



Australian Government

Australian Digital Health Agency



Service Referral

Structured Content Specification

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Document Information

Key Information

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Product version	Date	Release comments
1.0	27 Jun 2016	Initial public release.
1.1	9 Jul 2018	This version of the specification has been rebranded to the Australian Digital Health Agency. It follows current modelling conventions and uses the latest versions of DCMs.

Related Documents

Name	Version/Release Date
My Health Record Glossary	Issued 2016
Participation Data Specification	Version 3.3, Issued 30 January 2017
Adverse Reaction Detailed Clinical Model Specification	Version 3.3, Issued 5 August 2016
Medication Instruction and Action Detailed Clinical Model Specification	Version 2.4, Issued 5 August 2016
Medical History Detailed Clinical Model Specification	Version 1.1, Issued 5 August 2016
Pathology Test Result Detailed Clinical Model Specification	Version 3.3, To be published
Imaging Examination Result Detailed Clinical Model Specification	Version 3.2, Issued 5 August 2016
Requested Service Detailed Clinical Model Specification	Version 1.1, To be published
Alerts Detailed Clinical Model Specification	Version 1.0, Issued 5 August 2016
Service Referral CDA Implementation Guide	Version 1.1, Issued 9 July 2018
Service Referral Information Requirements	Version 1.1, Issued 9 July 2018

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Table of Contents

1. Introduction	1
1.1. Document Purpose	1
1.2. Intended Audience	1
1.3. Document Scope	1
1.4. Known Issues	1
2. Service Referral Structured Document	3
2.1. Purpose	3
2.2. Use	3
2.3. SERVICE REFERRAL	4
2.4. SUBJECT OF CARE	24
2.5. DOCUMENT AUTHOR	26
2.6. Document Instance Identifier	28
2.7. RELATED DOCUMENT	29
2.8. Link Nature	30
2.9. Link Nature Values	31
2.10. Document Target	33
2.11. DOCUMENT DETAILS	34
2.12. Document Type	36
2.13. Document Title	38
2.14. Document Identifier	39
2.15. Document Type	40
2.16. Document Title	41
2.17. PATIENT NOMINATED CONTACT	42
2.18. PRIMARY CARE PROVIDER	45
2.19. INTERESTED PARTY	47
2.20. DateTime Attested	49
2.21. SERVICE REFERRAL DETAIL	50
2.22. Service Referral Detail Instance Identifier	51
2.23. Section Type	52
2.24. CURRENT SERVICES	53
2.25. Current Services Instance Identifier	54
2.26. Section Type	55
2.27. ADVERSE REACTIONS	56
2.28. Adverse Reactions Instance Identifier	58
2.29. Section Type	59
2.30. MEDICATION ORDERS	60
2.31. Medication Orders Instance Identifier	62
2.32. Section Type	63
2.33. MEDICAL HISTORY	64
2.34. Medical History Instance Identifier	66
2.35. Section Type	67
2.36. DIAGNOSTIC INVESTIGATIONS	68
2.37. Diagnostic Investigations Instance Identifier	70
2.38. Section Type	71
3. Requested Service Detailed Clinical Model	73
3.1. Purpose	73
3.2. Use	73
3.3. Misuse	73
3.4. REQUESTED SERVICE	74
3.5. Reason for Service	77
3.6. Reason for Service Description	79
3.7. Service Category	81
3.8. Service Description	82
3.9. Request Urgency	84
3.10. Request Urgency Values	86
3.11. Request Urgency Notes	87
3.12. Service Commencement Window	88
3.13. Service Booking Status	89

3.14. Service Booking Status Values	90
3.15. SERVICE PROVIDER	91
3.16. Request Validity Period	94
3.17. Requested Service DateTime	95
3.18. Requested Service Instance Identifier	96
3.19. Detailed Clinical Model Identifier	97
4. Interpreter Required Alert Detailed Clinical Model	99
4.1. Purpose	99
4.2. COMMUNICATION ALERT	100
4.3. Alert Description	102
4.4. Preferred Language	103
4.5. Communication Alert Instance Identifier	104
4.6. Detailed Clinical Model Identifier	105
5. Other Alerts Detailed Clinical Model	107
5.1. Purpose	107
5.2. Misuse	107
5.3. ALERT	108
5.4. Alert Type	110
5.5. Alert Description	112
5.6. Alert Instance Identifier	114
5.7. Detailed Clinical Model Identifier	115
6. Current Service Detailed Clinical Model	117
6.1. Purpose	117
6.2. Use	117
6.3. Misuse	117
6.4. REQUESTED SERVICE	118
6.5. Service Category	120
6.6. Service Description	121
6.7. Service Booking Status	123
6.8. Service Booking Status Values	124
6.9. Service Comment	125
6.10. SERVICE PROVIDER	126
6.11. Requested Service DateTime	128
6.12. Requested Service Instance Identifier	129
6.13. Detailed Clinical Model Identifier	130
7. Exclusion Statement - Adverse Reactions Detailed Clinical Model	131
7.1. Purpose	131
7.2. Use	131
7.3. EXCLUSION STATEMENT - ADVERSE REACTIONS	132
7.4. Global Statement	134
7.5. Global Statement Values	135
7.6. Detailed Clinical Model Identifier	136
8. Adverse Reaction Detailed Clinical Model	137
8.1. Purpose	137
8.2. Use	137
8.3. Misuse	138
8.4. ADVERSE REACTION	139
8.5. Substance/Agent	141
8.6. Substance/Agent Values	142
8.7. REACTION EVENT	143
8.8. Manifestation	145
8.9. Clinical Manifestation Values	146
8.10. Reaction Type	147
8.11. Adverse Reaction Type Values	149
8.12. Adverse Reaction Instance Identifier	150
8.13. Detailed Clinical Model Identifier	151
9. Exclusion Statement - Medications Detailed Clinical Model	153
9.1. Purpose	153
9.2. Use	153
9.3. EXCLUSION STATEMENT - MEDICATIONS	154

9.4. Global Statement	155
9.5. Global Statement Values	156
9.6. Detailed Clinical Model Identifier	157
10. Known Medication Detailed Clinical Model	159
10.1. Purpose	159
10.2. Use	159
10.3. Misuse	159
10.4. MEDICATION INSTRUCTION	160
10.5. Therapeutic Good Identification	163
10.6. Medicines Terminology	165
10.7. Directions	166
10.8. Clinical Indication	167
10.9. Medication Instruction Comment	168
10.10. Medication Instruction Instance Identifier	169
10.11. Detailed Clinical Model Identifier	170
11. Problem/Diagnosis Detailed Clinical Model	171
11.1. Purpose	171
11.2. Use	171
11.3. Misuse	171
11.4. PROBLEM/DIAGNOSIS	172
11.5. Problem/Diagnosis Identification	174
11.6. Problem/Diagnosis Reference Set	175
11.7. Date of Onset	176
11.8. Date of Resolution/Remission	177
11.9. Problem/Diagnosis Comment	178
11.10. Problem/Diagnosis Instance Identifier	179
11.11. Detailed Clinical Model Identifier	180
12. Procedure Detailed Clinical Model	181
12.1. Purpose	181
12.2. Use	181
12.3. Misuse	181
12.4. PROCEDURE	182
12.5. Procedure Name	184
12.6. Procedure Foundation Reference Set	185
12.7. Procedure Comment	186
12.8. Procedure DateTime	187
12.9. Procedure Instance Identifier	188
12.10. Detailed Clinical Model Identifier	189
13. Uncategorised Medical History Item Detailed Clinical Model	191
13.1. Purpose	191
13.2. Use	191
13.3. Misuse	191
13.4. UNCATEGORISED MEDICAL HISTORY ITEM	192
13.5. Medical History Item Description	194
13.6. Medical History Item TimeInterval	195
13.7. Medical History Item Comment	196
13.8. Uncategorised Medical History Item Instance Identifier	197
13.9. Detailed Clinical Model Identifier	198
14. Pathology Test Result Detailed Clinical Model	199
14.1. Purpose	199
14.2. Use	199
14.3. Misuse	199
14.4. PATHOLOGY TEST RESULT	200
14.5. Pathology Test Result Name	202
14.6. Pathology Test Result Name Values	203
14.7. Diagnostic Service	204
14.8. Diagnostic Service Values	205
14.9. SPECIMEN	206
14.10. Specimen Tissue Type	208
14.11. Collection Procedure	210

14.12. ANATOMICAL LOCATION	211
14.13. SPECIFIC LOCATION	213
14.14. Anatomical Location Name	214
14.15. Body Structure Foundation Reference Set	215
14.16. Side	216
14.17. Laterality Reference Set	217
14.18. Anatomical Location Description	218
14.19. Anatomical Location Image	219
14.20. PHYSICAL PROPERTIES OF AN OBJECT	220
14.21. Weight	221
14.22. DIMENSIONS	222
14.23. Volume	223
14.24. Object Description	224
14.25. Image	225
14.26. COLLECTION AND HANDLING	226
14.27. Sampling Preconditions	227
14.28. HANDLING AND PROCESSING	228
14.29. Collection DateTime	229
14.30. Collection Setting	230
14.31. DateTime Received	231
14.32. IDENTIFIERS	232
14.33. Specimen Identifier	233
14.34. Parent Specimen Identifier	234
14.35. Container Identifier	235
14.36. Overall Pathology Test Result Status	236
14.37. Pathology Test Result Status Values	237
14.38. Clinical Information Provided	239
14.39. PATHOLOGY TEST RESULT GROUP	240
14.40. Pathology Test Result Group Name	241
14.41. INDIVIDUAL PATHOLOGY TEST RESULT	242
14.42. Individual Pathology Test Result Name	243
14.43. Individual Pathology Test Result Name Values	244
14.44. INDIVIDUAL PATHOLOGY TEST RESULT VALUE	245
14.45. Individual Pathology Test Result Value	246
14.46. REFERENCE RANGE DETAILS	247
14.47. Normal Status	248
14.48. REFERENCE RANGE	250
14.49. Reference Range Meaning	251
14.50. Reference Range	252
14.51. Individual Pathology Test Result Comment	253
14.52. Individual Pathology Test Result Reference Range Guidance	254
14.53. Individual Pathology Test Result Status	255
14.54. SPECIMEN	256
14.55. Specimen Tissue Type	258
14.56. Collection Procedure	260
14.57. ANATOMICAL LOCATION	261
14.58. SPECIFIC LOCATION	263
14.59. Anatomical Location Name	264
14.60. Body Structure Foundation Reference Set	265
14.61. Side	266
14.62. Laterality Reference Set	267
14.63. Anatomical Location Description	268
14.64. Anatomical Location Image	269
14.65. PHYSICAL PROPERTIES OF AN OBJECT	270
14.66. Weight	271
14.67. DIMENSIONS	272
14.68. Volume	273
14.69. Object Description	274
14.70. Image	275
14.71. COLLECTION AND HANDLING	276

