number value assigned to the person as a participant (subject of care) in the healthcare event or within the healthcare system. The number is unique within the organisation, establishment or agency at present (i.e. before a unique national identifier is available. A unique national identifier system and service are currently being designed by NEHTA). In the Discharge Summary, this data group name (INDIVIDUAL HEALTHCARE IDENTIFER) is not generally displayed. Instead, the Individual Healthcare Identifier Name data element value is displayed: MRN (display name) - display name used in the Discharge Summary Mock-up document URN (display name); or IHI (display name) The Standards Australia Healthcare Client Identification document (AS 5017 - 2006) specifies a four-data element identifier structure for Healthcare Client Identification Number/Identifier: (a) Healthcare Client Identifier Designation (A number or code assigned to a person by an organization, establishment or agency in order to uniquely identify that person as a subject of healthcare.) (b) Healthcare Client Identifier Geographic Area (e.g. local, state, national, etc) (c) Healthcare Client Identifier Issuer (The organization that allocates a client identifier which uniquely identifies a healthcare client within that organization. It specifies the name of the organisation or establishment). (d) Healthcare Client Identifier Type (e.g. DVA number, Medicare Number, IHI, etc)
Scope Source	NEHTA and Standards Australia (AS 5017 - 2006)
Assumptions	
Examples	URN: 123456A

3. Usage

Conditions of Use	Used to uniquely identify a subject of care within a local organisation, establishment or agency.
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice

Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	SUBJECT OF CARE	1.0	Essential	URN/MRN = Essential in the absence of IHI and Optional if IHI available; IHI = Essential if available	Multiple

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	INDIVIDUAL HEALTHCARE IDENTIFIER TYPE (e.g. IHI) (see external reference for full specification AS 5017 - 2006: Healthcare Client Identifier Type)	1.0	Essential		Single
	INDIVIDUAL HEALTHCARE IDENTIFIER DESIGNATION (e.g. 0015789) (see external reference for full specification AS 5017 - 2006: Healthcare Client Identifier Designation)	1.0	Essential		Single
	INDIVIDUAL HEALTHCARE IDENTIFIER ISSUER (e.g. Royal Adelaide Hospital) (see external reference for full specification AS 5017 - 2006: Healthcare Client Identifier Issurer)	1.0	Essential		Single
	INDIVIDUAL HEALTHCARE IDENTIFIER GEOGRAPHIC AREA (e.g. local; regional; state; national) (see external reference for full specification AS 5017 - 2006: Healthcare Client Identifier Geographic Area)	1.0	Conditional	May not be required if a national Identifier is in use nationally	Single

PERSON NAME

1. Identification

Name	PERSON NAME
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20105 *External Identifier* AS5017 - 2006
Version	1.0

2. Definition

Definition	An appellationname by which an individual (person) is called within a social context.
Definition Source	Adapted from NEHTA and Standards Australia AS 5017 - 2006 (Healthcare Client Identification) documents
Synonymous Names	Patient Name
Scope	Used in the healthcare setting. Captures the name details of a person (healthcare client). AS 5017 - 2006 Section 3, P.35 defines the Healthcare Client name as a composit data consisting of the following data elements - Name Title - Name Title Sequence Number - Family Name - Gven Name - Gven Name Sequence Nuimber - Name Suffix - Name Suffix Sequence Number - Name Usage - Name Usage Start Date - Name Usage Start Date Accuracy Indicator - Name Usage End Date - Name Usage End Date Accuracy Indicator - Preferred Name Indicator - Name Conditional Usuage Flag In the context of discharge summary, it is recommended that the following four Person Name data elements are included in the PERSON NAME data group: - Name title - Family name - Given names - Name suffix
Scope Source	
Assumptions	
Examples	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

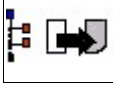
4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice

Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	SUBJECT OF CARE	1.0	Essential		Single
	SUBJECT OF CARE RECIPIENT	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation	Condition	Occurrence
	NAME TITLE (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Desirable		Single
	GIVEN NAMES (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Essential		Single
	FAMILY NAME (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Essential		Single
	NAME SUFFIX (see external reference for full specification AS 4846 - 2006 and AS 5017 - 2006)	1.0	Optional		Single

ADDRESS

1. Identification

Name	ADDRESS
Meta-data Type	Externally sourced Data Group specification
Identifier	DG-20106 *External Identifier*
Version	1.0

2. Definition

Definition	The referential description of a location where an entity (person or organisation) is located or can be otherwise reached or found.
Definition Source	
Synonymous Names	
Scope	Used in the healthcare setting. Captures detail information on the address of: • healthcare client • healthcare provider (person) • healthcare provider organisation • the discharge to address. A Healthcare Client Address is a composite data element (combination of data elements). These data elements are specified in (Section 5, P.69) the Standards Australia Healthcare Client Identification document (AS 5017 - 2006): • Australian Address line (Buidling/Complex Sub-Unit Type - Abbreviation; Building/Complex Sub-Unit Number; Building/Property Name; Floor/Level Number; Floor/Level Type; House/Property Number; Lot/Section Number; Street Name; Street Type Code; Street Suffix Code) • Australian Suburb/Town/Locality • Australian State/Territory Identifier - Postal • Australian Postcode • Healthcare Client International Address.International Address Line • Healthcare Client International Address.International State/Province • Healthcare Client International Address.International Postcode • Healthcare Client International Address.Country Identifier • Address Purpose Details (e.g. Address Purpose, Address Purpose Start Date + Start Date Accuracy Indicator; Address Purpose End Date + End Date Accuracy Indicator) • No fixed address indicator A Healthcare Provider Address is a composite data element (combination of data elements). These data elements are specified in (Section 5, P.51) the Standards Australia Healthcare Client Identification document (AS 4846 - 2006). The data group structure is same as the "Address" data group defined for Healthcare Client. In the context of discharge summary, it is recommended that six Address data elements from AS 5017 - 2006 and AS 4846 - 2006 are included in this data group: • Australian Address Line • Australian Suburb/Town/Locality • Australian Postcode - Australia • International Address Line • International State/Province • International Postcode • Country Identifier • Country (Country Name) [country name is included to provide human readable information as the Country Identifier specified in AS 4846 - 2006 consists only a four-character numeric code] The "Country Identifier" is defined in the Standards Australia Healthcare Client and Provider Identification documents as: "The four character numeric code should be used for data storage and messaging. The full descriptor should be used for data collection or onscreen display (where possible) and all printing or other forms of output." The "Country" data element is added to this specification to facilitate the capturing of the "full descriptor" (country name).
Scope Source	
Assumptions	

3. Usage

Conditions of Use	
Conditions of Use Source	
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	SUBJECT OF CARE	1.0	Essential		Single

Children

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	AUSTRALIAN ADDRESS LINE (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Essential		Single
	AUSTRALIAN SUBURB/TOWN/LOCALITY (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Essential		Single
	AUSTRALIAN STATE/PROVINCE (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Optional		Single
	AUSTRALIAN POSTCODE (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Optional	Essential/Desirable for Australian addresses	Single
	INTERNATIONAL ADDRESS LINE (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	If Subject of Care has international address	Single
	INTERNATIONAL SUBURB/TOWN/ LOCALITY (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	If Subject of Care has international address	Single
	INTERNATIONAL STATE/PROVINCE (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	If Subject of Care has international address	Single
	INTERNATIONAL POSTCODE (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	If Subject of Care has international address	Single

	COUNTRY IDENTIFIER (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	If Subject of Care has international address	Single
	COUNTRY (see external reference for full sepcification: AS 5017 - 2006 and AS 4846 - 2006)	1.0	Conditional	Essential for International addresses	Single

Sex

1. Identification

Name	Sex	
Meta-data Type	Data Element	
Identifier	DE-20107	*External Identifier*
Version	1.0	

2. Definition

Definition	Sex is a biological distinction between male and female. Where there is inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.
Definition Source	NEHTA
Synonymous Names	Administrative Gender (HL7)
Scope	
Scope Source	
Assumptions	
Data Type	CodeableText
Value Domain	Sex Values

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) Male Example 2) Female Example 3) Undetermined
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	SUBJECT OF CARE	1.0	Essential		Single

Sex Values

1. Identification

Name	Sex Values
Meta-data Type	Value Domain
Identifier	VD-20107
Version	1.0

2. Definition

Definition	
Definition Source	

3. Value Domain

Source	*to be determined*
Version Number	
Permissible Values	*to be developed*

4. Usage

Default Value	
Conditions of Use	
Conditions of Use Source	NEHTA
Misuse	

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
T/T010	Sex	1.0	Essential		Single

Date of Birth

1. Identification

Name	Date of Birth	
Meta-data Type	Data Element	
Identifier	DE-20108	*External Identifier*
Version	1.0	

2. Definition

Definition	The date or date and time of birth of a person.
Definition Source	NEHTA
Synonymous Names	Birth Date Birth Date and Time DOB
Scope	Used in healthcare setting. Used to capture the data of birth of a person (e.g. subject of care). Standards Australia AS 5017 - 2006 (Healthcare Client Identification) recommended that this data item to be used in conjunction with Date Accuracy Indicator. However, the Date Accuracy Indicator is not used in discharge summary.
Scope Source	
Assumptions	
Data Type	DateTime
Value Domain	

3. Usage

Conditions of Use	The formats used for Dates and Times in information exchange should conform to standards based on ISO 8601, whenever dates are represented as string literals.
Conditions of Use Source	
Examples	Example 1) 31/03/2004 Example 2) March 2004 Example 3) 2004 Example 4) 31/03/2004 13:10
Misuse	

4. Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation	Condition	Occurrence
	SUBJECT OF CARE	1.0	Essential		Single

Age

1. Identification

Name	Age	
Meta-data Type	Data Element	
Identifier	DE-20109	*External Identifier*
Version	1.0	

2. Definition

Definition	The age of a person/subject of care
Definition Source	NEHTA
Synonymous Names	
Scope	
Scope Source	
Assumptions	
Data Type	Quantity which has two components: - a numeric component - a unit component
Value Domain	Age Units: minute; hour; day; week; month; year

3. Usage

Conditions of Use	
Conditions of Use Source	
Examples	Example 1) 6 months Example 2) 67 years
Misuse	

4.Data Flow

Sender Type	Either system or human
Sender Role(s)/Organisation(s)/ Jurisdiction(s)	Sender Role(s) can include: Healthcare provider Sender Organisation Role(s) can include: Healthcare institution, Medical practice
Recipient Type	Either system or human
Recipient Role(s)/ Organisation(s)/Jurisdiction(s)	Recipient Role(s) can include: Healthcare provider Recipient Organisation Role(s) can include: Healthcare institution, Medical practice

5 Relationships

Parents

Data Type	Name	Version	Obligation within parent	Condition within parent	Occurrence within parent
	SUBJECT OF CARE	1.0	Essential		Single

4 Samples

The following samples illustrate how the Discharge Summary Specification template might be used to populate and display discharge information.

4.1 About the Samples

While the NEHTA discharge summary specification defines the standard clinical information content and data structure, it is not a discharge information transport and display format specification. The discharge summary sample documents are compiled to illustrate how the discharge information contents, as defined by the data groups and data elements in the discharge summary specification, may be used and displayed.

Using the medication data group as the focal data group, the three example discharge summary documents show the power and clinical usefulness of the NEHTA clinical information specification in meeting different display and safety requirements of clinical users.

In **Sample 1** – the Medication data group is used/displayed in two sections.

The "Discharge Medication" section contains information about medications that the subject of care has been prescribed at the time of discharge. This section also includes any "admission medication(s)" (i.e. medications the subject has been taking up to the time of admission) that is prescribed to be continued after discharge.

The "Medication Ceased: This Visit" section contains information about all medications that have been ceased during the in-hospital encounter. Any "admission medication(s)" that is/are discontinued during the in-hospital event or on discharge will be included in this section.

In **Sample 2** – the Medication data group is use/displayed in two sections.

The "Admission & Discharge Medications" section contains information about any "admission medications" and "discharge medications" prescribed on discharge and to be taken by the subject of care after discharge. Medication names of "admission medication" and "discharge medication" are displayed in two separate columns. Medication name(s) of any "admission medication" that is/are continued on discharge will appear in both columns.

The "Medication Ceased: This Visit" section contains information about all medications that have been ceased during the in-hospital encounter. Any "admission medication(s)" that is/are discontinued during the in-hospital event or on discharge will be included in this section.

In **Sample 3** – the Medication data group is used/displayed in three separate sections.

The "Admission Medications" section is used to display all medications the subject of care has been taking up to the time of admission.

The "Discharge Medication" section displays all medications the subject of care has been prescribed and to be taken after discharge. This includes any "admission medication(s)" that is/ are continued after the in-hospital encounter, as such any "admission medication(s)" to be continued as "discharge medication" will also be repeated in this section.

The "Medication Ceased: This Visit" section contains information about all medications that have been ceased during the in-hospital encounter. Any "admission medication(s)" that is/are discontinued during the in-hospital event or on discharge will be repeated in this section.

The differences in data elements reflect the different clinical purpose each section serves.