14.72. Sampling Preconditions	277
14.73. HANDLING AND PROCESSING	278
14.74. Collection DateTime	279
14.75. Collection Setting	280
14.76. DateTime Received	281
14.77. IDENTIFIERS	282
14.78. Specimen Identifier	283
14.79. Parent Specimen Identifier	284
14.80. Container Identifier	285
14.81. Pathological Diagnosis	286
14.82. Pathology Test Conclusion	287
14.83. Test Result Representation	288
14.84. Test Comment	289
14.85. TEST REQUEST DETAILS	290
14.86. Test Requested Name	291
14.87. Laboratory Test Result Identifier	292
14.88. Observation DateTime	293
14.89. Pathology Test Result Instance Identifier	295
14.90. Detailed Clinical Model Identifier	296
15. Imaging Examination Result Detailed Clinical Model	297
15.1. Purpose	297
15.2. Use	297
15.3. Misuse	297
15.4. IMAGING EXAMINATION RESULT	298
15.5. Imaging Examination Result Name	300
15.6. Imaging Modality	301
15.7. ANATOMICAL LOCATION	303
15.8. SPECIFIC LOCATION	305
15.9. Anatomical Location Name	306
15.10. Body Structure Foundation Reference Set	307
15.11. Side	308
15.12. Laterality Reference Set	309
15.13. Anatomical Location Description	310
15.14. Anatomical Location Image	311
15.15. Imaging Examination Result Status	312
15.16. Imaging Examination Result Status Values	313
15.17. Clinical Information Provided	315
15.18. Findings	316
15.19. IMAGING EXAMINATION RESULT GROUP	317
15.20. Imaging Examination Result Group Name	318
15.21. INDIVIDUAL IMAGING EXAMINATION RESULT	319
15.22. Individual Imaging Examination Result Name	320
15.23. IMAGING EXAMINATION RESULT VALUE	321
15.24. Imaging Examination Result Value	322
15.25. Result Value Values	323
15.26. REFERENCE RANGE DETAILS	324
15.27. Normal Status	325
15.28. REFERENCE RANGE	326
15.29. Reference Range Meaning	327
15.30. Reference Range	328
15.31. Result Comment	329
15.32. ANATOMICAL LOCATION	330
15.33. SPECIFIC LOCATION	332
15.34. Anatomical Location Name	333
15.35. Body Structure Foundation Reference Set	334
15.36. Side	335
15.37. Laterality Reference Set	336
15.38. Anatomical Location Description	337
15.39. Anatomical Location Image	338
15.40. Examination Result Representation	339

15.41. EXAMINATION REQUEST DETAILS	340
15.42. Examination Requested Name	341
15.43. DICOM Study Identifier	342
15.44. Report Identifier	343
15.45. IMAGE DETAILS	344
15.46. Image Identifier	345
15.47. DICOM Series Identifier	346
15.48. Image View Name	347
15.49. Subject Position	348
15.50. Image DateTime	349
15.51. Image	350
15.52. Observation DateTime	351
15.53. Imaging Examination Result Instance Identifier	353
15.54. Detailed Clinical Model Identifier	354
16. Pending Diagnostic Investigation Detailed Clinical Model	355
16.1. Purpose	355
16.2. Use	355
16.3. Misuse	355
16.4. REQUESTED SERVICE	356
16.5. Reason for Service	358
16.6. Reason for Service Description	360
16.7. Service Description	362
16.8. DateTime Service Scheduled	364
16.9. Service Commencement Window	365
16.10. Service Booking Status	366
16.11. Service Booking Status Values	367
16.12. Service Comment	368
16.13. Subject of Care Instruction Description	369
16.14. SERVICE PROVIDER	370
16.15. Requested Service DateTime	373
16.16. Requested Service Instance Identifier	374
16.17. Detailed Clinical Model Identifier	375
17. UML Class Diagrams	377
A. Mappings from Requirements	391
B. Known Issues	405
C. Change History	409
D. Specification Guide for Use	415
D.1. Overview	415
D.2. The Structured Content Specification Metamodel	415
Structured Document	416
Context	417
Content	417
Section	417
Data Group	417
Participation	417
Choice	417
Data Element	418
Value Domain	418
D.3. Icon Legend	418
Metadata Types Legend	419
Data Types Legend	419
Keywords Legend	423
Obligation Legend	424
D.4. Exceptional Values	425
D.5. Information Model Specification Parts Legends	426
Chapter Name	426
Identification Section Legend	426
Definition Section Legend	426
Data Hierarchy	427
Sample SCS Data Hierarchy	428

Value Domain Section Legend 428
Usage Section Legend 429
Relationships Section Legend 429
Reference List 431
Index 433

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1 Introduction

This document is a structured content specification (SCS) for service referral documents. The scope includes human services as well as healthcare.

[Appendix D, *Specification Guide for Use*](#) explains the data type constraints applied to data elements defined in this SCS. It also provides important information on how to read and use the SCS and is therefore an essential compendium for a better understanding of the SCS.

We value your questions and comments about this document. Please direct your questions or feedback to help@digitalhealth.gov.au.

1.1 Document Purpose

This document describes the recommended structured content of service referral documents for exchange between health and human service providers in Australian digital health systems.

The content within this document provides reviewers (software development teams, architects, designers, clinicians and informatics researchers) with the necessary information (or references to information held outside this document) to evaluate and assess the clinical suitability of the specification.

It is also a key input to the [Service Referral CDA Implementation Guide \[DH2018b\]](#), which describes how to implement Agency-compliant service referral documents using the [HL7 Clinical Document Architecture \[HL7CDAR2\]](#).

1.2 Intended Audience

This document is aimed at software development teams, architects, designers, clinicians and informatics researchers who are responsible for the delivery of clinical applications, infrastructure components and messaging interfaces, and also for those who wish to evaluate the clinical suitability of the Agency-endorsed specifications.

1.3 Document Scope

This document specifies the essential data groups, data elements, and the constraints that should be applied to them when creating a service referral document for exchange.

This specification covers exchanges between health and human service providers, as well as between healthcare providers.

Other uses of service referral, such as the exchange of information between a consumer (or their consumer representative) and other related parties (such as general practitioners and specialists), have not been considered for this design.

This specification is not to be used for requesting medications or requesting diagnostic investigations.

This is not a guide to the implementation of any specific messaging standard.

This document is not to be used as a guide to presentation (or rendering) of the data. It contains no information as to how the data described by it should be displayed and no such guidance should be inferred from this document.

1.4 Known Issues

Known issues with this document are described in [Appendix B, *Known Issues*](#).

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2 Service Referral Structured Document

2.1 Purpose

To permit a care provider to seek the input of another care provider to assist with a given aspect of a subject of care's wellbeing. Care providers include healthcare providers and human service providers.

2.2 Use

There are two overarching scenarios of procuring the input of another care provider that have been considered in this design.

- The provider initiating the service referral (the *Document Author*) knows precisely what is required by the service being requested. Further, the provider initiating the service referral has, and wishes to exercise, the authority (and expertise) to decide exactly what service will be provided by the requested service provider.

In this scenario, it would be expected that values for some data elements do not need to be provided. For example, some of the clinical elements such as diagnostic investigations, medications or the request validity period, particularly in the context of Medicare rebateable services.

- The initiating provider (the *Document Author*) defers to the expertise of the referred-to provider. This is used when the initiating provider is seeking another provider or organisation to use their own expertise and authority to determine the specific action to take.

In this scenario, it would be expected that values for many of the clinically focussed data elements would have values provided, for example medications, adverse reactions and medical history.

The scenario used may be driven by organisation practice and by context. Systems should be prepared for some degree of overlap.

2.3 SERVICE REFERRAL

Identification

Label	SERVICE REFERRAL
Metadata Type	Structured Document
Identifier	SD-17034
OID	1.2.36.1.2001.1001.101.100.17034

Definition

Definition	Referral of a subject of care from one healthcare or human services provider to another.
Definition Source	Australian Digital Health Agency
Synonymous Names	Referral

Data Hierarchy






































Note

























Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. Typically, such identifiers will be generated internally by systems and not displayed to users since they rarely have clinical significance.


























Items below with a grey background are data components that are included in the relevant detailed clinical model specification, but whose use is discouraged in this particular scenario.

Items below with a clear background are data components whose use is encouraged in this particular scenario.