4.2 Sample 1

DISCHARGE SUMMARY– Admitted patient

Episode ID XXXXX**Date Sent**:26/02/2006 2:58 PM
Version Number: 1
Summary Status: Final

Facility Details:
NEHTA General Hospital
Department: Respiratory Medicine
162 Grenfell Street,
ADELAIDE SA 5000
Tel: (08) 8205 3500Fax: (08) 8205 2300
Email: nehta.general@somewhere.else
Specialist: Dr Nehta Specialist
Registrar: Dr Neville Registrar, Pager:
Summary Author/RMO: Dr Neil Rmo

Patient Details:
MRN: 0952657
SMITH, John Michael

12 Lavender Street,
HAWTHORN SA 5566
Sex: MaleDOB: 9/10/1924Age: 81

Patient's Usual GP:
Dr Patrick GeneralPractice
Good Health General Practice
5 Good Health Street,
HAWTHORN SA 5566
Tel: (08)-8225 4579Fax: (08)-8225 4580
Email: patrick-GP@goodhealth.net.au

Referred by: Dr Patrick GeneralPractice, (08)-8225 4579
Referral Reason: Difficulty breathing and Haemoptysis
Service Requested: To rule out malignancy
Admission Date/ Time: 16/2/2006 17:47
Admission Reason: Dyspnoea and Haemoptysis
Discharge Date & Time: 26/2/2006 15:25
Discharge Reason: Routine discharge
Discharge Destination: Usual place of residence
Summary Recipient
Recipient Name:
Organisation Name:

PROBLEMS/DIAGNOSES: THIS VISIT

Primary Problem/Diagnosis:

Problem/Diagnosis	Date Start	Note	Awareness	Person	Reason
Right bronchogenic carcinoma	19/02/2006	Probable – Diagnosed on bronchoscopic exam. Histology result pending.	no	Patient	Request of family

Secondary Problems/Diagnoses:

Problem/Diagnosis	Date Start	Note	Awareness	Person	Reason
Iron Deficiency Anaemia	18/02/2006	? Dietary; ? haemoptysis induced	yes		
Chronic Obstructive Pulmonary Disease	2003		yes		
Atrial Fibrillation	2003		yes		

Complications:

Complications	Date Start	Note	Awareness	Person	Reason
Post biopsy haemoptysis/ bleeding	18/02/ 2006	Post bronchoscopic biopsy	yes	Patient & family	
Acute lower respiratory infection	19/3/2005	Post bronchoscopic biopsy	yes	Patient & family	
Laceration Right Arm	19/3/2005	Fall	yes	Patient & family	Secondary to acute confusion/LRI

ASSOCIATED PROBLEMS/COMORBIDITIES:

Problem/Diagnosis	Date Start	Note	Awareness	Person	Reason
Chronic Ischaemic Heart Disease	2002		yes	Patient & family	
Osteoarthritis	1996		yes	Patient & family	
Tuberculosis	1964		yes	Patient & family	

PROCEDURES PERFORMED: THIS VISIT

Procedure	Performed Date	Procedure Note
Bronchoscopy and biopsy	17/02/2006	Haemorrhagic growth noted on right bronchus. Brush biopsy taken. Histology result pending.

DISCHARGE MEDICATIONS

Medication Name	Form	Strength	Dose	Frequency	Frequency Qualifier	Route	Quantity	Duration	Reason for Medication	Status	Change Description	Change Reason
Cefuroxine	Tablet	250 mg	500 mg	Twice daily		Oral	8	2 Days	Respira-tory. infec-tion	New		
	Take 2 tablets twice daily for 2 days											
Ferrous Sul-phate(Ferro-Gradumet)	Tablet	105 micro-gram	105 micro-gram	once daily		Oral	30	1 month	Fe defi-ciency anaemia	New		
	Take 1 tablet once daily for 1 month then see GP to recheck Ferritin and Iron Studies											
Salbutamol (Ventolin)	Metere d Dose Inhaler	100 micro-gram	100-200 micro-gram	3-4 times daily	PRN	Inhale	1 pack	On-going		Existing (admis-sion medi-cation) - unaltered		
	1-2 inhalations 3-4 times daily as required											
Voltaren SR	Tablet	50 mg	50 mg	once daily	After meals	Oral	7	7 days		Existing (admis-sion medi-cation) - altered	dose decrease d from 75 mg	Prevent major side effect (GI Bleed-ing)
	Must not take drug on empty stomach											

MEDICATIONS CEASED: THIS VISIT

Medication Name	Form	Strength	Dose	Frequency	Route	Quantity	Duration	Change Reason
Warfarin	Tablet		5 mg	Once daily	Oral		3 years	Due to post broncho-scopic biopsy bleeding
	See GP after 1 week to check INR and consider re-commencing Warfarin therapy.							

KNOWN ADVERSE REACTIONS & ALERTS

Adverse Reactions/Allergies:

Agent	Reaction	Finding Sites	Site Qualifier	Date Start	Reaction Note
Penicillin	Skin rash	abdomen	Right upper quadrant	10/1996	Suspected. No further episode since.
Peanuts	Swelling	Face		Since child-hood	

Alerts/Warnings:

Alert Description	Date Start	Alert Note
Post anaesthetic/bronchoscopic biopsy acute confusion	23/02/2006	Acute confusion lasted for three days. Resolved spontaneously.

CLINICAL MANAGEMENT

81 year old man with past history of 60 pack-years cigarette smoking, admitted after 3 days of progressive dyspnoea, tachypnoea and haemoptysis. Bronchoscopy performed on 23/03 reviewed haemorrhagic growth about 1.5 cm in diameter at right bronchus 2.5 cm distal to the tracheal bifurcation. Appears consistent with squamous cell carcinoma. Brush biopsy taken. Developed post-biopsy acute lower respiratory tract infection, haemoptysis and acute confusion. Confusion resulted in a fall and laceration to right forearm. Treated with IV fluids, IV Ceftriaxone, oxygen, nebulised Salbutamol. Improvement after 3 days, changed to oral Cefuroxime. Histology result pending. Discussion with patient and family who requested no further investigations or treatment for that problem, except support and palliative care if/when needed. Mild Iron Deficiency Anaemia treated with oral Iron initiated.

FOLLOW UP

Requested Service

Referred to	Service Requested	Service Reason	Proposed Start
Dr Palliative Care 24 Palliative Road Adelaide SA 5000	Palliative care assessment, planning and placement	Patient family requested palliative care instead of active surgical or oncology intervention in view of age and frailty of patient	27/3/2006
Ms Gin Nutrition Nutritionist	Nutritional Planning	Assess and advise on dietary intake	1/03/2006

Patient Instructions

See GP within 1 week to renew medications – anticoagulant in particular and discuss options for support regarding probable lung malignancy. Watch out for gastro-intestinal bleeding which might be caused by Voltaren and discuss options for support regarding probable lung malignancy. Return to emergency department in case of respiratory distress and signs of bleeding.

RECOMMENDATIONS TO GP

Please review patient's anticoagulant therapy to maintain INR at 2.5 to 3.5; discuss palliative care and issues with patient and family; monitor patient for risk of GI bleeding associated with Voltaren.

INVESTIGATIONS - DETAILED REPORTS

PATHOLOGY

Test name:	Iron Studies	**Requesting Provider:**	NEHTA Registrar
Performed Date:	17/02/2006	**Reporting Pathologist:**	Jones Haematologist
		Result Status:	Final

Result name	Value	Reference Range	Abnormal Indicator
Iron	5 umol/L	8 – 30	L
Serum/Plasma Ferritin	23 ug/L	20 – 300	
SATURATION	8 %	10 – 50	L
Transferrin	2.2 g/L	2.0 – 3.6	

Note: Iron deficiency cannot be excluded in inflammation or chronic disease are present as these may elevate the ferritin into the normal range. Suggest other haematinics screening if not known. Dr Jones Haematologist.

Test name:	Full Blood Count	**Requesting Provider:**	NEHTA Registrar
Performed Date:	17/02/2006	**Reporting Pathologist:**	Jones Haematologist
		Result Status:	Final

Result name	Value	Reference Range	Abnormal Indicator
Haemoglobin	130 g/L	135 – 175	L
RBC	4.5x10^12/L	4.5 - 6.0	
PCV	0.40 L/L	0.40 - 0.50	
MCV	78 fl	80.0 – 98.0	L
MCH	28.0 pg	27.0-33.0	
MCHC	320 g/L	315-355	
RDW	11.0%	11.5-15.5	L
White Cell Count	20.0x10^9/L	4.00-11.00	HH
Neutrophils	16.0x10^9/L	1.80 -7.50	HH
Neutrophils %	80.0%		
Lymphocytes	3.05x10^9/L	1.00 – 3.50	
Lymphocytes %	15.25%		
Monocytes	0.8x10^9/L	0.20 – 0.80	
Monocytes %	4.0%		
Eosinophils	0.03x10^9/L	0.02 – 0.50	
Eosinophils %	0.15%		
Basophils	0.02x10^9/L	0.02 – 0.10	
Basophils %	0.1%		

Note: Microcytic anaemia. Suggest Ferritin and Iron Studies. High white cell count with neutrophilia – ? infection.
Dr Jones Haematologist.

Test name:	Biochemistry	**Requesting Provider:**	NEHTA Registrar
Performed Date:	17/02/2006	**Reporting Pathologist:**	Richard Biochemist
		Result Status:	Final

Result name	Value	Reference Range	Abnormal Indicator
Electrolytes			
Sodium	141 mmol/L	137 – 145	
Potassium	4.0 mmol/L	3.5 – 4.9	
Chloride	103 mmol/L	100 – 109	
Bicarbonate	30 mmol/L	22 – 32	
Anion Gap	12 mmol/L	7 – 17	
Glucose	5.0 mmol/L	3.5 – 5.5	
Urea	7.1 mmol/L	2.7 – 8.0	
Creatinine	0.095 mmol/L	0.050 – 0.120	
Cholesterol	5.0 mmol/L	< 5.5	
Urate	0.28 mmol/L	0.15 – 0.45	
Phosphate	1.00 mmol/L	0.65 – 1.45	
Total Calcium	2.30 mmol/L	2.10 – 2.55	
Ionised Calcium	1.15 mmol/L	1.10 -1.25	
Liver Function Tests			
Albumin	43 g/L	34 – 48	
Globulin	35 g/L	26 – 41	
Protein	80 g/L	65 – 85	
Total Bilirubin	7 umol/L	6 – 24	
GGT	24 U/L	0 – 60	
ALP	47 U/L	30 – 110	
ALT	40 U/L	0 – 55	
AST	24 U/L	0 – 45	
LDH	220 U/L	110 – 230	

Note: No abnormalities detected. Dr Richard Biochemist.

Test name:	Sputum MC&S	**Requesting Provider:**	NEHTA Registrar
Performed Date:	18/02/2006	**Reporting Pathologist:**	Collin Microbiologist
		Result Status:	Final

Mixed oral flora only. No Acid Fast Bacilli detected.
Dr. Collin Microbiologist

DIAGNOSTIC IMAGING

Investigation name:	CHEST: (AP/T/LATERAL)	**Requesting Provider:**	NEHTA Registrar
Performed Date:	18/02/2006	**Reporting Provider:**	Ray Radiologist
		Result Status:	Final

CLINICAL: History of old pulmonary tuberculosis. Right mid lung mass, presents with haemoptysis.
No previous images are available for comparison at the time of reporting. Calcification spots throughout both upper lung fields consistent with old pulmonary tuberculosis. No hilar mass is seen however the right pulmonary hila appears slightly elevated. Appearances are suspicious of neoplasm and further imaging is suggested. The right lateral costophrenic angle is blunted and this maybe secondary to pleural thickening or a tiny basal effusion.
Dr S. Ray

Investigation name:	CHEST: (AP/T/LATERAL)	**Requesting Provider:**	NEHTA Registrar
Performed Date:	24/02/2006	**Reporting Provider:**	Ray Radiologist
		Result Status:	Final

CLINICAL: History of old pulmonary tuberculosis. Right mid lung mass, presents with haemoptysis. Post bronchoscopic fever and confusion.
Mark increased infiltration and inflammatory signs in right and left lower lobes consistent with signs of pneumonia. Not consolidation or fluid effusion noted. Impression: lower lobes pneumonia, both lungs.
Dr S. Ray

Investigation name:	CT CHEST	**Requesting Provider:**	James
Performed Date:	25/02/2006	**Reporting Provider:**	Roberts
		Result Status:	Final

CLINICAL: Right mid lung mass. Bronchoscopy revealed right main bronchus mass distal to tracheal bifurcation. Confirmed a right bronchogenic mass distal to the tracheal bifurcation consistent with a primary lung neoplasm.
Dr Ray Radiologist

OTHER INVESTIGATIONS

Date	Description	Result	Abnormal Flag
18/02/2006	ECG	Controlled atrial Fibrillation, rate 85/min	

4.3 Sample 2

DISCHARGE SUMMARY– Admitted patient

Episode ID XXXXX**Date Sent**:26/02/2006 2:58 PM
Version Number: 1
Summary Status: Final

Facility Details:
NEHTA General Hospital
Department: Respiratory Medicine
162 Grenfell Street,
ADELAIDE SA 5000
Tel: (08) 8205 3500Fax: (08) 8205 2300
Email: nehta.general@somewhere.else
Specialist: Dr Nehta Specialist
Registrar: Dr Neville Registrar, Pager:
Summary Author/RMO: Dr Neil Rmo