	SERVICE REFERRAL		
CONTEXT			
		SUBJECT OF CARE	1..1
		DOCUMENT AUTHOR	1..1
		ENCOUNTER	0..0
		Document Instance Identifier	1..1
		RELATED DOCUMENT	0..*
		Link Nature	1..1
		Link Role	0..0
		Document Target	1..1

		DOCUMENT DETAILS	1..1
		DateTime Health Event Ended	0..0
		Document Type	0..1
		DOCUMENT AUTHOR	0..0
		DOCUMENT CUSTODIAN	0..0
		Document Title	1..1
		ADDITIONAL DOCUMENT DETAIL	0..0
		Document Summary	0..0
		Effective Period	0..0
		Document Identifier	0..1
		Document Status	0..0
		Document Type	1..1
		Document Title	0..1
		PATIENT NOMINATED CONTACT	0..*
		PRIMARY CARE PROVIDER	0..1
		INTERESTED PARTY	0..*
		DateTime Attested	0..1
CONTENT			
		SERVICE REFERRAL DETAIL	1..1
		REQUESTED SERVICE	1..*
		Reason for Service	0..1
		Reason for Service Description	0..1
		Service Category	0..1
		Service Description	0..1
		Intent of Request	0..0
		Request Urgency	0..1























		Request Urgency Notes	0..1
		DateTime Service Scheduled	0..0
		Service Commencement Window	0..1
		Service Booking Status	1..1
		Service Comment	0..0
		Supplementary Information to Follow	0..0
		Supplementary Information Expected	0..0
		Subject of Care Instruction Description	0..0
		REPORTER	0..0
		SERVICE REQUESTER	0..0
		SERVICE PROVIDER	0..1
		Request Validity Period	0..1
		Request Identifier (Instruction Identifier)	0..0
		INFORMATION PROVIDER	0..0
		SUBJECT	0..0
		Requested Service DateTime	1..1
		Requested Service Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Detailed Clinical Model Identifier	1..1
		Interpreter Required Alert (COMMUNICATION ALERT)	0..1
		Alert Description	1..1
		Preferred Language	1..*
		Alert Note	0..0
		REPORTER	0..0


























		INFORMATION PROVIDER	0..0
		SUBJECT	0..0
		Communication Alert Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Detailed Clinical Model Identifier	1..1
		Other Alerts (ALERT)	0..*
		Alert Type	1..1
		Alert Description	1..1
		Effective Period	0..0
		DateTime Reviewed	0..0
		Active Status	0..0
		Alert Certainty	0..0
		Alert Note	0..0
		DateTime Reported	0..0
		Information Provided by	0..0
		REPORTER	0..0
		INFORMATION PROVIDER	0..0
		SUBJECT	0..0
		Alert Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Detailed Clinical Model Identifier	1..1
		Service Referral Detail Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Section Type	1..1
		CURRENT SERVICES	0..1























	Current Service (REQUESTED SERVICE)		1..*
	Reason for Service		0..0
	Reason for Service Description		0..0
	Service Category		0..1
	Service Description		0..1
	Intent of Request		0..0
	Request Urgency		0..0
	Request Urgency Notes		0..0
	DateTime Service Scheduled		0..0
	Service Commencement Window		0..0
	Service Booking Status		1..1
	Service Comment		0..1
	Supplementary Information to Follow		0..0
	Supplementary Information Expected		0..0
	Subject of Care Instruction Description		0..0
	REPORTER		0..0
	SERVICE REQUESTER		0..0
	SERVICE PROVIDER		1..1
	Request Validity Period		0..0
	Request Identifier (Instruction Identifier)		0..0
	INFORMATION PROVIDER		0..0
	SUBJECT		0..0
	Requested Service DateTime		1..1
	Requested Service Instance Identifier		0..1


























		RELATED INFORMATION	0.0
		Detailed Clinical Model Identifier	1.1
		Current Services Instance Identifier	0.1
		RELATED INFORMATION	0.0
		Section Type	1.1
		ADVERSE REACTIONS	0.1
		EXCLUSION STATEMENT - ADVERSE REACTIONS	0.1
		Global Statement	1.1
		No Known Adverse Reaction to	0.0
		No Known Allergic Reaction to	0.0
		No Known Hypersensitivity Reaction to	0.0
		No Known Intolerance to	0.0
		INFORMATION PROVIDER	0.0
		SUBJECT	0.0
		Exclusion Statement - Adverse Reactions Instance Identifier	0.0
		RELATED INFORMATION	0.0
		Detailed Clinical Model Identifier	1.1
		ADVERSE REACTION	0..*
		Substance/Agent	1.1
		Absolute Contraindication	0.0
		Adverse Reaction Comment	0.0
		REACTION EVENT	0.1
		Specific Substance/Agent	0.0
		Manifestation	0..*
		Reaction Type	0.1
























		Adverse Reaction Certainty	0..0
		Reaction Description	0..0
		Reaction Onset Date	0..0
		Duration of Reaction	0..0
		Additional Reaction Detail (ANATOMICAL LOCATION)	0..0
		Exposure Description	0..0
		Earliest Exposure	0..0
		Duration of Exposure	0..0
		ADDITIONAL EXPOSURE DETAIL	0..0
		Clinical Management Description	0..0
		Multimedia	0..0
		Reporting Details	0..0
		Adverse Reaction Event Comment	0..0
		Reaction Reported	0..0
		Adverse Reaction Report	0..0
		Supporting Clinical Record Information	0..0
		INFORMATION PROVIDER	0..0
		SUBJECT	0..0
		Adverse Reaction Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Detailed Clinical Model Identifier	1..1
		Adverse Reactions Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Section Type	1..1
		Medications (MEDICATION ORDERS)	0..1


























	EXCLUSION STATEMENT - MEDICATIONS	0..1
	Global Statement	1..1
	Not Currently Taking	0..0
	Not Ever Taken	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Exclusion Statement - Medications Instance Identifier	0..0
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1
	Known Medication (MEDICATION INSTRUCTION)	0..*
	Therapeutic Good Identification	1..1
	Additional Therapeutic Good Detail	0..0
	Directions	1..1
	Formula	0..0
	Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)	0..0
	Dose Description	0..0
	Structured Dose (AMOUNT OF MEDICATION)	0..0
	Timing (MEDICATION TIMING)	0..0
	Additional Instruction	0..0
	Clinical Indication	0..1
	Administration Details (MEDICATION ADMINISTRATION)	0..0
	Medication Instruction Comment	0..1
	DISPENSING	0..0
	Change Type	0..0
	Change Status	0..0


























		Change Description	0..0
		Change or Recommendation Reason	0..0
		Indication for Authorised Use	0..0
		Medication Instruction ID	0..0
		Concession Benefit	0..0
		DateTime Medication Instruction Written	0..0
		Administrative Manufacturer Code	0..0
		INFORMATION PROVIDER	0..0
		SUBJECT	0..0
		Medication Instruction Narrative	0..0
		DateTime Medication Instruction Expires	0..0
		Medication Instruction Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Detailed Clinical Model Identifier	1..1
		Medication Orders Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Section Type	1..1
		Past and Current Medical History (MEDICAL HISTORY)	0..1
		PROBLEM/DIAGNOSIS	0..*
		Problem/Diagnosis Identification	1..1
		Clinical Description	0..0
		Severity	0..0
		Date of Onset	0..1
		Age at Onset	0..0
		ANATOMICAL LOCATION	0..0




		Occurrence Summary (PROBLEM/DIAGNOSIS OCCURRENCE SUMMARY)	0..0
		RELATED ITEMS	0..0
		Date of Resolution/Remission	0..1
		Age at Resolution/Remission	0..0
		Diagnostic Criteria	0..0
		Clinical Stage/Grade	0..0
		Problem/Diagnosis Comment	0..1
		Link to Supporting Clinical Evidence	0..0
		Status	0..0
		INFORMATION PROVIDER	0..0
		SUBJECT	0..0
		Problem/Diagnosis Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Detailed Clinical Model Identifier	1..1
		EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	0..0
		PROCEDURE	0..*
		Procedure Name	1..1
		Procedure Description	0..0
		Procedure Reason	0..0
		ANATOMICAL LOCATION	0..0
		Procedure Detail	0..0
		Multimedia	0..0
		Procedure Comment	0..1
		DEVICE	0..0
		INFORMATION PROVIDER	0..0



























		SUBJECT	0..0
		Procedure DateTime	1..1
		Procedure Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Detailed Clinical Model Identifier	1..1
		EXCLUSION STATEMENT - PROCEDURES	0..0
		UNCATEGORISED MEDICAL HISTORY ITEM	0..*
		Medical History Item Description	1..1
		Medical History Item TimeInterval	0..1
		Medical History Item Comment	0..1
		INFORMATION PROVIDER	0..0
		SUBJECT	0..0
		Uncategorised Medical History Item Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Detailed Clinical Model Identifier	1..1
		Medical History Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Section Type	1..1
		DIAGNOSTIC INVESTIGATIONS	0..1
		PATHOLOGY TEST RESULT	0..*
		Pathology Test Result Name	1..1
		Diagnostic Service	0..1
		Test Specimen Detail (SPECIMEN)	1..*
		Specimen Tissue Type	0..1
		Collection Procedure	0..1

























		Anatomical Site (ANATOMICAL LOCATION)	0..*
		SPECIFIC LOCATION	0..1
		Anatomical Location Name	0..1
		Side	0..1
		Numerical Identifier	0..0
		Anatomical Plane	0..0
		RELATIVE LOCATION	0..0
		Anatomical Location Description	0..1
		Visual Markings/Orientation	0..0
		Anatomical Location Image	0..*
		Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..*
		Name (Physical Object Name)	0..0
		Weight	0..1
		DIMENSIONS	0..1
		Diameter	0..0
		Circumference	0..0
		Length	0..0
		Breadth	0..0
		Depth	0..0
		Area	0..0
		Volume	0..1
		Description (Object Description)	0..1
		Image	0..1
		NEEDLE BIOPSY CORE DETAILS	0..0
		COLLECTION AND HANDLING	0..1


