Patient Details:
MRN: 0952657
SMITH, John Michael

12 Lavender Street,
HAWTHORN SA 5566
Sex: MaleDOB: 9/10/1924Age: 81

Patient's Usual GP:
Dr Patrick GeneralPractice
Good Health General Practice
5 Good Health Street,
HAWTHORN SA 5566
Tel: (08)-8225 4579Fax: (08)-8225 4580
Email: patrick-GP@goodhealth.net.au

Referred by: Dr Patrick GeneralPractice, (08)-8225 4579
Referral Reason: Difficulty breathing and Haemoptysis
Service Requested: To rule out malignancy
Admission Date / Time: 16/2/2006 17:47
Admission Reason: Dyspnoea and Haemoptysis
Discharge Date & Time: 26/2/2006 15:25
Discharge Reason: Routine discharge
Discharge Destination: Usual place of residence
Summary Recipient
Recipient Name:
Organisation Name:

PROBLEMS/DIAGNOSES: THIS VISIT

Primary Problem/Diagnosis:

Problem/Diagnosis	Date Start	Note	Awareness	Person	Reason
Right bronchogenic carcinoma	19/02/2006	Probable – Diagnosed on bronchoscopic exam. Histology result pending.	no	Patient	Request of family

Secondary Problems/Diagnoses:

Problem/Diagnosis	Date Start	Note	Awareness	Person	Reason
Iron Deficiency Anaemia	18/02/2006	? Dietary; ? haemoptysis induced	yes		

Chronic Obstructive Pulmonary Disease	2003		yes		
Atrial Fibrillation	2003		yes		

Complications:

Complications	Date Start	Note	Awareness	Person	Reason
Post biopsy haemoptysis/ bleeding	18/02/ 2006	Post bronchoscopic biopsy	yes	Patient & family	
Acute lower respiratory infection	19/3/2005	Post bronchoscopic biopsy	yes	Patient & family	
Laceration Right Arm	19/3/2005	Fall	yes	Patient & family	Secondary to acute confusion/LRI

ASSOCIATED PROBLEMS/COMORBIDITIES:

Problem/Diagnosis	Date Start	Note	Awareness	Person	Reason
Chronic Ischaemic Heart Disease	2002		yes	Patient & family	
Osteoarthritis	1996		yes	Patient & family	
Tuberculosis	1964		yes	Patient & family	

PROCEDURES PERFORMED: THIS VISIT

Procedure	Performed Date	Procedure Note
Bronchoscopy and biopsy	17/02/2006	Haemorrhagic growth noted on right bronchus. Brush biopsy taken. Histology result pending.

ADMISSION & DISCHARGE MEDICATIONS

Admission Medication	Discharge Medication	Form	Strength	Dose	Frequency	Frequency Qualifier	Route	Quantity	Duration	Reason for Medication	Status	Change Description	Change Reason
	Cefurox-ine	Tablet	250 mg	500 mg	Twice daily		Oral	8	2 Days	Respira-tory. infection	New		
		Take 2 tablets twice daily for 2 days											
	Ferrous Sulphate (Ferro-Gra-dumet)	Tablet	105 micro-gram	105 micro-gram	once daily		Oral	30	1 month	Fe defi-ciency anaemia	New		
		Take 1 tablet once daily for 1 month then see GP to recheck Ferritin and Iron Studies											
Salbuta-mol (Ven-tolin)	Salbuta-mol (Ven-tolin)	Metered Dose Inhaler	100 micro-gram	100-200 micro-gram	3-4 times daily	PRN	Inhale	1 pack	On-going		Existing (admis-sion medi-cation) - unaltered		
		1-2 inhalations 3-4 times daily as required											
Voltaren SR	Voltaren SR	Tablet	50 mg	50 mg	once daily	After meals	Oral	7	7 days		Existing (admis-sion medi-cation) - altered	dose decreas ed from 75 mg	Prevent major side effect (GI Bleeding)
		Must not take drug on empty stomach											

MEDICATIONS CEASED: THIS VISIT

Medication Name	Form	Strength	Dose	Frequency	Route	Quantity	Duration	Change Reason
Warfarin	Tablet		5 mg	Once daily	Oral		3 years	Due to post broncho-scopic biopsy bleeding
	See GP after 1 week to check INR and consider re-commencing Warfarin therapy.							

KNOWN ADVERSE REACTIONS & ALERTS

Adverse Reactions/Allergies:

Agent	Reaction	Finding Sites	Site Qualifier	Date Start	Reaction Note
Penicillin	Skin rash	abdomen	Right upper quadrant	10/1996	Suspected. No further episode since.
Peanuts	Swelling	Face		Since child-hood	

Alerts/Warnings:

Alert Description	Date Start	Alert Note
Post anaesthetic/bronchoscopic biopsy acute confusion	23/02/2006	Acute confusion lasted for three days. Resolved spontaneously.

CLINICAL MANAGEMENT

81 year old man with past history of 60 pack-years cigarette smoking, admitted after 3 days of progressive dyspnoea, tachypnoea and haemoptysis. Bronchoscopy performed on 23/03 reviewed haemorrhagic growth about 1.5 cm in diameter at right bronchus 2.5 cm distal to the tracheal bifurcation. Appears consistent with squamous cell carcinoma. Brush biopsy taken. Developed post-biopsy acute lower respiratory tract infection, haemoptysis and acute confusion. Confusion resulted in a fall and laceration to right forearm. Treated with IV fluids, IV Ceftriaxone, oxygen, nebulised Salbutamol. Improvement after 3 days, changed to oral Cefuroxime. Histology result pending. Discussion with patient and family who requested no further investigations or treatment for that problem, except support and palliative care if/when needed. Mild Iron Deficiency Anaemia treated with oral Iron initiated.

FOLLOW UP

Requested Service

Referred to	Service Requested	Service Reason	Proposed Start
Dr Palliative Care 24 Palliative Road Adelaide SA 5000	Palliative care assessment, planning and placement	Patient family requested palliative care instead of active surgical or oncology intervention in view of age and frailty of patient	27/3/2006
Ms Gin Nutrition Nutritionist	Nutritional Planning	Assess and advise on dietary intake	1/03/2006

Patient Instructions

See GP within 1 week to renew medications – anticoagulant in particular and discuss options for support regarding probable lung malignancy. Watch out for gastro-intestinal bleeding which might be caused by Voltaren and discuss options for support regarding probable lung malignancy. Return to emergency department in case of respiratory distress and signs of bleeding.

RECOMMENDATIONS TO GP

Please review patient's anticoagulant therapy to maintain INR at 2.5 to 3.5; discuss palliative care and issues with patient and family; monitor patient for risk of GI bleeding associated with Voltaren.

INVESTIGATIONS - DETAILED REPORTS

PATHOLOGY

Test name:	Iron Studies	**Requesting Provider:**	NEHTA Registrar
Performed Date:	17/02/2006	**Reporting Pathologist:**	Jones Haematologist
		Result Status:	Final

Result name	Value	Reference Range	Abnormal Indicator
Iron	5 umol/L	8 – 30	L
Serum/Plasma Ferritin	23 ug/L	20 – 300	
SATURATION	8 %	10 – 50	L
Transferrin	2.2 g/L	2.0 – 3.6	

Note: Iron deficiency cannot be excluded in inflammation or chronic disease are present as these may elevate the ferritin into the normal range. Suggest other haematinics screening if not known. Dr Jones Haematologist.

Test name:	Full Blood Count	**Requesting Provider:**	NEHTA Registrar
Performed Date:	17/02/2006	**Reporting Pathologist:**	Jones Haematologist
		Result Status:	Final

Result name	Value	Reference Range	Abnormal Indicator
Haemoglobin	130 g/L	135 – 175	L
RBC	4.5x10^12/L	4.5 - 6.0	
PCV	0.40 L/L	0.40 - 0.50	
MCV	78 fl	80.0 – 98.0	L
MCH	28.0 pg	27.0-33.0	
MCHC	320 g/L	315-355	
RDW	11.0%	11.5-15.5	L
White Cell Count	20.0x10^9/L	4.00-11.00	HH
Neutrophils	16.0x10^9/L	1.80 -7.50	HH
Neutrophils %	80.0%		
Lymphocytes	3.05x10^9/L	1.00 – 3.50	
Lymphocytes %	15.25%		
Monocytes	0.8x10^9/L	0.20 – 0.80	
Monocytes %	4.0%		
Eosinophils	0.03x10^9/L	0.02 – 0.50	
Eosinophils %	0.15%		
Basophils	0.02x10^9/L	0.02 – 0.10	
Basophils %	0.1%		

Note: Microcytic anaemia. Suggest Ferritin and Iron Studies. High white cell count with neutrophilia – ? infection.
Dr Jones Haematologist.

Test name:	Biochemistry	**Requesting Provider:**	NEHTA Registrar
Performed Date:	17/02/2006	**Reporting Pathologist:**	Richard Biochemist
		Result Status:	Final

Result name	Value	Reference Range	Abnormal Indicator
Electrolytes			
Sodium	141 mmol/L	137 – 145	
Potassium	4.0 mmol/L	3.5 – 4.9	
Chloride	103 mmol/L	100 – 109	
Bicarbonate	30 mmol/L	22 – 32	
Anion Gap	12 mmol/L	7 – 17	
Glucose	5.0 mmol/L	3.5 – 5.5	
Urea	7.1 mmol/L	2.7 – 8.0	
Creatinine	0.095 mmol/L	0.050 – 0.120	
Cholesterol	5.0 mmol/L	< 5.5	
Urate	0.28 mmol/L	0.15 – 0.45	
Phosphate	1.00 mmol/L	0.65 – 1.45	
Total Calcium	2.30 mmol/L	2.10 – 2.55	
Ionised Calcium	1.15 mmol/L	1.10 -1.25	
Liver Function Tests			
Albumin	43 g/L	34 – 48	
Globulin	35 g/L	26 – 41	
Protein	80 g/L	65 – 85	
Total Bilirubin	7 umol/L	6 – 24	
GGT	24 U/L	0 – 60	
ALP	47 U/L	30 – 110	
ALT	40 U/L	0 – 55	
AST	24 U/L	0 – 45	
LDH	220 U/L	110 – 230	

Note: No abnormalities detected. Dr Richard Biochemist.

Test name:	Sputum MC&S	**Requesting Provider:**	NEHTA Registrar
Performed Date:	18/02/2006	**Reporting Pathologist:**	Collin Microbiologist
		Result Status:	Final

Mixed oral flora only. No Acid Fast Bacilli detected.
Dr. Collin Microbiologist

DIAGNOSTIC IMAGING

Investigation name:	CHEST: (AP/T/LATERAL)	**Requesting Provider:**	NEHTA Registrar
Performed Date:	18/02/2006	**Reporting Provider:**	Ray Radiologist
		Result Status:	Final

CLINICAL: History of old pulmonary tuberculosis. Right mid lung mass, presents with haemoptysis.
No previous images are available for comparison at the time of reporting. Calcification spots throughout both upper lung fields consistent with old pulmonary tuberculosis. No hilar mass is seen however the right pulmonary hila appears slightly elevated. Appearances are suspicious of neoplasm and further imaging is suggested. The right lateral costophrenic angle is blunted and this maybe secondary to pleural thickening or a tiny basal effusion.
Dr S. Ray

Investigation name:	CHEST: (AP/T/LATERAL)	Requesting Provider:	NEHTA Registrar
Performed Date:	24/02/2006	Reporting Provider:	Ray Radiologist
		Result Status:	Final

CLINICAL: History of old pulmonary tuberculosis. Right mid lung mass, presents with haemoptysis. Post bronchoscopic fever and confusion.
Mark increased infiltration and inflammatory signs in right and left lower lobes consistent with signs of pneumonia. Not consolidation or fluid effusion noted. Impression: lower lobes pneumonia, both lungs.
Dr S. Ray

Investigation name:	CT CHEST	Requesting Provider:	James
Performed Date:	25/02/2006	Reporting Provider:	Roberts
		Result Status:	Final

CLINICAL: Right mid lung mass. Bronchoscopy revealed right main bronchus mass distal to tracheal bifurcation.
Confirmed a right bronchogenic mass distal to the tracheal bifurcation consistent with a primary lung neoplasm.
Dr Ray Radiologist

OTHER INVESTIGATIONS

Date	Description	Result	Abnormal Flag
18/02/2006	ECG	Controlled atrial Fibrillation, rate 85/min	

4.4 Sample 3

DISCHARGE SUMMARY– Admitted patient

Episode ID XXXXX**Date Sent**:26/02/2006 2:58 PM
Version Number: 1
Summary Status: Final

Facility Details:
NEHTA General Hospital
Department: Respiratory Medicine
162 Grenfell Street,
ADELAIDE SA 5000
Tel: (08) 8205 3500Fax: (08) 8205 2300
Email: nehta.general@somewhere.else
Specialist: Dr Nehta Specialist
Registrar: Dr Neville Registrar, Pager:
Summary Author/RMO: Dr Neil Rmo

Patient Details:
MRN: 0952657
SMITH, John Michael

12 Lavender Street,
HAWTHORN SA 5566
Sex: MaleDOB: 9/10/1924Age: 81

Patient's Usual GP:
Dr Patrick GeneralPractice
Good Health General Practice
5 Good Health Street,
HAWTHORN SA 5566
Tel: (08)-8225 4579Fax: (08)-8225 4580
Email: patrick-GP@goodhealth.net.au

Referred by: Dr Patrick GeneralPractice, (08)-8225 4579
Referral Reason: Difficulty breathing and Haemoptysis
Service Requested: To rule out malignancy
Admission Date/ Time: 16/2/2006 17:47
Admission Reason: Dyspnoea and Haemoptysis
Discharge Date & Time: 26/2/2006 15:25
Discharge Reason: Routine discharge
Discharge Destination: Usual place of residence
Summary Recipient
Recipient Name:
Organisation Name:

PROBLEMS/DIAGNOSES: THIS VISIT

Primary Problem/Diagnosis:

Problem/Diagnosis	Date Start	Note	Awareness	Person	Reason
Right bronchogenic carcinoma	19/02/ 2006	Probable – Diagnosed on bronchoscopic exam. Histology result pending.	no	Patient	Request of family

Secondary Problems/Diagnoses:

Problem/Diagnosis	Date Start	Note	Awareness	Person	Reason
Iron Deficiency Anaemia	18/02/ 2006	? Dietary; ? haemoptysis induced	yes		

Chronic Obstructive Pulmonary Disease	2003		yes		
Atrial Fibrillation	2003		yes		

Complications:

Complications	Date Start	Note	Awareness	Person	Reason
Post biopsy haemoptysis/ bleeding	18/02/ 2006	Post bronchoscopic biopsy	yes	Patient & family	
Acute lower respiratory infection	19/3/2005	Post bronchoscopic biopsy	yes	Patient & family	
Laceration Right Arm	19/3/2005	Fall	yes	Patient & family	Secondary to acute confusion/LRI

ASSOCIATED PROBLEMS/COMORBIDITIES:

Problem/Diagnosis	Date Start	Note	Awareness	Person	Reason
Chronic Ischaemic Heart Disease	2002		yes	Patient & family	
Osteoarthritis	1996		yes	Patient & family	
Tuberculosis	1964		yes	Patient & family	

PROCEDURES PERFORMED: THIS VISIT

Procedure	Performed Date	Procedure Note
Bronchoscopy and biopsy	17/02/2006	Haemorrhagic growth noted on right bronchus. Brush biopsy taken. Histology result pending.

ADMISSION MEDICATIONS

Generic Name	Tradr Name	Form	Strength	Dose	Frequency	Frequency Qualifier	Route	Quantity	Duration	Reason for Medication
Salbutamol	Ventolin	Metered Dose Inhaler	100 micro-gram	100-200 micro-gram	3-4 times daily	PRN	Inhale	1 pack	On-going	
		1-2 inhalations 3-4 times daily as required								
	Voltaren SR	Tablet	50 mg	50 mg	once daily	After meals	Oral	7	7 days	
		Must not take drug on empty stomach								

DISCHARGE MEDICATIONS

Generic Name	Trade Name	Form	Strength	Dose	Frequency	Frequency Qualifier	Route	Quantity	Duration	Reason for Medication	Status	Change Description	Change Reason
Cefurox-ine		Tablet	250 mg	500 mg	Twice daily		Oral	8	2 Days	Respiratory. infection	New		
		Take 2 tablets twice daily for 2 days											

Ferrous Sulphate	Ferro-Gra-dumet	Tablet	105 micro-gram	105 micro-gram	once daily		Oral	30	1 month	Fe defi-ciency anaemia	New		
		Take 1 tablet once daily for 1 month then see GP to recheck Ferritin and Iron Studies											
Salbuta-mol	Ventolin	Metered Dose Inhaler	100 micro-gram	100-200 micro-gram	3-4 times daily	PRN	Inhale	1 pack	On-going		Existing unal-tered		
		1-2 inhalations 3-4 times daily as required											
	Voltaren SR	Tablet	50 mg	50 mg	once daily	After meals	Oral	7	7 days		Existing altered	dose decreased from 75 mg	Prevent major side effect (GI Bleeding)
		Must not take drug on empty stomach											

MEDICATIONS CEASED: THIS VISIT

Medication Name	Form	Strength	Dose	Frequency	Route	Quantity	Duration	Change Reason
Warfarin	Tablet		5 mg	Once daily	Oral		3 years	Due to post broncho-scopic biopsy bleeding
	See GP after 1 week to check INR and consider re-commencing Warfarin therapy.							

KNOWN ADVERSE REACTIONS & ALERTS

Adverse Reactions/Allergies:

Agent	Reaction	Finding Sites	Site Qualifier	Date Start	Reaction Note
Penicillin	Skin rash	abdomen	Right upper quadrant	10/1996	Suspected. No further episode since.
Peanuts	Swelling	Face		Since child-hood	

Alerts/Warnings:

Alert Description	Date Start	Alert Note
Post anaesthetic/bronchoscopic biopsy acute confusion	23/02/2006	Acute confusion lasted for three days. Resolved spontaneously.

CLINICAL MANAGEMENT

81 year old man with past history of 60 pack-years cigarette smoking, admitted after 3 days of progressive dyspnoea, tachypnoea and haemoptysis. Bronchoscopy performed on 23/03 reviewed haemorrhagic growth about 1.5 cm in diameter at right bronchus 2.5 cm distal to the tracheal bifurcation. Appears consistent with squamous cell carcinoma. Brush biopsy taken. Developed post-biopsy acute lower respiratory tract infec-tion, haemoptysis and acute confusion. Confusion resulted in a fall and laceration to right forearm. Treated with IV fluids, IV Ceftriaxone, oxygen, nebulised Salbutamol. Improvement after 3 days, changed to oral Cefuroxime. Histology result pending. Discussion with patient and family who requested no further investi-gations or treatment for that problem, except support and palliative care if/when needed. Mild Iron Defi-ciency Anaemia treated with oral Iron initiated.

FOLLOW UP

Requested Service

Referred to	Service Requested	Service Reason	Proposed Start

Dr Palliative Care 24 Palliative Road Adelaide SA 5000	Palliative care assessment, planning and placement	Patient family requested palliative care instead of active surgical or oncology intervention in view of age and frailty of patient	27/3/2006
Ms Gin Nutrition Nutritionist	Nutritional Planning	Assess and advise on dietary intake	1/03/2006

Patient Instructions

See GP within 1 week to renew medications – anticoagulant in particular and discuss options for support regarding probable lung malignancy. Watch out for gastro-intestinal bleeding which might be caused by Voltaren and discuss options for support regarding probable lung malignancy. Return to emergency department in case of respiratory distress and signs of bleeding.

RECOMMENDATIONS TO GP

Please review patient's anticoagulant therapy to maintain INR at 2.5 to 3.5; discuss palliative care and issues with patient and family; monitor patient for risk of GI bleeding associated with Voltaren.

INVESTIGATIONS - DETAILED REPORTS

PATHOLOGY

Test name:	Iron Studies	**Requesting Provider:**	NEHTA Registrar
Performed Date:	17/02/2006	**Reporting Pathologist:**	Jones Haematologist
		Result Status:	Final

Result name	Value	Reference Range	Abnormal Indicator
Iron	5 umol/L	8 – 30	L
Serum/Plasma Ferritin	23 ug/L	20 – 300	
SATURATION	8 %	10 – 50	L
Transferrin	2.2 g/L	2.0 – 3.6	

Note: Iron deficiency cannot be excluded in inflammation or chronic disease are present as these may elevate the ferritin into the normal range. Suggest other haematinics screening if not known. Dr Jones Haematologist.

Test name:	Full Blood Count	**Requesting Provider:**	NEHTA Registrar
Performed Date:	17/02/2006	**Reporting Pathologist:**	Jones Haematologist
		Result Status:	Final

Result name	Value	Reference Range	Abnormal Indicator
Haemoglobin	130 g/L	135 – 175	L
RBC	4.5x10^12/L	4.5 - 6.0	
PCV	0.40 L/L	0.40 - 0.50	
MCV	78 fl	80.0 – 98.0	L
MCH	28.0 pg	27.0-33.0	
MCHC	320 g/L	315-355	
RDW	11.0%	11.5-15.5	L
White Cell Count	20.0x10^9/L	4.00-11.00	HH
Neutrophils	16.0x10^9/L	1.80 -7.50	HH
Neutrophils %	80.0%		
Lymphocytes	3.05x10^9/L	1.00 – 3.50	
Lymphocytes %	15.25%		
Monocytes	0.8x10^9/L	0.20 – 0.80	

Monocytes %	4.0%		
Eosinophils	0.03x10^9/L	0.02 – 0.50	
Eosinophils %	0.15%		
Basophils	0.02x10^9/L	0.02 – 0.10	
Basophils %	0.1%		

Note: Microcytic anaemia. Suggest Ferritin and Iron Studies. High white cell count with neutrophilia – ? infection.
Dr Jones Haematologist.

Test name:	Biochemistry	**Requesting Provider:**	NEHTA Registrar
Performed Date:	17/02/2006	**Reporting Pathologist:**	Richard Biochemist
		Result Status:	Final

Result name	Value	Reference Range	Abnormal Indicator
Electrolytes			
Sodium	141 mmol/L	137 – 145	
Potassium	4.0 mmol/L	3.5 – 4.9	
Chloride	103 mmol/L	100 – 109	
Bicarbonate	30 mmol/L	22 – 32	
Anion Gap	12 mmol/L	7 – 17	
Glucose	5.0 mmol/L	3.5 – 5.5	
Urea	7.1 mmol/L	2.7 – 8.0	
Creatinine	0.095 mmol/L	0.050 – 0.120	
Cholesterol	5.0 mmol/L	< 5.5	
Urate	0.28 mmol/L	0.15 – 0.45	
Phosphate	1.00 mmol/L	0.65 – 1.45	
Total Calcium	2.30 mmol/L	2.10 – 2.55	
Ionised Calcium	1.15 mmol/L	1.10 -1.25	
Liver Function Tests			
Albumin	43 g/L	34 – 48	
Globulin	35 g/L	26 – 41	
Protein	80 g/L	65 – 85	
Total Bilirubin	7 umol/L	6 – 24	
GGT	24 U/L	0 – 60	
ALP	47 U/L	30 – 110	
ALT	40 U/L	0 – 55	
AST	24 U/L	0 – 45	
LDH	220 U/L	110 – 230	

Note: No abnormalities detected. Dr Richard Biochemist.

Test name:	Sputum MC&S	**Requesting Provider:**	NEHTA Registrar
Performed Date:	18/02/2006	**Reporting Pathologist:**	Collin Microbiologist
		Result Status:	Final

Mixed oral flora only. No Acid Fast Bacilli detected.
Dr. Collin Microbiologist

DIAGNOSTIC IMAGING

Investigation name:	CHEST: (AP/T/LATERAL)	**Requesting Provider:**	NEHTA Registrar
Performed Date:	18/02/2006	**Reporting Provider:**	Ray Radiologist
		Result Status:	Final

CLINICAL: History of old pulmonary tuberculosis. Right mid lung mass, presents with haemoptysis.
No previous images are available for comparison at the time of reporting. Calcification spots throughout both upper lung fields consistent with old pulmonary tuberculosis. No hilar mass is seen however the right pulmonary hila appears slightly elevated. Appearances are suspicious of neoplasm and further imaging is suggested. The right lateral costophrenic angle is blunted and this maybe secondary to pleural thickening or a tiny basal effusion.
Dr S. Ray

Investigation name:	CHEST: (AP/T/LATERAL)	**Requesting Provider:**	NEHTA Registrar
Performed Date:	24/02/2006	**Reporting Provider:**	Ray Radiologist
		Result Status:	Final

CLINICAL: History of old pulmonary tuberculosis. Right mid lung mass, presents with haemoptysis. Post bronchoscopic fever and confusion.
Mark increased infiltration and inflammatory signs in right and left lower lobes consistent with signs of pneumonia. Not consolidation or fluid effusion noted. Impression: lower lobes pneumonia, both lungs.
Dr S. Ray

Investigation name:	CT CHEST	**Requesting Provider:**	James
Performed Date:	25/02/2006	**Reporting Provider:**	Roberts
		Result Status:	Final

CLINICAL: Right mid lung mass. Bronchoscopy revealed right main bronchus mass distal to tracheal bifurcation.
Confirmed a right bronchogenic mass distal to the tracheal bifurcation consistent with a primary lung neoplasm.
Dr Ray Radiologist

OTHER INVESTIGATIONS

Date	Description	Result	Abnormal Flag
18/02/2006	ECG	Controlled atrial Fibrillation, rate 85/min	

5 UML Diagrams

The following pages contain stylised UML class diagrams that represent the standardised content for the National Discharge Summary.

5.1 About the UML Diagrams

☞ When interpreting these diagrams, it is important to note that this NEHTA clinical data specification reflects **clinical practice requirements** and **not implementation design requirements**.

There may be a number of different ways in which the Discharge Summary can be modelled using UML that are implementation specific (i.e. have different designs or patterns of the structure to suit specific implementations). For instance, sub-typing and inheritance relationships have not been represented where a Medication Item might be of 'type' 'Product' or 'Formulation' class from which its attributes are inherited. This approach is one implementation design choice out of possibly many. Such designs have yet to be developed.