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


























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



























		Weight	0..1
		DIMENSIONS	0..1
		Diameter	0..0
		Circumference	0..0
		Length	0..0
		Breadth	0..0
		Depth	0..0
		Area	0..0
		Volume	0..1
		Description (Object Description)	0..1
		Image	0..1
		NEEDLE BIOPSY CORE DETAILS	0..0
		COLLECTION AND HANDLING	0..1
		Potential Risk / Biohazard	0..0
		Sampling Preconditions	0..1
		Number of Containers	0..0
		Collection Procedure Details	0..0
		Transport Medium	0..0
		Testing Method	0..0
		DEVICE	0..0
		HANDLING AND PROCESSING	1..1
		Collection DateTime	1..1
		Collection Setting	0..1
		Date and Time of Receipt (DateTime Received)	0..1
		Date and Time Processed (DateTime Processed)	0..0

		SPECIMEN QUALITY	0.0
		IDENTIFIERS	0.1
		Specimen Identifier	0.1
		Parent Specimen Identifier	0.1
		Container Identifier	0.1
		Specimen Collector Identifier	0.0
		SPECIMEN COLLECTOR DETAILS	0.0
		Pathological Diagnosis	0..*
		Conclusion (Pathology Test Conclusion)	0.1
		Test Result Representation	0.1
		Test Comment	0.1
		RECEIVING LABORATORY	0.0
		TEST REQUEST DETAILS	0..*
		Requester Order Identifier	0.0
		Test Requested Name	0..*
		REQUESTER	0.0
		Receiver Order Identifier	0.0
		Laboratory Test Result Identifier	0.1
		Test Procedure	0.0
		REPORTING PATHOLOGIST	0.0
		INFORMATION PROVIDER	0.0
		SUBJECT	0.0
		Observation DateTime	1.1
		Pathology Test Result Instance Identifier	0.1
		RELATED INFORMATION	0.0

		Detailed Clinical Model Identifier	1..1
		IMAGING EXAMINATION RESULT	0..*
		Examination Result Name (Imaging Examination Result Name)	1..1
		Imaging Modality	0..1
		Anatomical Site (ANATOMICAL LOCATION)	0..*
		SPECIFIC LOCATION	0..1
		Anatomical Location Name	0..1
		Side	0..1
		Numerical Identifier	0..0
		Anatomical Plane	0..0
		RELATIVE LOCATION	0..0
		Anatomical Location Description	0..1
		Visual Markings/Orientation	0..0
		Anatomical Location Image	0..*
		Anatomical Region	0..0
		Imaging Examination Result Status	1..1
		Clinical Information Provided	0..1
		Findings	0..1
		Result Group (IMAGING EXAMINATION RESULT GROUP)	0..*
		Imaging Examination Result Group Name	1..1
		Result (INDIVIDUAL IMAGING EXAMINATION RESULT)	1..*
		Individual Imaging Examination Result Name	1..1
		Result Value (IMAGING EXAMINATION RESULT VALUE)	0..1
		Result Value (Imaging Examination Result Value)	1..1

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

		Receiver Order Identifier	0..0
		DICOM Study Identifier	0..1
		Report Identifier	0..1
		IMAGE DETAILS	0..*
		Image Identifier	0..1
		DICOM Series Identifier	0..1
		Image View Name	0..1
		Subject Position	0..1
		Image DateTime	0..1
		Image	0..1
		Examination Procedure	0..0
		COMPARED IMAGE DETAILS	0..0
		REPORTING RADIOLOGIST	0..0
		INFORMATION PROVIDER	0..0
		SUBJECT	0..0
		Observation DateTime	1..1
		Imaging Examination Result Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Detailed Clinical Model Identifier	1..1
		Diagnostic Investigation Synopsis (CLINICAL SYNOPSIS)	0..0
		Pending Diagnostic Investigation (REQUESTED SERVICE)	0..*
		Reason for Service	0..1
		Reason for Service Description	0..1
		Service Category	0..0
		Service Description	1..1

		Intent of Request	0..0
		Request Urgency	0..0
		Request Urgency Notes	0..0
		DateTime Service Scheduled	0..1
		Service Commencement Window	0..1
		Service Booking Status	1..1
		Service Comment	0..1
		Supplementary Information to Follow	0..0
		Supplementary Information Expected	0..0
		Subject of Care Instruction Description	0..*
		REPORTER	0..0
		SERVICE REQUESTER	0..0
		SERVICE PROVIDER	0..1
	 	Request Validity Period	0..0
		Request Identifier (Instruction Identifier)	0..0
		INFORMATION PROVIDER	0..0
		SUBJECT	0..0
	 	Requested Service DateTime	1..1
		Requested Service Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Detailed Clinical Model Identifier	1..1
		Diagnostic Investigations Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Section Type	1..1

2.4 SUBJECT OF CARE

Identification

Label	SUBJECT OF CARE
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	Person who receives care services.
Definition Source	Australian Digital Health Agency
Synonymous Names	Patient Individual
Scope	The person who is the focus of the document.
Scope Source	Australian Digital Health Agency

Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [DH2017a]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <p>Obligation and occurrence constraints:</p> <ul style="list-style-type: none"> • Participation Period is PROHIBITED. • LOCATION OF PARTICIPATION is PROHIBITED. • Entity Identifier is ESSENTIAL. • ADDRESS is ESSENTIAL. • Relationship to Subject of Care is PROHIBITED. • EMPLOYMENT DETAIL is PROHIBITED. • DEMOGRAPHIC DATA is ESSENTIAL. • Sex is ESSENTIAL. • DATE OF BIRTH DETAIL is ESSENTIAL. • Indigenous Status is ESSENTIAL. • Qualifications is PROHIBITED. <p>Other constraints:</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to “Subject of Care”. • Role SHALL have an implementation-specific value equivalent to “Patient”.
--------------------------	---

**Conditions of Use
Source**


- PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.

Terms used in obligation and occurrence constraints are explained in [Appendix D, Specification Guide for Use](#).

Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL	1..1

2.5 DOCUMENT AUTHOR

Identification

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

Definition

Definition	Composer of the document.
Definition Source	Australian Digital Health Agency
Synonymous Names	Author Referrer Referral Sender
Scope	The referral sender, who is the healthcare or human services provider responsible for the content of the letter, even if another party physically authored or composed the referral.
Scope Source	Australian Digital Health Agency
Notes	The date, or date and time, that the authoring of the document was completed is recorded in the <i>Participation Period</i> of the <i>Author</i> .


Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [DH2017a]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <p>Obligation and occurrence constraints:</p> <ul style="list-style-type: none"> • Participation Period is ESSENTIAL. • LOCATION OF PARTICIPATION is PROHIBITED. • Entity Identifier is ESSENTIAL. • Relationship to Subject of Care is PROHIBITED. • EMPLOYMENT DETAIL is ESSENTIAL. • EMPLOYER ORGANISATION is ESSENTIAL. • EMPLOYER ORGANISATION.Entity Identifier is ESSENTIAL. • EMPLOYER ORGANISATION.ELECTRONIC COMMUNICATION DETAIL is ESSENTIAL. • DEMOGRAPHIC DATA is PROHIBITED. <p>Other constraints:</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to “Document Author”.
--------------------------	---

<p>Conditions of Use</p> <p>Source</p>	<ul style="list-style-type: none"> • Role SHOULD have a value chosen from 1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 [ABS2009]. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available MAY be used. • The value of ADDRESS.Address Purpose SHALL be “B” (Business). • The value of ELECTRONIC COMMUNICATION DETAIL.Electronic Communication Usage Code SHALL be “B” (Business). • AUSTRALIAN OR INTERNATIONAL ADDRESS SHALL be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON. <p>Terms used in obligation and occurrence constraints are explained in Appendix D, Specification Guide for Use.</p> <p>Australian Digital Health Agency</p>
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL	1..1

2.6 Document Instance Identifier

Identification

Label	Document Instance Identifier
Metadata Type	Data Element
Identifier	DE-20101
OID	1.2.36.1.2001.1001.101.103.20101

Definition


Definition	Globally unique identifier for each instance of a <i>Service Referral</i> document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	A document can have multiple instances as it passes through its life cycle of creation, revisions before it is first sent, and revised versions thereafter. The value of this data element enables systems to identify all instances of a document uniquely, thus enabling efficient storage, query and audit trail of information about a subject of care.
Context Source	Australian Digital Health Agency
Data Type	UniqueIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniqueIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL	1..1

2.7 RELATED DOCUMENT

Identification

Label	RELATED DOCUMENT
Metadata Type	Data Group
Identifier	DG-16971
OID	1.2.36.1.2001.1001.101.102.16971

Definition


Definition	Information about a document of interest.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Attached document relevant to the referral, for example additional referral forms or templates, reports, or care plans.
Scope Source	Australian Digital Health Agency

Usage





Misuse	Not to be used for links to external files, repositories, or other external content.
---------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL	0..*

Children

Data Type	Name	Occurrences
	Link Nature	1..1
	Link Role	0..0
	Document Target	1..1
	DOCUMENT DETAILS	1..1

2.8 Link Nature

Identification

Label	Link Nature
Metadata Type	Data Element
Identifier	DE-16698
OID	1.2.36.1.2001.1001.101.103.16698

Definition


Definition	General semantic category of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs or document. This attribute is intended to be a coarse-grained category that can be used to enable interoperability between sender and receiver.
Data Type	CodedText
Value Domain	Link Nature Values

Usage

Conditions of Use	The value of this item SHALL be “LINK-E0” (is a related documentation).
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodedText .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED DOCUMENT	1..1

2.9 Link Nature Values

Identification

Label	Link Nature Values
Metadata Type	Value Domain
Identifier	VD-16698
OID	1.2.36.1.2001.1001.101.104.16698
External Identifier	LINK_NATURE

Definition


Definition	Set of values for the general semantic category of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency

Value Domain

Source	ISO 13606-3:2009	
Permissible Values	The permissible values are those specified in Termlist LINK_NATURE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] . The values are listed here with brief descriptions.	
	LINK-A0, is related to	The most general category of Link.
	LINK-B0, is confirmed by or authorised by	The link target contains an instance of a DCM or document that is either a legal or authoritative basis for what is documented in the source DCM instance, or is a declaration of intent to provide (or not provide) requested care.
	LINK-C0, is related to the same problem or health issue	The target instance of a DCM or document describes health or healthcare that concerns the same clinical situation as the source DCM instance.
	LINK-D0, is related to the same care plan, act or episode	The source and the target instances of DCMs or documents both describe parts of the same care plan, act or episode.
	LINK-E0, is a related documentation	The target instance of a DCM or document is an alternative documentary form of the source DCM instance. For example, a re-expression of the same clinical information or supplementary explanatory information.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Nature	1..1

2.10 Document Target

Identification

Label	Document Target
Metadata Type	Data Element
Identifier	DE-16972
OID	1.2.36.1.2001.1001.101.103.16972

Definition


Definition	“Linked to” or identified document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	The <i>EncapsulatedData</i> data type permits attachments as well as encapsulated data. MIME types allowed as attachments are defined in the <i>Clinical Documents Common Conformance Profile</i> .
Data Type	EncapsulatedData

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for <i>EncapsulatedData</i> .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED DOCUMENT	1..1

2.11 DOCUMENT DETAILS

Identification


Label	DOCUMENT DETAILS
Metadata Type	Data Group
Identifier	DG-16720
OID	1.2.36.1.2001.1001.101.102.16720

Definition








Definition	Information about a document of interest.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Includes, among other things, document metadata (e.g. title and document type), information about the origin of the document (e.g. author name and date of creation) and the life cycle (e.g. document status).
Scope Source	Australian Digital Health Agency




Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED DOCUMENT	1..1

Children

Data Type	Name	Occurrences
	DateTime Health Event Ended	0..0
	Document Type	0..1
	DOCUMENT AUTHOR	0..0
	DOCUMENT CUSTODIAN	0..0
	Document Title	1..1
	ADDITIONAL DOCUMENT DETAIL	0..0
	Document Summary	0..0

Data Type	Name	Occurrences
	Effective Period	0..0
	Document Identifier	0..1
	Document Status	0..0

2.12 Document Type

Identification

Label	Document Type
Metadata Type	Data Element
Identifier	DE-10335
OID	1.2.36.1.2001.1001.101.103.10335

Definition

Definition	Type of the document of interest.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Each clinical document can contain, as a coded value, an identification of its document type. This data element contains the coded value of <i>Document Type</i> of the document of interest.</p> <p>When appropriate, the value of <i>Document Type</i> should be a LOINC code. When an appropriate LOINC code is not available, the value should be an Agency OID.</p>
Data Type	CodedText
Value Domain	<p><i>Not specified.</i></p> <p>In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure¹ with an appropriate object identifier (OID), and SHALL be publicly available.</p> <p>When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.</p>


Usage

Examples	<ol style="list-style-type: none"> 1) 18842-5 (Discharge Summarization Note) 2) 100.16650 (Pharmaceutical Benefits Report)
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

¹ <http://www.hl7.org/oid/index.cfm>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT DETAILS	0..1

2.13 Document Title

Identification

Label	Document Title
Metadata Type	Data Element
Identifier	DE-16966
OID	1.2.36.1.2001.1001.101.103.16966

Definition


Definition	Title of the document of interest.
Definition Source	Australian Digital Health Agency
Synonymous Names	Attachment Name Document Name
Data Type	Text

Usage

Examples	1) Care plan 2) Referral form
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT DETAILS	1..1

2.14 Document Identifier

Identification

Label	Document Identifier
Metadata Type	Data Element
Identifier	DE-20101
OID	1.2.36.1.2001.1001.101.103.20101

Definition


Definition	Unique identifier of the document of interest.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DOCUMENT DETAILS	0..1

2.15 Document Type

Identification

Label	Document Type
Metadata Type	Data Element
Identifier	DE-10335
OID	1.2.36.1.2001.1001.101.103.10335

Definition


Definition	Type of document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	A document's type is identified by a unique identifier, not by a name.
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system, for example LOINC.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.100.17034
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL	1..1

2.16 Document Title

Identification

Label	Document Title
Metadata Type	Data Element
Identifier	DE-16966
OID	1.2.36.1.2001.1001.101.103.16966

Definition


Definition	Title of the document.
Definition Source	Australian Digital Health Agency
Synonymous Names	Document Name
Notes	This data element is only used when the title of the document is distinct from the name of the document type.
Data Type	Text

Usage

Examples	1) Referral
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL	0..1

2.17 PATIENT NOMINATED CONTACT

Identification

Label	PATIENT NOMINATED CONTACT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	Contact nominated to receive information about the subject of care.
Definition Source	Australian Digital Health Agency
Synonymous Names	Nominated Contact
Notes	The subject of care themselves may not be the primary point of contact (e.g. in paediatrics or an individual with dementia).

Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [DH2017a]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <p>Obligation and occurrence constraints:</p> <ul style="list-style-type: none"> PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or an ORGANISATION. <p>PATIENT NOMINATED CONTACT as a PERSON - Healthcare or Human Services Provider</p> <p>Additional obligation and occurrence constraints when the interested party is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON):</p> <ul style="list-style-type: none"> Participation Period is PROHIBITED. LOCATION OF PARTICIPATION is PROHIBITED. Entity Identifier is PROHIBITED. Relationship to Subject of Care is PROHIBITED. DEMOGRAPHIC DATA is PROHIBITED. ENTITLEMENT is PROHIBITED. Qualifications is PROHIBITED. <p>Other constraints:</p> <ul style="list-style-type: none"> Participation Type SHALL have an implementation-specific value equivalent to "Patient Nominated Contact". Role SHOULD have a value chosen from 1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 [ABS2009]. However, if a suitable value
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in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used.

- Each instance of this data group **SHALL** contain at least one instance of ADDRESS or at least one instance of ELECTRONIC COMMUNICATION DETAILS.
- AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.
- PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.

PATIENT NOMINATED CONTACT as a PERSON - Not a Healthcare or Human Services Provider

Additional obligation and occurrence constraints when the interested party is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON):

- Participation Period is **PROHIBITED**.
- LOCATION OF PARTICIPATION is **PROHIBITED**.
- Entity Identifier is **PROHIBITED**.
- DEMOGRAPHIC DATA is **PROHIBITED**.
- ENTITLEMENT is **PROHIBITED**.
- Qualifications is **PROHIBITED**.

Other constraints:

- Participation Type **SHALL** have an implementation-specific value equivalent to “Patient Nominated Contacts”.
- Role **MAY** have an implementation-specific value equivalent to “Subject of Care's representative” or “Not applicable”.
- Each instance of this data group **SHALL** contain at least one instance of ADDRESS or at least one instance of ELECTRONIC COMMUNICATION DETAILS.
- AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.
- PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.

PATIENT NOMINATED CONTACT as an ORGANISATION

Additional obligation and occurrence constraints when the interested party is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as a ORGANISATION):

- Participation Period is **PROHIBITED**.
- LOCATION OF PARTICIPATION is **PROHIBITED**.
- ENTITLEMENT is **PROHIBITED**.
- Qualifications is **PROHIBITED**.


Other constraints:

- Participation Type **SHALL** have an implementation-specific value equivalent to “Patient Nominated Contacts”.
- Role **SHOULD** have a value representing the type of Facility e.g. Hospital, Clinic, Community Service Centre, Home care/housekeeping assistance.

<p>Conditions of Use Source</p>	<ul style="list-style-type: none"> • Each instance of this data group SHALL contain at least one instance of ADDRESS or at least one instance of ELECTRONIC COMMUNICATION DETAILS. • AUSTRALIAN OR INTERNATIONAL ADDRESS SHALL be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a ORGANISATION. <p>Terms used in obligation and occurrence constraints are explained in Appendix D, Specification Guide for Use.</p> <p>Australian Digital Health Agency</p>
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL	0..*

2.18 PRIMARY CARE PROVIDER

Identification

Label	PRIMARY CARE PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	Healthcare provider (person or organisation) nominated by the subject of care as being primarily responsible for their ongoing healthcare.
Definition Source	Australian Digital Health Agency
Synonymous Names	Usual GP
Scope	In general, this is the healthcare provider nominated by the subject of care at the time as being their primary healthcare provider or the primary healthcare provider with whom communications should be conducted for the purposes of the healthcare event in question. As such, it is not necessarily the subject of care's "usual GP" but can be another provider responsible for managing their primary care, for example, nursing staff, nurse practitioner, Aboriginal Health Workers, or even specialists.
Scope Source	Australian Digital Health Agency

Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [DH2017a]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <p>Obligation and occurrence constraints:</p> <ul style="list-style-type: none"> PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or an ORGANISATION. <p>PRIMARY CARE PROVIDER as a PERSON</p> <p>Additional obligation and occurrence constraints when the primary care provider is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON):</p> <ul style="list-style-type: none"> Participation Period is PROHIBITED. LOCATION OF PARTICIPATION is PROHIBITED. Relationship to Subject of Care is PROHIBITED. EMPLOYMENT DETAIL is ESSENTIAL. EMPLOYER ORGANISATION is ESSENTIAL. DEMOGRAPHIC DATA is PROHIBITED. <p>Other constraints:</p>
--------------------------	---

- Participation Type **SHALL** have an implementation-specific value equivalent to “Primary Care Provider”.
- Role **SHOULD** have a value chosen from [1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 \[ABS2009\]](#). However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used.
- The value of ADDRESS.Address Purpose **SHALL** be “B” (Business).
- The value of ELECTRONIC COMMUNICATION DETAIL.Electronic Communication Usage Code **SHALL** be “B” (Business).
- AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.
- PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.

PRIMARY CARE PROVIDER as an ORGANISATION

Additional obligation and occurrence constraints when the primary care provider is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an ORGANISATION):

- Participation Period is **PROHIBITED**.
- LOCATION OF PARTICIPATION is **PROHIBITED**.
- Entity Identifier is **ESSENTIAL**.
- ENTITLEMENT is **PROHIBITED**.
- Qualifications is **PROHIBITED**.

Other constraints:

- Participation Type **SHALL** have an implementation-specific value equivalent to “Primary Care Provider”.
- Role **SHALL** have a value representing the type of Facility e.g. Hospital, Clinic.
- AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.
- PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as an ORGANISATION.


Terms used in obligation and occurrence constraints are explained in [Appendix D, Specification Guide for Use](#).

Conditions of Use Source

Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL	0..1

2.19 INTERESTED PARTY

Identification

Label	INTERESTED PARTY
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	Party who should receive correspondence from the referral receiver regarding the referral.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	It is not required to record the original referrer (<i>Document Author</i>) in this section. However, if the referral was on-referred to additional healthcare providers, the original referrer should be informed of that action.

Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [DH2017a]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <p>Obligation and occurrence constraints:</p> <ul style="list-style-type: none"> PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or an ORGANISATION. <p>INTERESTED PARTY as a PERSON</p> <p>Additional obligation and occurrence constraints when the patient nominated contact is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON):</p> <ul style="list-style-type: none"> Participation Period is PROHIBITED. LOCATION OF PARTICIPATION is PROHIBITED. Relationship to Subject of Care is PROHIBITED. EMPLOYMENT DETAIL is ESSENTIAL. EMPLOYER ORGANISATION is ESSENTIAL. EMPLOYER ORGANISATION.ELECTRONIC COMMUNICATION DETAILS is ESSENTIAL. DEMOGRAPHIC DATA is PROHIBITED. <p>Other constraints:</p> <ul style="list-style-type: none"> Participation Type SHALL have an implementation-specific value equivalent to “Party to receive correspondence”.
--------------------------	--

- Role **SHOULD** have a value chosen from [1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 \[ABS2009\]](#). However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used.
- The value of ADDRESS.Address Purpose **SHALL** be “B” (Business).
- The value of ELECTRONIC COMMUNICATION DETAIL.Electronic Communication Usage Code **SHALL** be “B” (Business).
- AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.
- PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.

INTERESTED PARTY as an ORGANISATION

Additional obligation and occurrence constraints when the patient nominated contact is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an ORGANISATION):

- Participation Period is **PROHIBITED**.
- LOCATION OF PARTICIPATION is **PROHIBITED**.
- Entity Identifier is **ESSENTIAL**.
- ELECTRONIC COMMUNICATION DETAILS is **ESSENTIAL**.
- ENTITLEMENT is **PROHIBITED**.
- Qualifications is **PROHIBITED**.

Other constraints:

- Participation Type **SHALL** have an implementation-specific value equivalent to “Party to receive correspondence”.
- Role **SHOULD** have a value representing the type of Facility e.g. Hospital, Clinic, Community Service Centre, Home care/housekeeping assistance.
- AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.
- PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as an ORGANISATION.


Terms used in obligation and occurrence constraints are explained in [Appendix D, Specification Guide for Use](#).

Conditions of Use
Source

Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL	0..*

2.20 DateTime Attested

Identification

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

Definition


Definition	Date and time that the document author, authoriser or approver confirms that a document is complete and genuine.
Definition Source	Australian Digital Health Agency
Synonymous Names	Date completed
Context	The date and time value when the document author determines the document is complete and can be sent by the authoring provider to the document recipients. In an electronic environment, the date and time when the document is last saved by the document authoring application.
Context Source	Australian Digital Health Agency
Notes	Confirmation that a document is complete and genuine is usually by signature.
Data Type	DateTime

Usage

Conditions of Use	<i>DateTime Attested</i> SHALL include a date and a time component.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for <i>DateTime</i> .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL	0..1

2.21 SERVICE REFERRAL DETAIL

Identification


Label	SERVICE REFERRAL DETAIL
Metadata Type	Section
Identifier	S-17032
OID	1.2.36.1.2001.1001.101.101.17032

Definition







Definition	Information about the healthcare or human services requested for the subject of care.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL	1..1

Children

Data Type	Name	Occurrences
	REQUESTED SERVICE	1..*
	Interpreter Required Alert (COMMUNICATION ALERT)	0..1
	Other Alerts (ALERT)	0..*
	Service Referral Detail Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Section Type	1..1

2.22 Service Referral Detail Instance Identifier

Identification

Label	Service Referral Detail Instance Identifier
Metadata Type	Data Element
Identifier	DE-17033
OID	1.2.36.1.2001.1001.101.103.17033

Definition


Definition	Globally unique identifier for each instance of a <i>Service Referral Detail</i> section.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL DETAIL	0..1

2.23 Section Type

Identification

Label	Section Type
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Type of section.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	A section's type is identified by a unique identifier, not by a name.
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.101.17032
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL DETAIL	1..1

2.24 CURRENT SERVICES

Identification


Label	CURRENT SERVICES
Metadata Type	Section
Identifier	S-21021
OID	1.2.36.1.2001.1001.101.101.21021

Definition





Definition	Information about any health and community services that are currently being delivered to the subject of care, that are relevant to the referral.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Captures details about health and community services provided to the subject of care in the twelve month period leading up to the <i>Service Referral</i> .
Scope Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL	0..1

Children

Data Type	Name	Occurrences
	Current Service (REQUESTED SERVICE)	1..*
	Current Services Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Section Type	1..1

2.25 Current Services Instance Identifier

Identification

Label	Current Services Instance Identifier
Metadata Type	Data Element
Identifier	DE-17025
OID	1.2.36.1.2001.1001.101.103.17025

Definition


Definition	Globally unique identifier for each instance of a <i>Current Services</i> section.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	CURRENT SERVICES	0..1

2.26 Section Type

Identification

Label	Section Type
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Type of section.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	A section's type is identified by a unique identifier, not by a name.
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.101.21021
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	CURRENT SERVICES	1..1

2.27 ADVERSE REACTIONS

Identification

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

Definition


Definition	Information about adverse reactions of the patient (including allergies and intolerances), and any relevant reaction details. This includes statements about adverse reactions that need to be positively recorded as absent or excluded.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Includes allergies and adverse reactions to all substances, which might include food allergies, bee sting allergies as well as prescription and non-prescription medicines.
Scope Source	Australian Digital Health Agency

Usage


Conditions of Use	<p>This section SHALL contain either:</p> <ul style="list-style-type: none"> • exactly one instance of EXCLUSION STATEMENT - ADVERSE REACTIONS, or • at least one instance of ADVERSE REACTION. <p>This section SHALL NOT contain both an instance of EXCLUSION STATEMENT - ADVERSE REACTIONS and an instance of ADVERSE REACTION.</p>
Conditions of Use Source	Australian Digital Health Agency





Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL	0..1

Children

Data Type	Name	Occurrences
	EXCLUSION STATEMENT - ADVERSE REACTIONS	0..1

Data Type	Name	Occurrences
	ADVERSE REACTION	0..*
	Adverse Reactions Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Section Type	1..1

2.28 Adverse Reactions Instance Identifier

Identification

Label	Adverse Reactions Instance Identifier
Metadata Type	Data Element
Identifier	DE-16963
OID	1.2.36.1.2001.1001.101.103.16963

Definition


Definition	Globally unique identifier for each instance of an <i>Adverse Reactions</i> section.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

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

2.29 Section Type

Identification

Label	Section Type
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Type of section.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	A section's type is identified by a unique identifier, not by a name.
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.101.20113
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

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

2.30 MEDICATION ORDERS

Identification

Label	Medications
Metadata Type	Section
Identifier	S-16146
OID	1.2.36.1.2001.1001.101.101.16146

Definition


Definition	Medicines that the subject of care is using at the time of referral.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Medicines include prescribed and over-the-counter medicines.
Scope Source	Australian Digital Health Agency
Notes	Inclusion of medicines will be at the discretion of the referral sender; it is likely that medicines that are considered relevant to the event will be included.

Usage


Conditions of Use	<p>Each instance of this section SHALL contain either:</p> <ul style="list-style-type: none"> • exactly one instance of EXCLUSION STATEMENT - MEDICATIONS, or • at least one instance of MEDICATION INSTRUCTION. <p>This section SHALL NOT contain both an instance of EXCLUSION STATEMENT - MEDICATIONS and an instance of MEDICATION INSTRUCTION.</p>
Conditions of Use Source	Australian Digital Health Agency





Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL	0..1

Children

Data Type	Name	Occurrences
	EXCLUSION STATEMENT - MEDICATIONS	0..1

Data Type	Name	Occurrences
	Known Medication (MEDICATION INSTRUCTION)	0..*
	Medication Orders Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Section Type	1..1

2.31 Medication Orders Instance Identifier

Identification

Label	Medication Orders Instance Identifier
Metadata Type	Data Element
Identifier	DE-16964
OID	1.2.36.1.2001.1001.101.103.16964

Definition


Definition	Globally unique identifier for each instance of a <i>Medication Orders</i> section.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniqueIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

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

2.32 Section Type

Identification

Label	Section Type
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Type of section.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	A section's type is identified by a unique identifier, not by a name.
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.101.16146
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

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

2.33 MEDICAL HISTORY

Identification

Label	Past and Current Medical History
Metadata Type	Section
Identifier	S-16117
OID	1.2.36.1.2001.1001.101.101.16117

Definition


Definition	Information about the subject of care's problems, diagnoses and medical or surgical procedures.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Assumptions	Every entry in a person's medical history is either a procedure or a problem/diagnosis.
Assumptions Source	Australian Digital Health Agency
Notes	<i>A Medical History section</i> is allowed to contain <i>Procedure</i> , <i>Problem/Diagnosis</i> , and <i>Uncategorised Medical History Item</i> data groups. Having both categorised items (<i>Procedure</i> and <i>Problem/Diagnosis</i>) and uncategorised items (<i>Uncategorised Medical History Item</i>) would be unusual, because generally if a system is able to differentiate some items, it is able to differentiate them all. However a system may be able to categorise some, and not others – possibly because of legacy data, or partial classification in the underlying terminology. For this reason, the rules allow a mix of categorised and uncategorised items.