In a number of cases, relationships are not explicitly represented in the diagram. Instead, they appear as attributes of 'type' Healthcare Provider Identification, Problem/Diagnosis, Pathology, Adverse Reaction, or Observation, etc., where separate class diagrams express the structure of these types. In addition to the NEHTA data specifications published in PDF format, the UML models are also documented in a browseable HTML format, allowing readers to move seamlessly from one information model to another. An XMI (XML Metadata Interchange) (version 2.1) file is also available to enable system designers and implementers to use and share the NEHTA UML model.

In addition to being included as an appendix in this data specification, the UML class model is available as a separate standalone document. The standalone publication includes a dictionary of class and attribute definitions.

5.2 Discharge Summary UML Legend

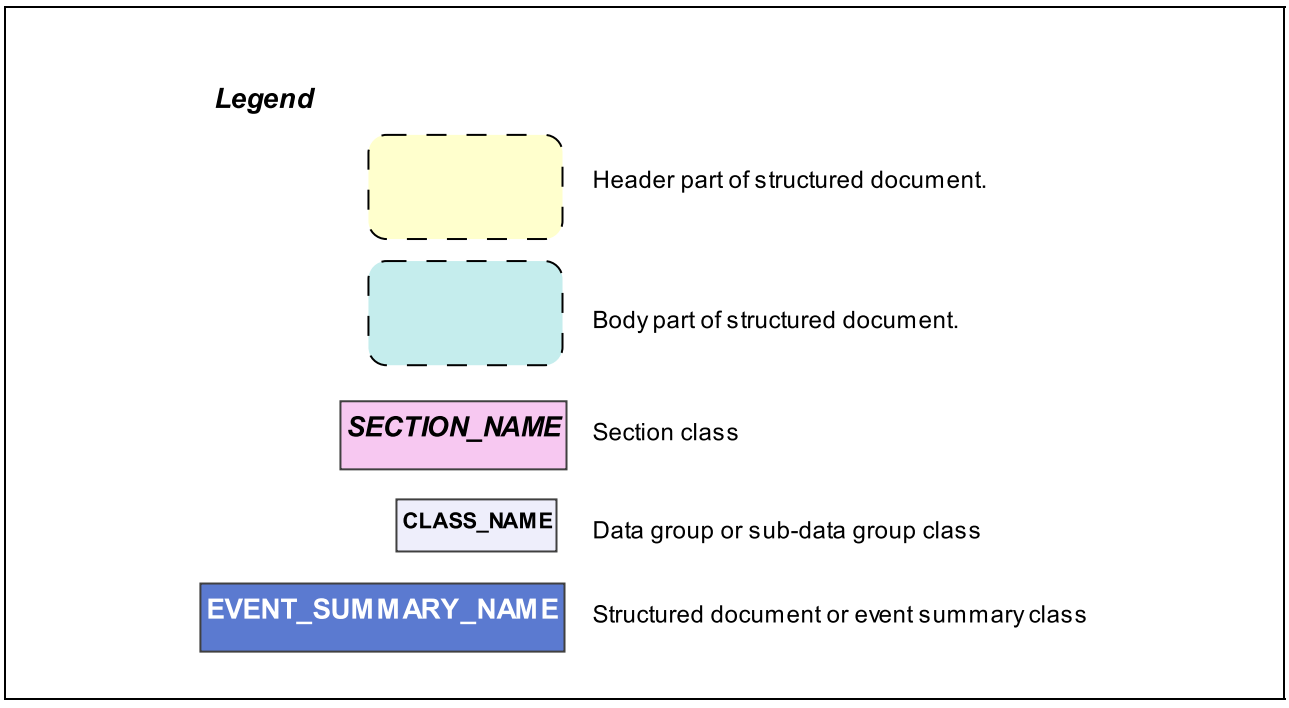


Figure 6 Discharge Summary - Legend

5.3 Discharge Summary Class Overview

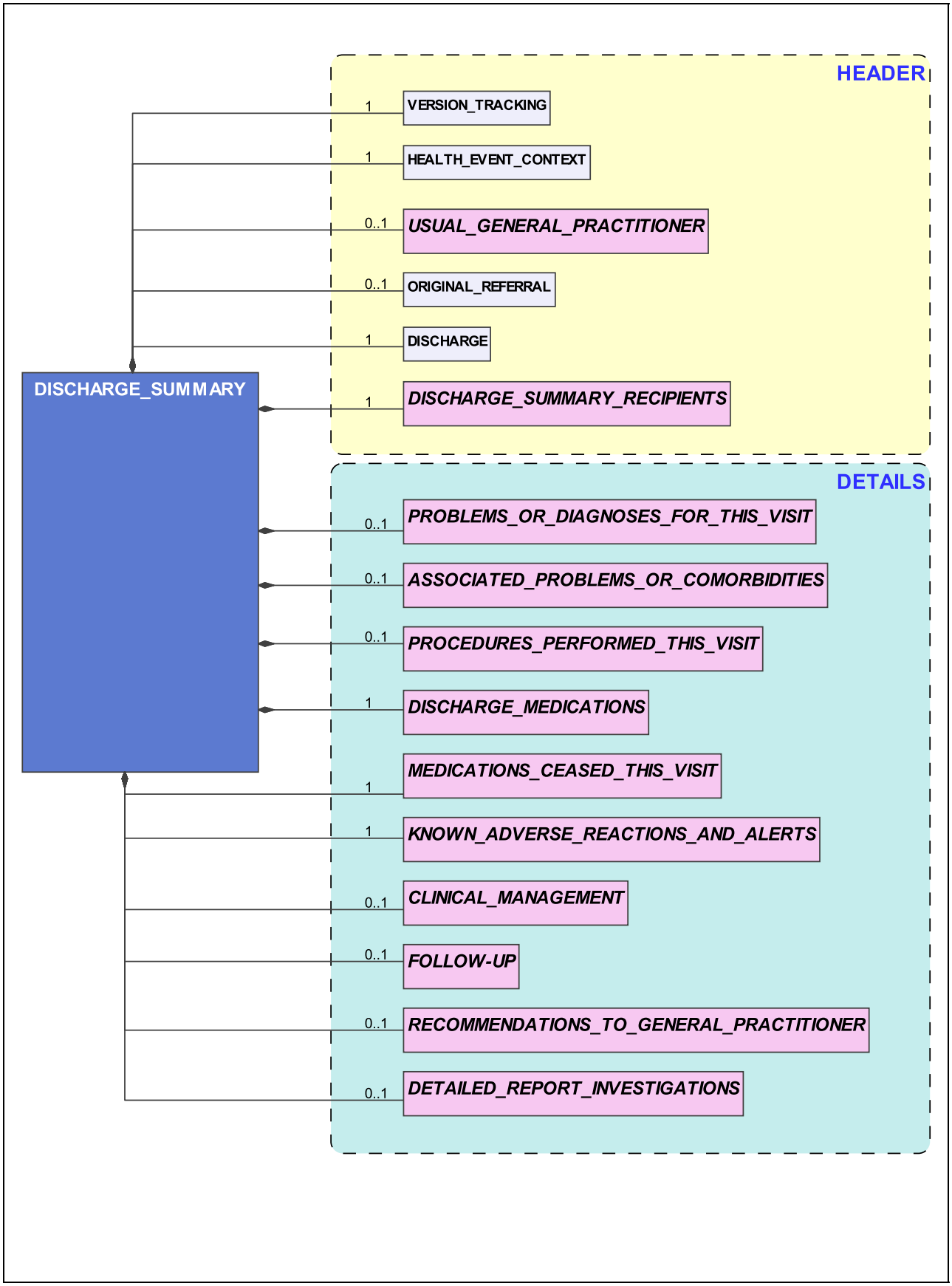


Figure 7 Discharge Summary - High Level Overview

5.4 Header - Version Tracking

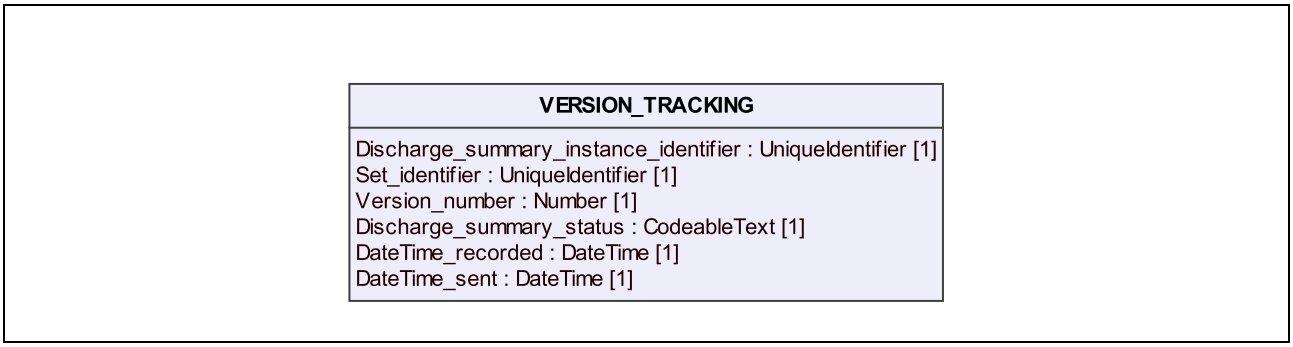


Figure 8 Header - Version Tracking

5.5 Header - Health Event Context

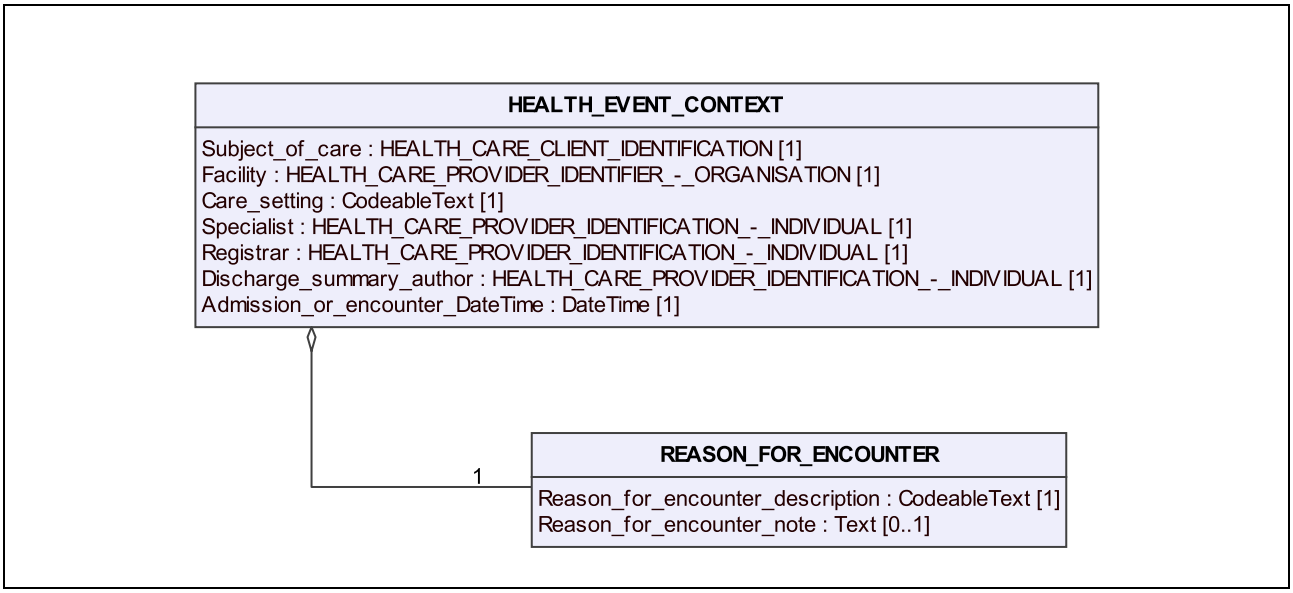


Figure 9 Header - Health Event Context

5.6 Header - Discharge

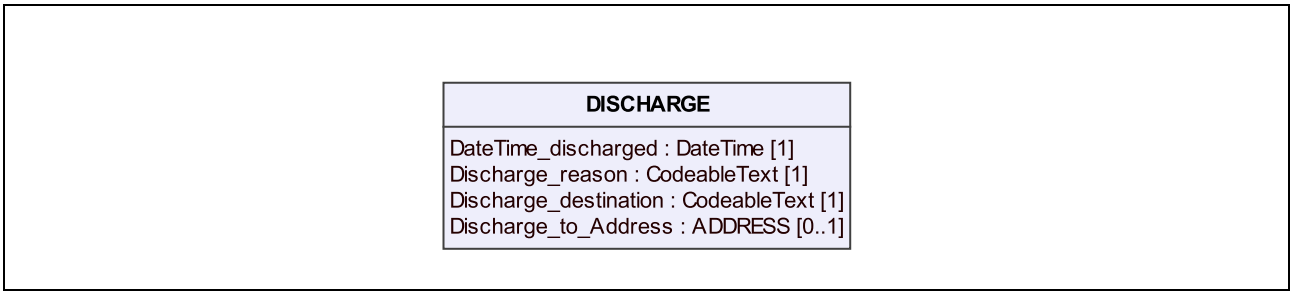


Figure 10 Header - Discharge