Usage









Conditions of Use	Each instance of this section SHALL contain at least one instance of: <ul style="list-style-type: none"> • PROBLEM/DIAGNOSIS, or • PROCEDURE, or • UNCATEGORISED MEDICAL HISTORY ITEM.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL	0..1

Children

Data Type	Name	Occurrences
	PROBLEM/DIAGNOSIS	0..*
	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	0..0
	PROCEDURE	0..*
	EXCLUSION STATEMENT - PROCEDURES	0..0
	UNCATEGORISED MEDICAL HISTORY ITEM	0..*
	Medical History Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Section Type	1..1

2.34 Medical History Instance Identifier

Identification

Label	Medical History Instance Identifier
Metadata Type	Data Element
Identifier	DE-16965
OID	1.2.36.1.2001.1001.101.103.16965

Definition


Definition	Globally unique identifier for each instance of a <i>Medical History</i> section.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

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

2.35 Section Type

Identification

Label	Section Type
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Type of section.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	A section's type is identified by a unique identifier, not by a name.
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.101.16117
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

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

2.36 DIAGNOSTIC INVESTIGATIONS

Identification

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

Definition


Definition	Describes the diagnostic tests or procedures performed on or requested for the subject of care during the healthcare event, that are considered to be relevant to the subject of care’s ongoing care.
Definition Source	Australian Digital Health Agency
Synonymous Names	Pathology/Diagnostic Imaging Results Investigations Performed

Usage


Conditions of Use	Each instance of this section SHALL contain at least one instance of: <ul style="list-style-type: none"> • PATHOLOGY TEST RESULT, or • IMAGING EXAMINATION RESULT, or • REQUESTED SERVICE.
Conditions of Use Source	Australian Digital Health Agency
Misuse	Use to record diagnostic tests or procedures performed on or requested for the subject of care that are not relevant to the healthcare event.







Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL	0..1

Children

Data Type	Name	Occurrences
	PATHOLOGY TEST RESULT	0..*

Data Type	Name	Occurrences
	IMAGING EXAMINATION RESULT	0..*
	Diagnostic Investigation Synopsis (CLINICAL SYNOPSIS)	0..0
	Pending Diagnostic Investigation (REQUESTED SERVICE)	0..*
	Diagnostic Investigations Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Section Type	1..1

2.37 Diagnostic Investigations Instance Identifier

Identification

Label	Diagnostic Investigations Instance Identifier
Metadata Type	Data Element
Identifier	DE-17011
OID	1.2.36.1.2001.1001.101.103.17011

Definition


Definition	Globally unique identifier for each instance of a <i>Diagnostic Investigations</i> section.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DIAGNOSTIC INVESTIGATIONS	0..1

2.38 Section Type

Identification

Label	Section Type
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Type of section.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	A section's type is identified by a unique identifier, not by a name.
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.101.20117
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DIAGNOSTIC INVESTIGATIONS	1..1

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3 Requested Service Detailed Clinical Model

This chapter describes a reuse of version 5.2 of the *Requested Service (Action)* Detailed Clinical Model.

See [Requested Service Detailed Clinical Model Specification \[DH2017k\]](#) for more information.

3.1 Purpose

To describe services requested for, or provided to, the subject.

3.2 Use

Use to record a group of one or more services that are to be provided in the future (e.g. referral) or a group of services that have already been provided. All services would have the same value for other data elements such as *Service Category* and *Service Booking Status*.

Use when the initiating provider knows precisely what is required by the service and when the requesting provider has and wishes to exercise the authority (and expertise) to decide exactly what action will be done. For example, an aged care patient might need to have meals on wheels arranged as well as assistance with house cleaning. In this scenario, it would be expected that values would be provided for both *Service Category* and *Service Description*. Other data elements may not be relevant in this scenario, such as *Request Validity Period*.

Use when the initiating provider defers to the expertise of the referred-to provider. This is used when the initiating provider is seeking another provider or organisation to use their own expertise or authority to determine the specific action to take, for example, when referring to an orthopaedic surgeon for management of advanced knee osteoarthritis. The referral requests an assessment by the surgeon and any consequential management that the surgeon determines. The referrer may query whether a total knee replacement is required, but that decision is left to the surgeon. In this scenario, it would be expected that values would only optionally need to be provided for *Service Description*. Other data elements would likely be included in such a request, such as *Request Validity Period*.

Use in relation to services that have already occurred where it can be recorded that an individual is having or has had a number of services. In this scenario, certain data elements may not be necessary, such as some of the details about the original referral that instigated the service (or services). For example, *Request Urgency* and *Request Validity Period*.

3.3 Misuse

Not to be used to specify medication prescriptions.

3.4 REQUESTED SERVICE

Identification

Label	REQUESTED SERVICE
Metadata Type	Data Group
Identifier	DG-20158
OID	1.2.36.1.2001.1001.101.102.20158

Definition


Definition	Details of the services requested for the subject of care.
Definition Source	Australian Digital Health Agency
Synonymous Names	Service Referral Referral Arranged Service

Usage


Conditions of Use	Each instance of this data group SHALL contain at least one instance of: <ul style="list-style-type: none"> • Reason for Service, or • Reason for Service Description, or • Service Category, or • Service Description.
Conditions of Use Source	Australian Digital Health Agency
Misuse	Using to specify medication prescriptions or to request diagnostic investigations.























Relationships



Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL DETAIL	1..*

Children

Data Type	Name	Occurrences
	Reason for Service	0..1

Data Type	Name	Occurrences
	Reason for Service Description	0..1
	Service Category	0..1
	Service Description	0..1
	Intent of Request	0..0
	Request Urgency	0..1
	Request Urgency Notes	0..1
	DateTime Service Scheduled	0..0
	Service Commencement Window	0..1
	Service Booking Status	1..1
	Service Comment	0..0
	Supplementary Information to Follow	0..0
	Supplementary Information Expected	0..0
	Subject of Care Instruction Description	0..0
	REPORTER	0..0
	SERVICE REQUESTER	0..0
	SERVICE PROVIDER	0..1
	Request Validity Period	0..1
	Request Identifier (Instruction Identifier)	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Requested Service DateTime	1..1
	Requested Service Instance Identifier	0..1

Data Type	Name	Occurrences
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

3.5 Reason for Service

Identification

Label	Reason for Service
Metadata Type	Data Element
Identifier	DE-20172
OID	1.2.36.1.2001.1001.101.103.20172

Definition

Definition	Reason for the services being requested or provided.
Definition Source	Australian Digital Health Agency
Synonymous Names	Reason for Requesting Service Service Reason Referral Reason
Context	Used to communicate information about the reason for services; for example, reason for requesting admission if the subject was referred to the organisation, or for requesting services (by the healthcare provider) to be provided to the subject after discharge from the healthcare facility. In a discharge summary, this data component captures information about reasons for requesting services (by the healthcare provider) to be provided to the subject after discharge from the healthcare facility.
Context Source	Australian Digital Health Agency
Data Type	CodeableText
Value Domain	<i>Not specified.</i> In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ¹ with an appropriate object identifier (OID), and SHALL be publicly available. When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.


Usage

Examples	1) To rule out ischaemic heart disease. 2) To rule out organic brain lesions.
Exceptional Values	Absent values are PROHIBITED .

¹ <http://www.hl7.org/oid/index.cfm>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REQUESTED SERVICE	0..1

3.6 Reason for Service Description

Identification

Label	Reason for Service Description
Metadata Type	Data Element
Identifier	DE-17030
OID	1.2.36.1.2001.1001.101.103.17030

Definition


Definition	Narrative about the reason for the services being requested or provided.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	Used to communicate to the referee information about the reasons for the referral, which may include information about the problems or issues experienced by the subject of care as identified by the referrer, clinical presentation, etc.
Context Source	Australian Digital Health Agency
Notes	<p>This data element is used when there is no coded information available in <i>Reason for Service</i>, or to provide additional information that the code cannot provide.</p> <p>In the referral scenario, it complements the structured information contained in the referral specification. The content in this data element may vary from a single line in simple cases to many paragraphs for more complex circumstances.</p>
Data Type	Text

Usage

Examples	<ol style="list-style-type: none"> 1) Thank you for seeing this 14-year-old schoolboy who fell whilst playing football at school yesterday. On examination he has a swollen painful R ankle and cannot bear weight on it today. I suspect he has a fracture of his right tibia and fibula. 2) Thank you for seeing this 43-year-old lady who has had 2 episodes of cholecystitis in the last month. She is currently well. Ultrasound of her abdomen done at the Public Hospital Emergency Department shows she has gall stones. She has private cover and wishes to see you to consider cholecystectomy at the Private Hospital. 3) Thank you for seeing this 88-year-old recently widowed woman. She was previously dependent upon her husband for help around the house for activities such as the heavy cleaning of the house and assistance with driving and shopping. Please arrange assistance for house cleaning and transportation to the local shops once a week.
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REQUESTED SERVICE	0..1

3.7 Service Category

Identification

Label	Service Category
Metadata Type	Data Element
Identifier	DE-17021
OID	1.2.36.1.2001.1001.101.103.17021

Definition


Definition	Specialty of the services requested or provided.
Definition Source	Australian Digital Health Agency
Synonymous Names	Specialty
Notes	In the context of referral (GP to a specialist), this information is often inferred and does not need to be explicitly stated.
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ² with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	<ol style="list-style-type: none"> 1) Gynaecology 2) Paediatric Cardiology 3) Podiatry 4) Disability supported accommodation
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REQUESTED SERVICE	0..1

² <http://www.hl7.org/oid/index.cfm>

3.8 Service Description

Identification

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

Definition

Definition	Description of the services requested or provided.
Definition Source	Australian Digital Health Agency
Synonymous Names	Service Requested Arranged Service Description
Context	Used to identify clinical services (e.g. diagnostic procedures, clinical procedures and clinical management) and non-clinical services (e.g. community care services).
Context Source	Australian Digital Health Agency
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ³ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.