5.7 Header - Original Referral

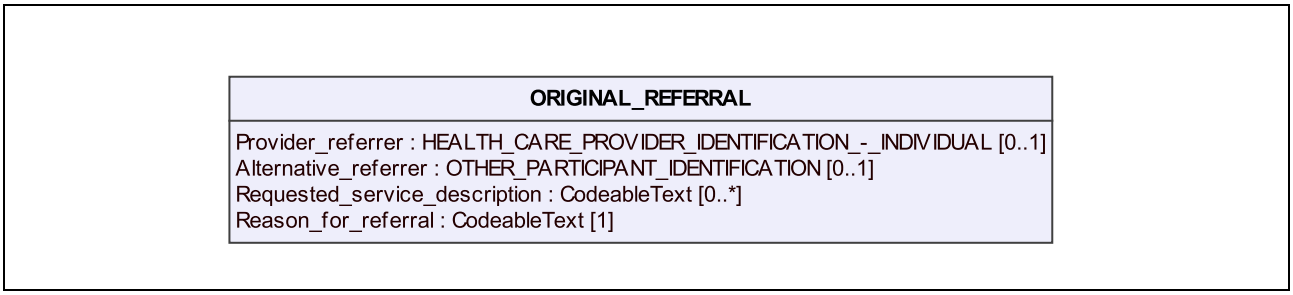


Figure 11 Header - Original Referral

5.8 Problems and Diagnoses

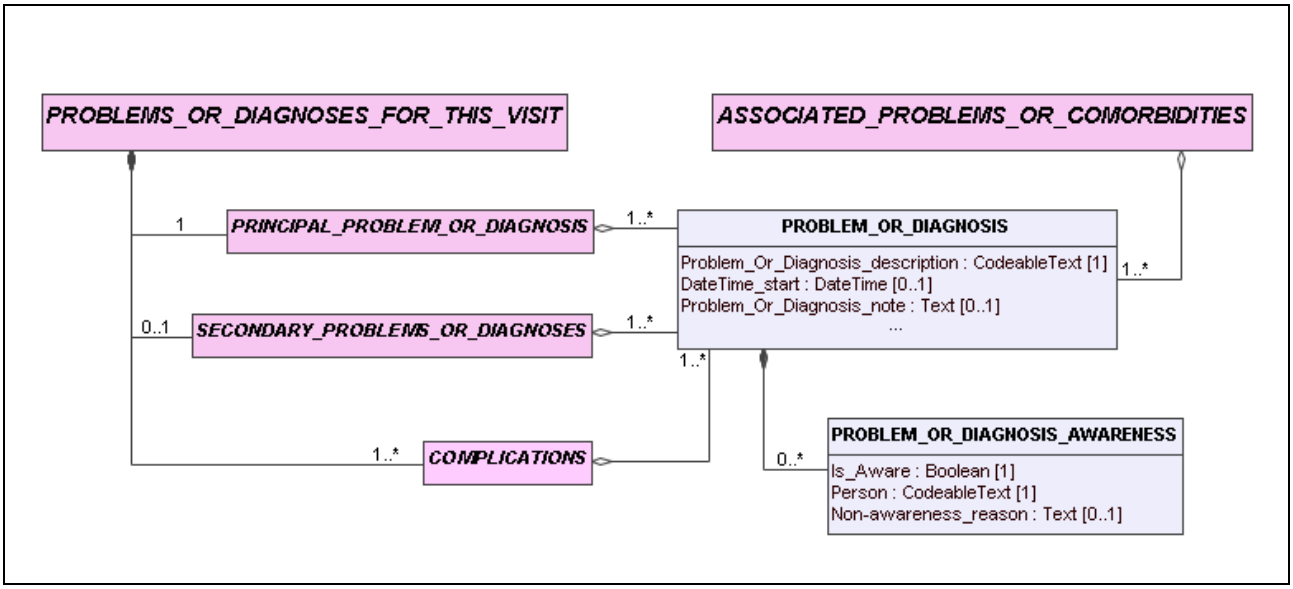


Figure 12 Discharge Summary Problems & Diagnoses

5.9 Procedures This Visit

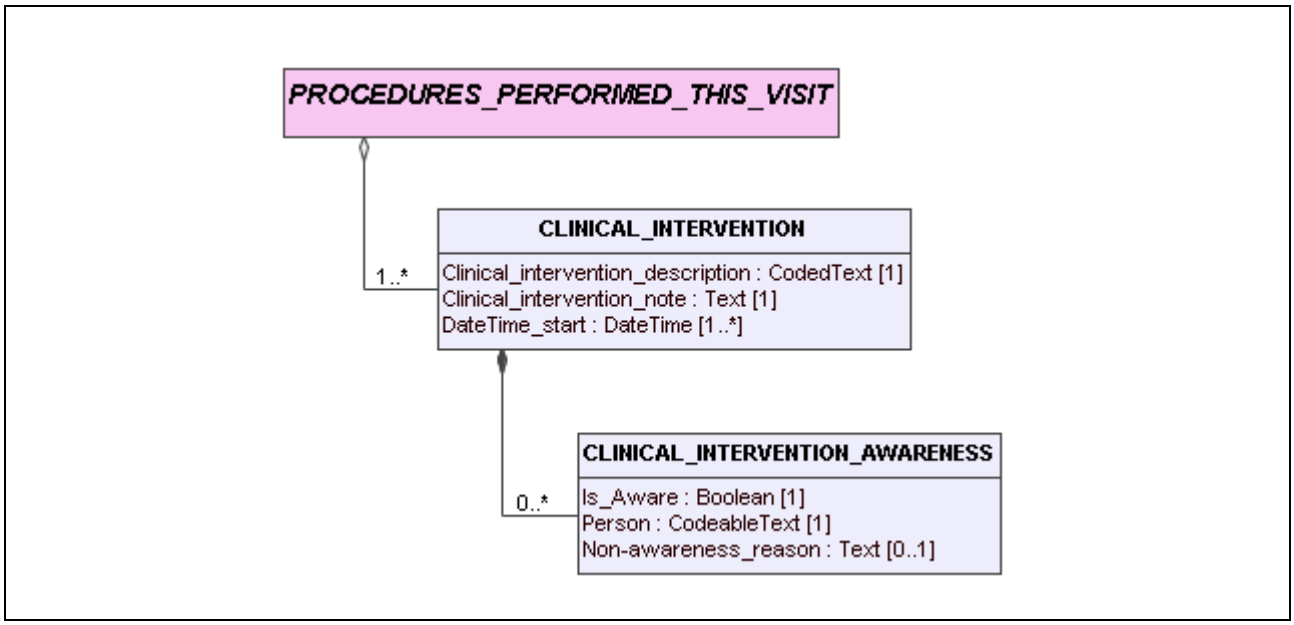


Figure 13 Procedures this visit

5.10 Medications

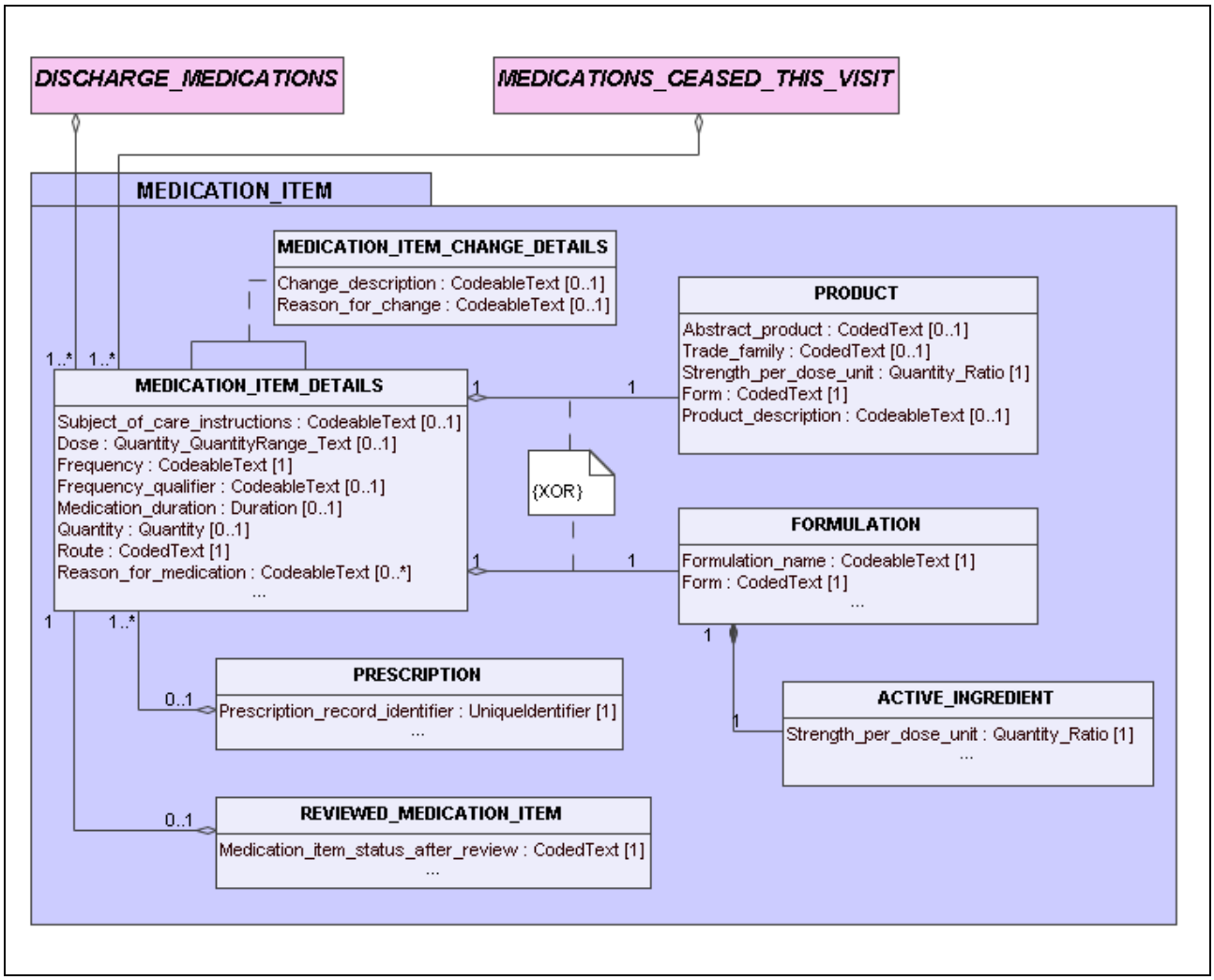


Figure 14 Medications

5.11 Known Adverse Reactions & Alerts

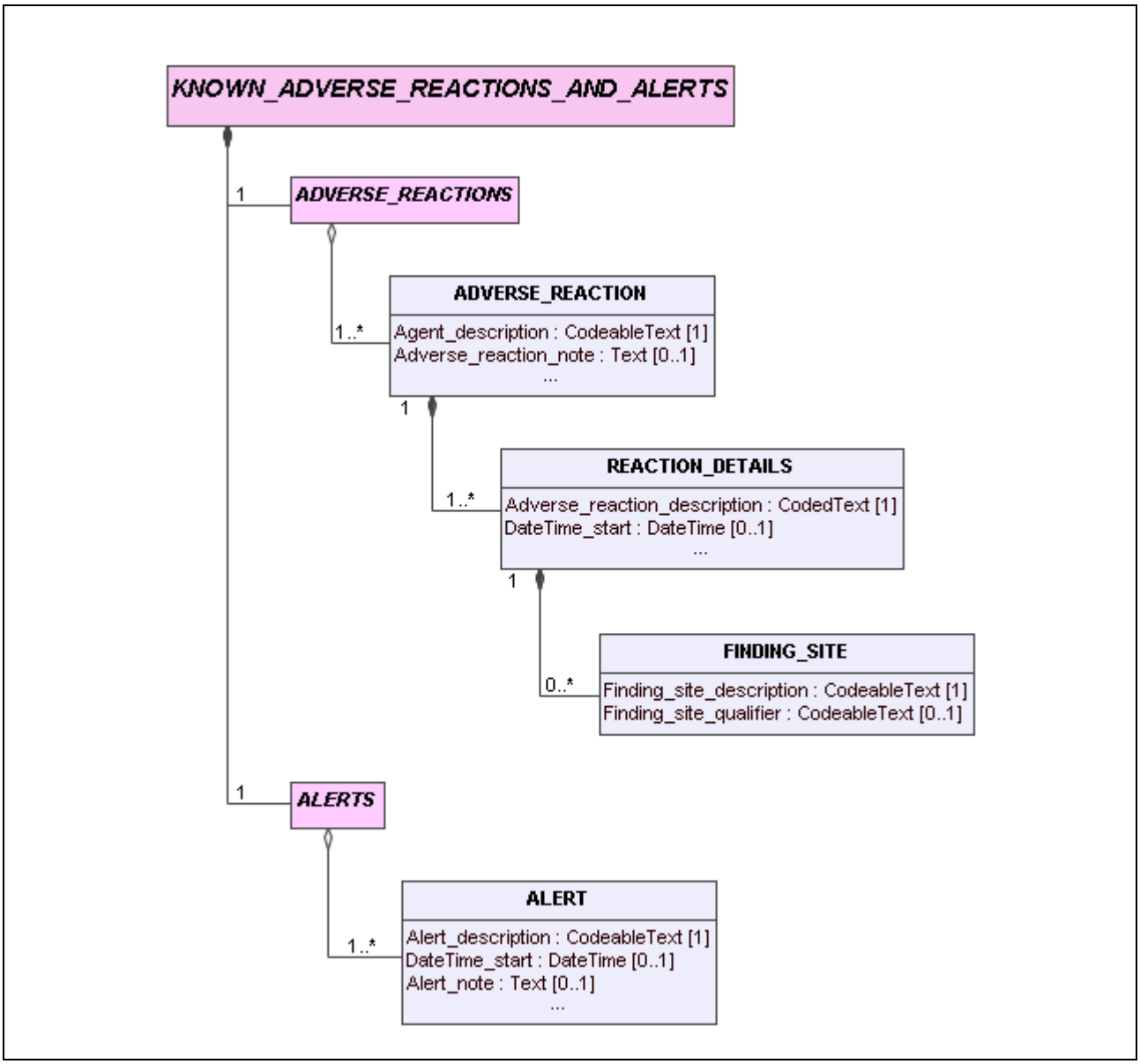


Figure 15 Known Adverse Reactions & Alerts

5.12 Detailed Report - Investigations

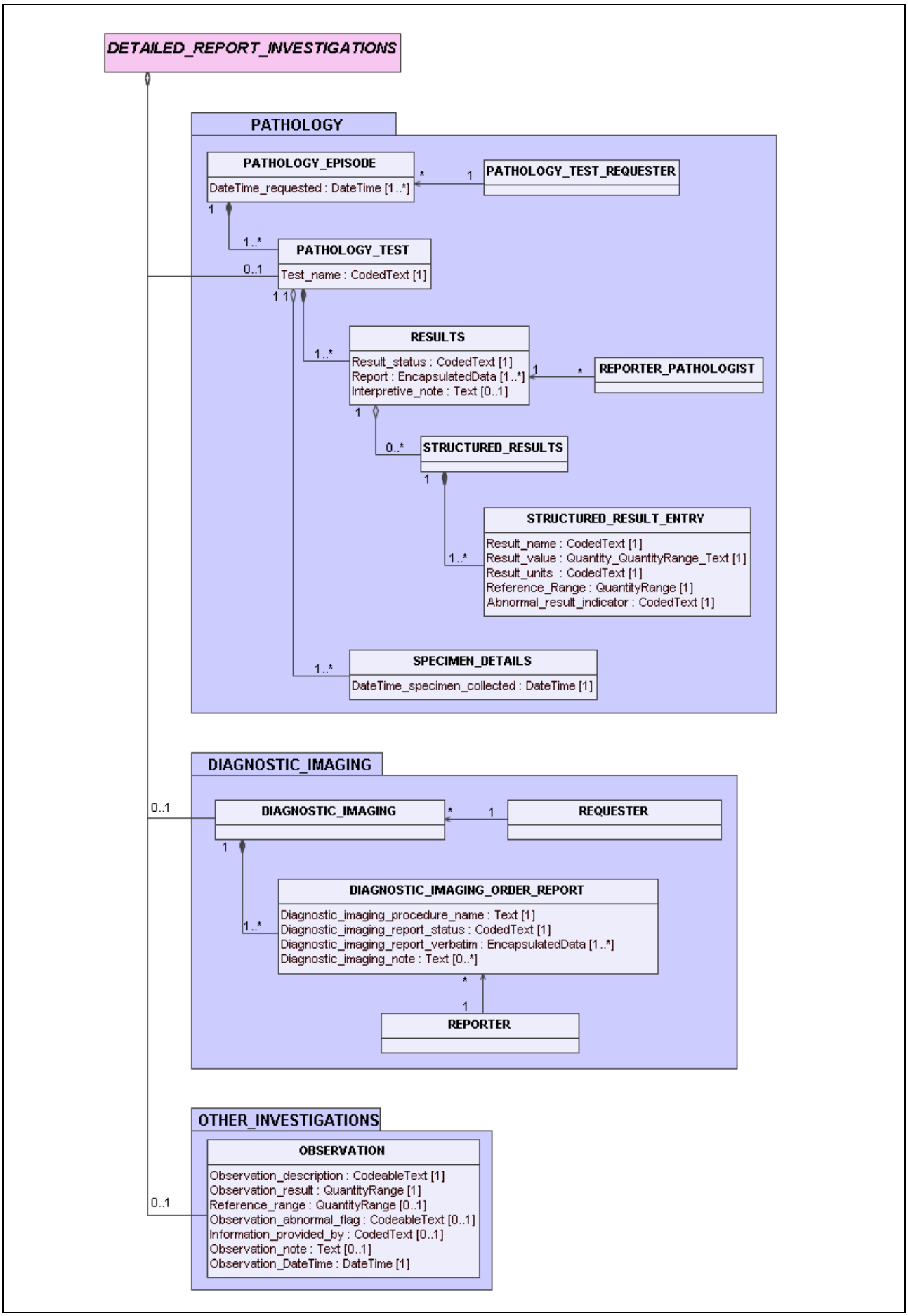


Figure 16 Detailed Report - Investigations

5.13 Clinical Management

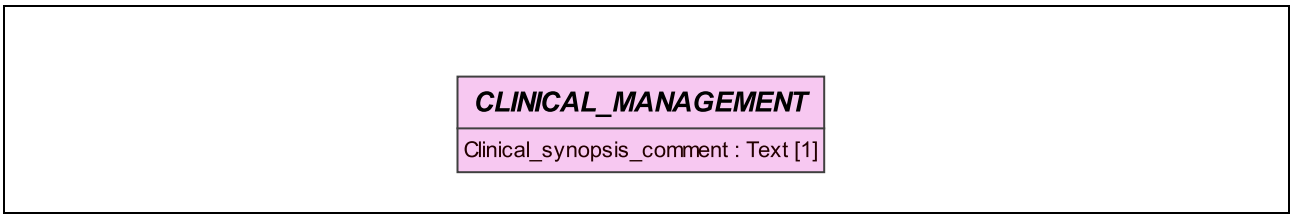


Figure 17 Clinical Management

5.14 Follow-Up

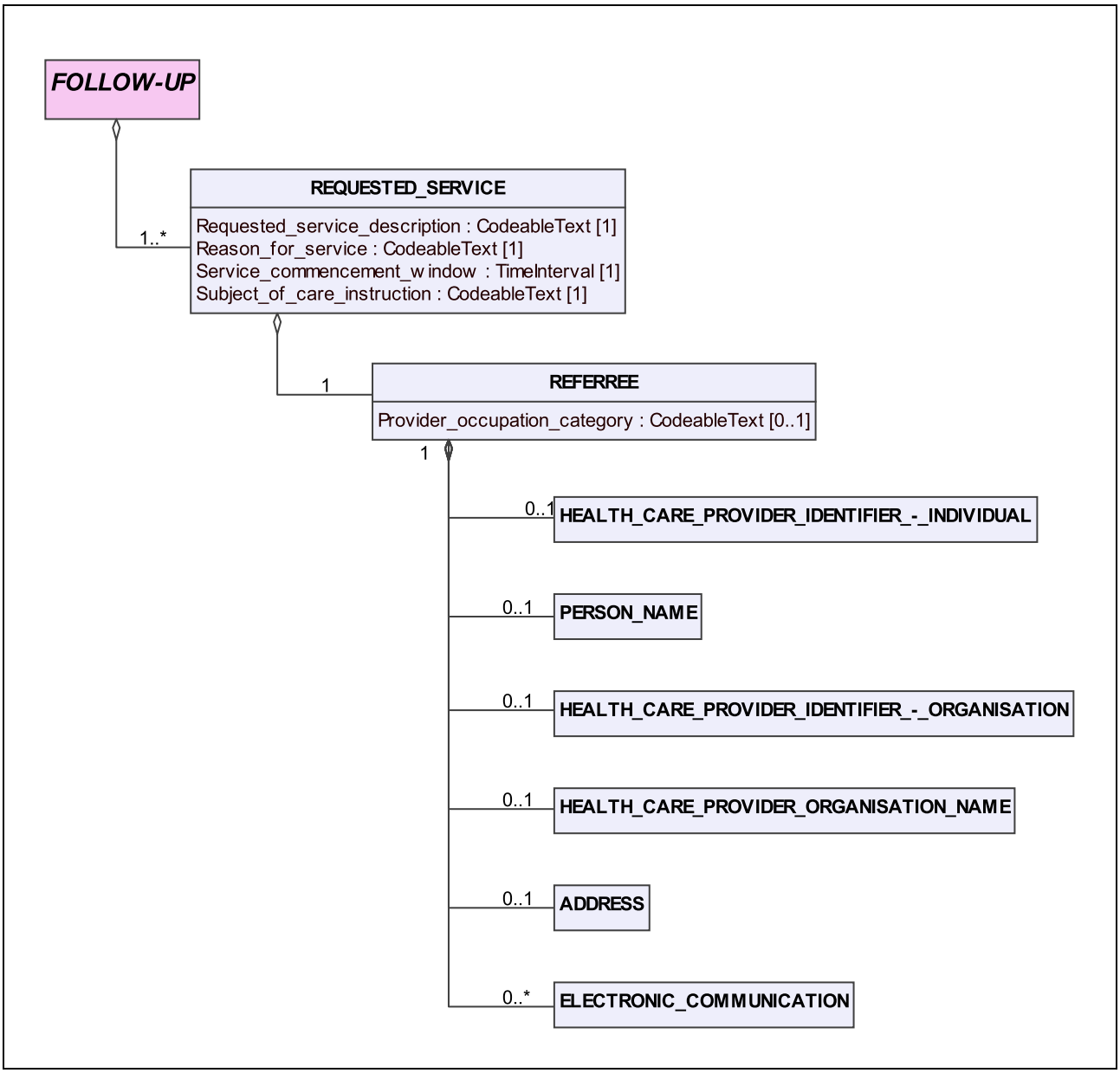


Figure 18 Follow-up

5.15 Recommendations to GP

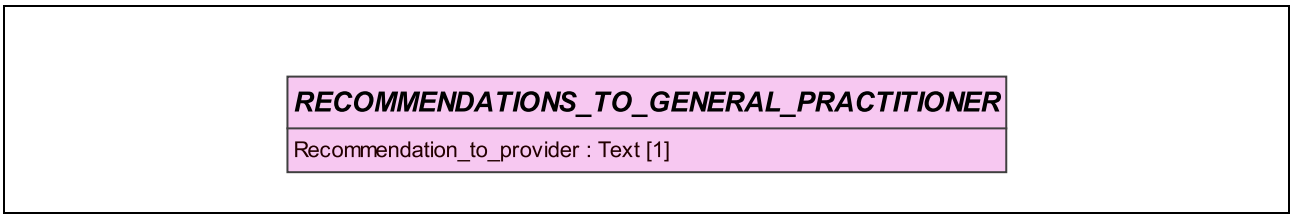


Figure 19 Recommendations to GP

5.16 Healthcare Provider

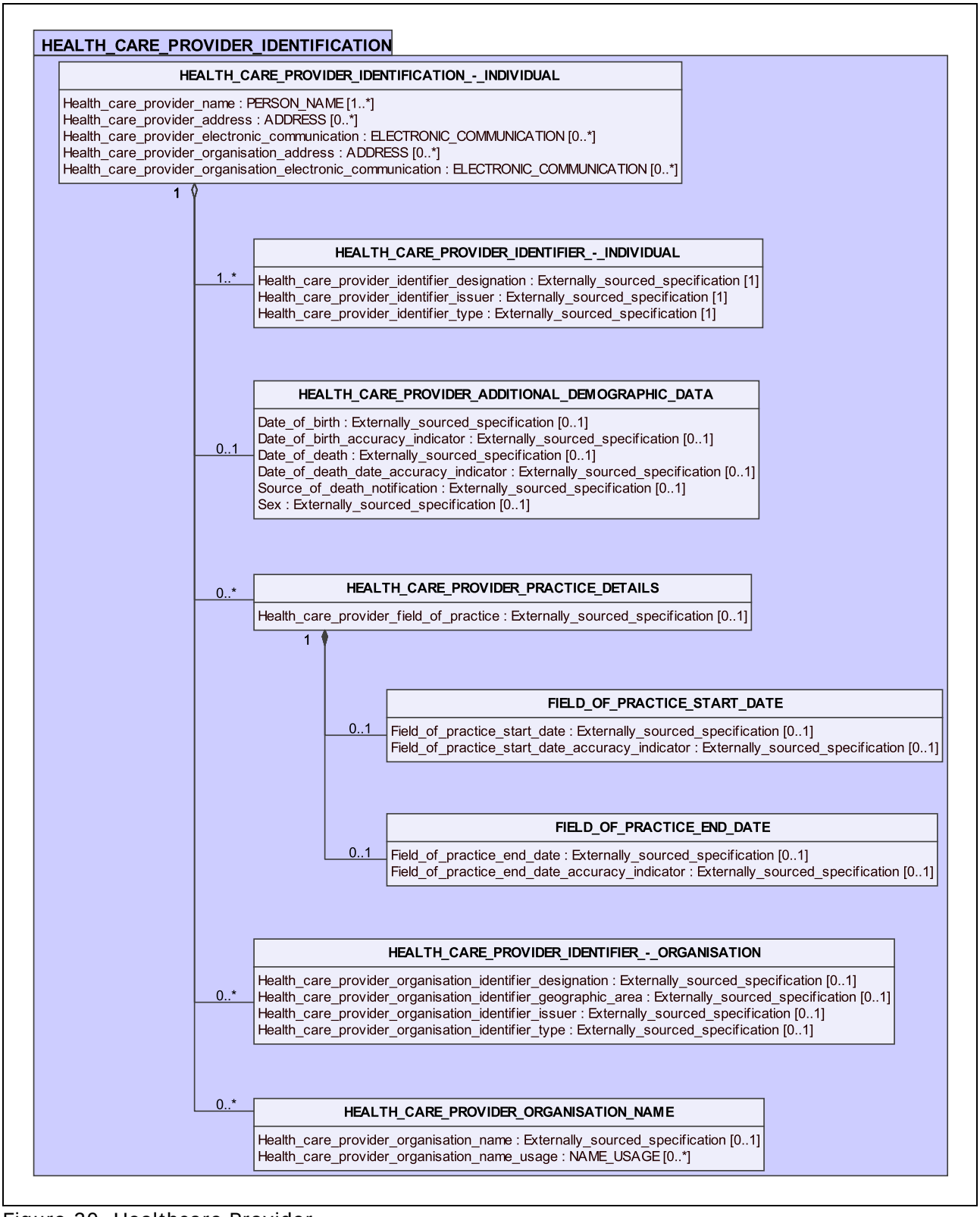


Figure 20 Healthcare Provider

5.17 Healthcare Client Identification

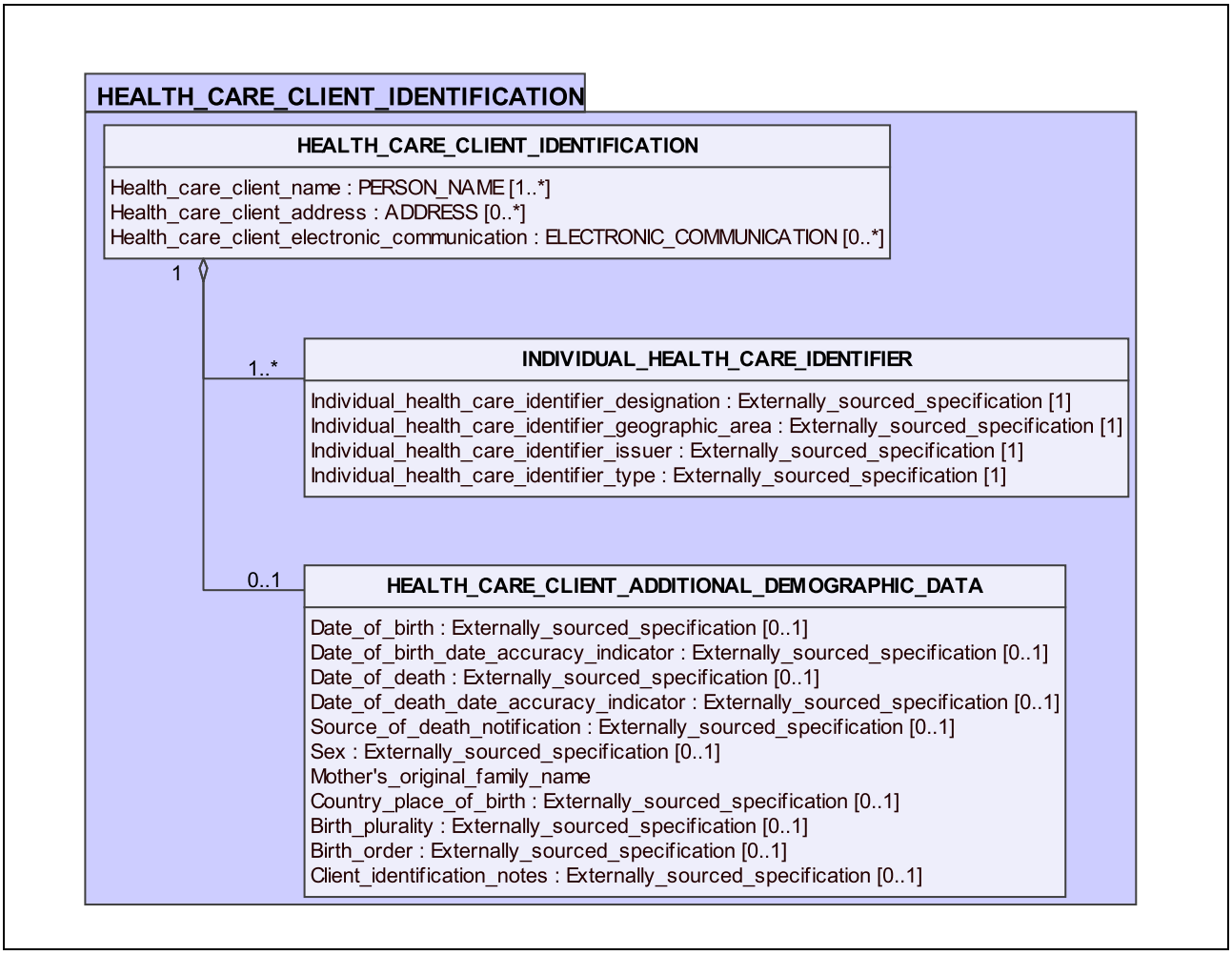


Figure 21 Discharge Summary - Healthcare Client

5.18 Name

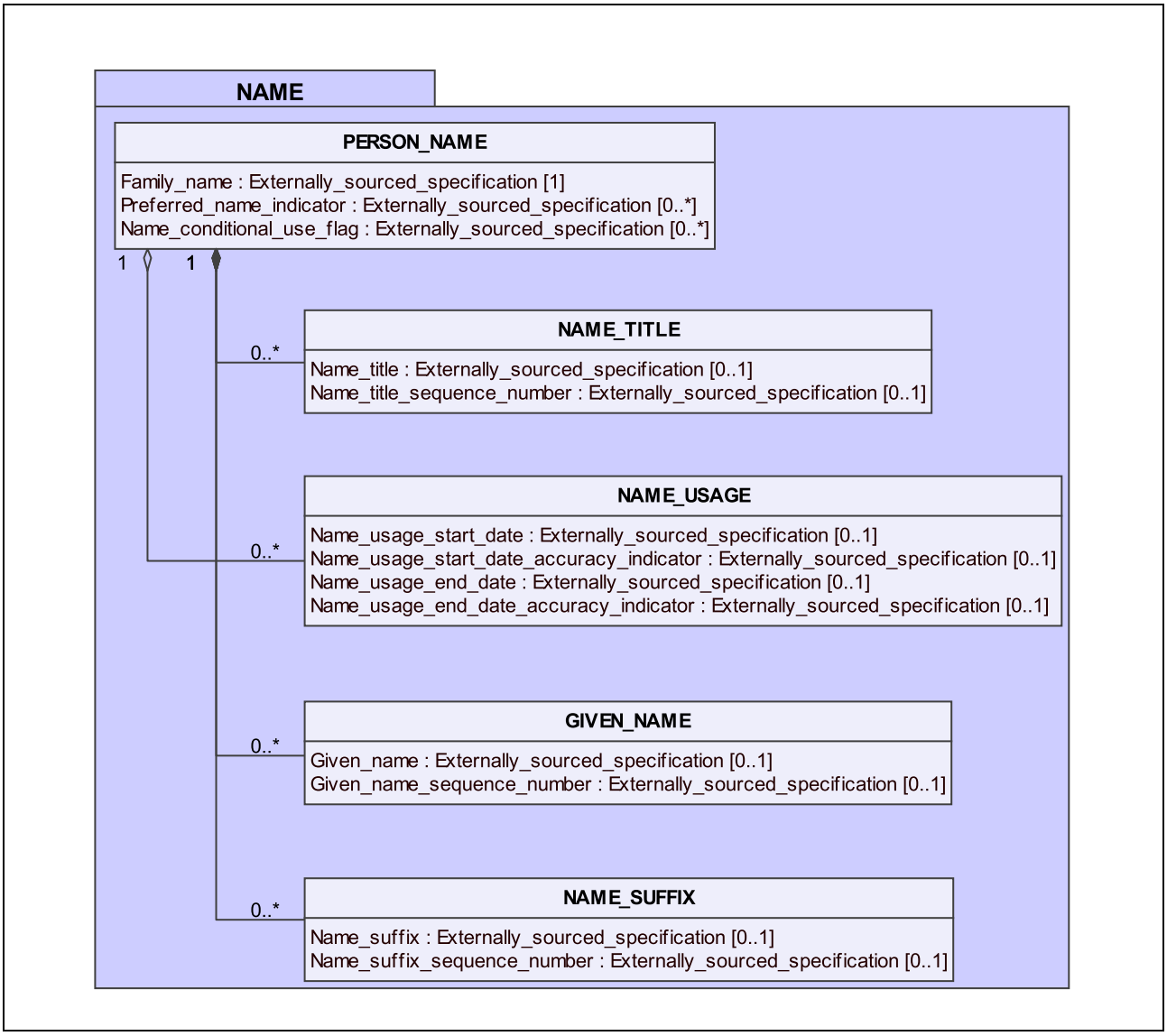


Figure 22 Discharge Summary - Name

5.19 Address

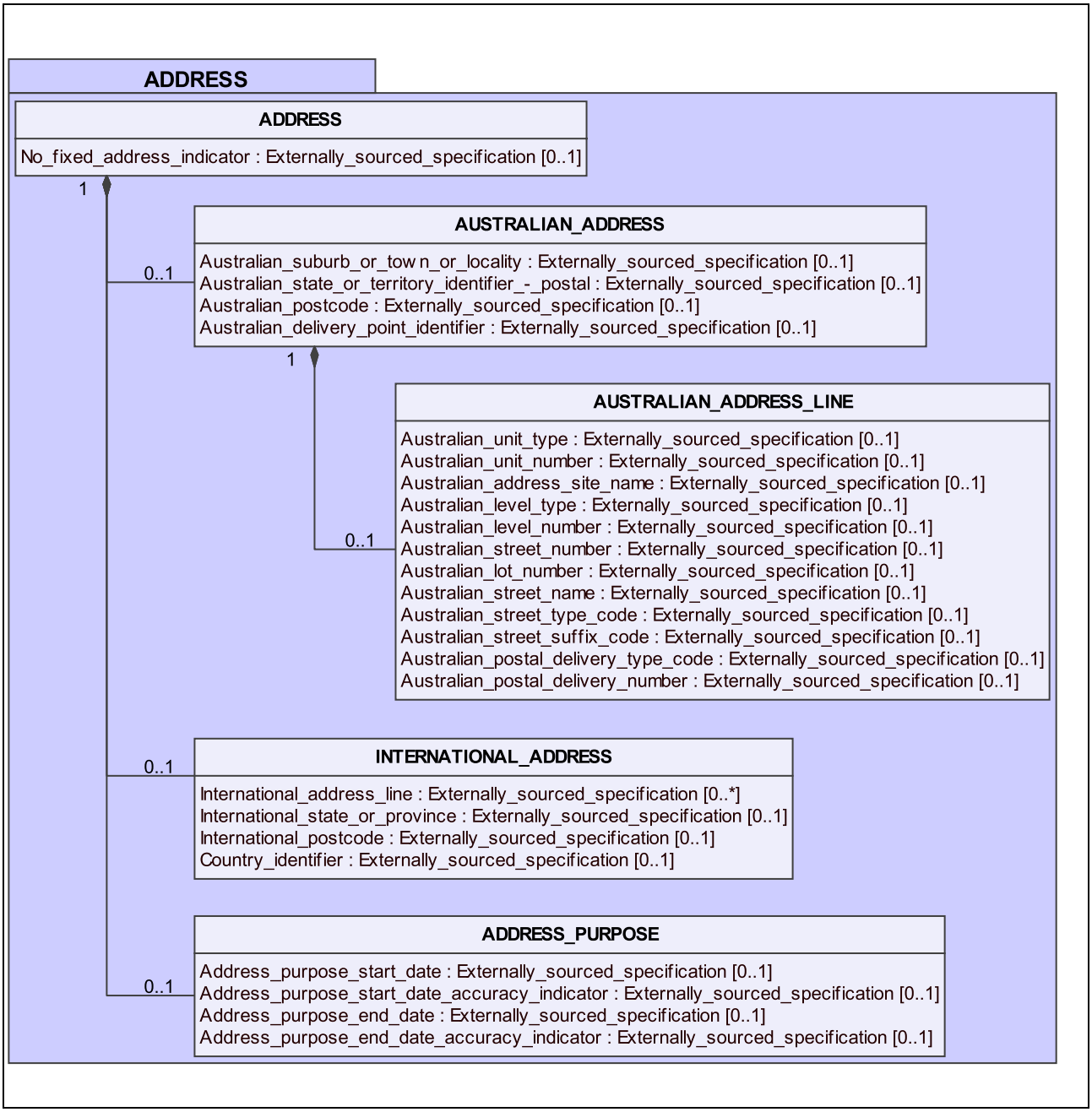


Figure 23 Discharge Summary - Address

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End of
Discharge Summary Content Specification