Usage

Examples	<ol style="list-style-type: none"> 1) Dialysis 2) Adjustment of heart failure/hypertensive medications 3) Adjust INR to therapeutic range 4) Elective orthopaedic surgery for TKR 5) Ultrasound pelvis 6) Full blood count
Exceptional Values	Absent values are PROHIBITED .

³ <http://www.hl7.org/oid/index.cfm>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REQUESTED SERVICE	0..1

3.9 Request Urgency

Identification

Label	Request Urgency
Metadata Type	Data Element
Identifier	DE-16128
OID	1.2.36.1.2001.1001.101.103.16128

Definition


Definition	Assessment of the criticality of a rapid response.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	<p>This is the relative urgency of this individual in relation to other individuals who require the same service. Urgent is a recommendation that the individual will have priority over others being seen routinely from a waiting list.</p> <p>The referral receiver will often consider this urgency attribute when doing their assessment but is not obligated to use, or agree with, the sender's perception of urgency. The service receiving the referral may change the urgency rating based on their program priority criteria. The referral is not to be updated if the perceived urgency changes over time.</p>
Context Source	Australian Digital Health Agency
Notes	Only include this data element to identify urgent requests. The absence of data in this data element cannot be assumed to mean that the request is not urgent or that the request is routine.
Data Type	CodedText
Value Domain	Request Urgency Values

Usage

Conditions of Use	The value SHALL be 01 ("Urgent").
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodedText .
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REQUESTED SERVICE	0..1

3.10 Request Urgency Values

Identification

Label	Request Urgency Values
Metadata Type	Value Domain
Identifier	VD-16127
OID	1.2.36.1.2001.1001.101.104.16127

Definition


Definition	Set of values to describe the urgency of a request.
Definition Source	Australian Digital Health Agency

Value Domain

Source	Australian Digital Health Agency
Permissible Values	01, Urgent The request requires immediate or prioritised attention. 02, The request does not require prioritised attention. Routine

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Request Urgency	1..1

3.11 Request Urgency Notes

Identification

Label	Request Urgency Notes
Metadata Type	Data Element
Identifier	DE-17022
OID	1.2.36.1.2001.1001.101.103.17022

Definition


Definition	Narrative about the request urgency that is not captured in other fields.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This data element is used to explain the reason for an urgent request.
Data Type	Text

Usage

Examples	<ol style="list-style-type: none"> 1) This is urgent because the patient has had sudden onset of severe headache, with minor neurological impairment and is at risk of quick deterioration. 2) The patient's full-time carer has suddenly fallen ill and is unable to provide needed assistance for activities of daily living.
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REQUESTED SERVICE	0..1

3.12 Service Commencement Window

Identification

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

Definition


Definition	Period of time during which it would be ideal for the subject to be seen, in the opinion of the requester.
Definition Source	Australian Digital Health Agency
Synonymous Names	Service Commences
Notes	Specifies the range of time within which the requesting provider is expecting the arranged service to be provided to the subject. It can be used as a means of conveying objective urgency.
Data Type	TimeInterval

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for TimeInterval .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REQUESTED SERVICE	0..1

3.13 Service Booking Status

Identification

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

Definition


Definition	Indication of the status of the requested or provided services.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	Provides the meaning for the date recorded in <i>Requested Service DateTime</i> data element; for example, whether it is the date that the service is first requested, the date that the booking was made, or the date that the service was supplied.
Context Source	Australian Digital Health Agency
Notes	For a service request (request for a service to be provided in the future), it is expected that a status value "EVN" would not be used for this data element.
Data Type	CodedText
Value Domain	Service Booking Status Values

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodedText .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REQUESTED SERVICE	1..1

3.14 Service Booking Status Values

Identification

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

Definition


Definition	Set of values that indicate the status of the requested or provided services.
Definition Source	Australian Digital Health Agency

Value Domain

Source	HL7 v3 CDA: Act.moodCode.	
Permissible Values	APT, Appointment	Planned act for specific time and place
	ARQ, Appointment Request	Request for Booking of an Appointment
	EVN, Event	Service actually happens or happened or is ongoing
	RQO, Request	Request or Order for a service

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Service Booking Status	1..1

3.15 SERVICE PROVIDER

Identification

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

Definition

Definition	Provider (individual or organisation) to whom the subject of care is being referred.
Definition Source	Australian Digital Health Agency
Synonymous Names	Referred to Provider Referred to Referee
Scope	A service request would normally be sent to an authorised healthcare provider, but could go directly to a carer or to a representative of an organisation to provide services, other than those normally deemed to be healthcare services, such as a Child Protection Agency, Police, etc.
Scope Source	Australian Digital Health Agency
Notes	This does not have to be a person and, in particular, does not have to be a healthcare provider. Types of provider include: <ul style="list-style-type: none"> • a clinician; • human services provider; and • a service at an organisation.

Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [DH2017a]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <p>Obligation and occurrence constraints:</p> <ul style="list-style-type: none"> • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or an ORGANISATION. <p>SERVICE PROVIDER as a PERSON</p> <p>Additional obligation and occurrence constraints when the service provider is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON):</p> <ul style="list-style-type: none"> • Participation Period is PROHIBITED. • LOCATION OF PARTICIPATION is PROHIBITED. • Entity Identifier is ESSENTIAL. • Relationship to Subject of Care is PROHIBITED.
--------------------------	---

- EMPLOYMENT DETAIL is **ESSENTIAL**.
- EMPLOYER ORGANISATION is **ESSENTIAL**.
- EMPLOYER ORGANISATION.Entity Identifier is **ESSENTIAL**.
- EMPLOYER ORGANISATION.ELECTRONIC COMMUNICATION DETAIL is **ESSENTIAL**.
- DEMOGRAPHIC DATA is **PROHIBITED**.

Other constraints:

- Participation Type **SHALL** have an implementation-specific value equivalent to “Referee”.
- Role **SHOULD** have a value chosen from [1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 \[ABS2009\]](#). However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used.
- The value of ADDRESS.Address Purpose **SHALL** be “B” (Business).
- The value of ELECTRONIC COMMUNICATION DETAIL.Electronic Communication Usage Code **SHALL** be “B” (Business).
- AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.
- PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.

SERVICE PROVIDER as an ORGANISATION

Additional obligation and occurrence constraints when the service provider is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an ORGANISATION):

- Participation Period is **PROHIBITED**.
- LOCATION OF PARTICIPATION is **PROHIBITED**.
- Entity Identifier is **ESSENTIAL**.
- ELECTRONIC COMMUNICATION DETAIL is **ESSENTIAL**.
- ENTITLEMENT is **PROHIBITED**.
- Qualifications is **PROHIBITED**.

Other constraints:

- Participation Type **SHALL** have an implementation-specific value equivalent to “Referee”.
- Role **SHOULD** have a value representing the type of Facility e.g. Hospital, Clinic, Community Service Centre, Home care/housekeeping assistance.
- AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.
- PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as an ORGANISATION.

Terms used in obligation and occurrence constraints are explained in [Appendix D, Specification Guide for Use](#).

**Conditions of Use
Source**

Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REQUESTED SERVICE	0..1

3.16 Request Validity Period

Identification

Label	Request Validity Period
Metadata Type	Data Element
Identifier	DE-16132
OID	1.2.36.1.2001.1001.101.103.16132

Definition


Definition	Period during which the request is valid.
Definition Source	Australian Digital Health Agency
Synonymous Names	Referral Validity Duration
Context	This data element is only applicable in the service request scenario.
Context Source	Australian Digital Health Agency
Notes	This may be open ended. In the context of referral, this data element captures the valid duration of the referral that may be constrained by, for example, Medicare funding policy.
Data Type	TimeInterval Duration

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for TimeInterval , and Duration .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REQUESTED SERVICE	0..1

3.17 Requested Service DateTime

Identification

Label	Requested Service DateTime
Metadata Type	Data Element
Identifier	DE-16635
OID	1.2.36.1.2001.1001.101.103.16635

Definition


Definition	Period or date (and optionally time) of completion of the <i>Requested Service</i> action.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	The status of the request changes on this date, and optionally time, or at the end of this period. For a service request, this is the date, and optionally time, of the request. There is no point in recording the period during which the request is created.
Data Type	DateTime TimeInterval

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for DateTime , and TimeInterval .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REQUESTED SERVICE	1..1

3.18 Requested Service Instance Identifier

Identification

Label	Requested Service Instance Identifier
Metadata Type	Data Element
Identifier	DE-16716
OID	1.2.36.1.2001.1001.101.103.16716

Definition


Definition	Globally unique identifier for each instance of a <i>Requested Service</i> action.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REQUESTED SERVICE	0..1

3.19 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.20158
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REQUESTED SERVICE	1..1

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4 Interpreter Required Alert Detailed Clinical Model

This chapter describes a reuse of version 1.0 of the *Communication Alert Detailed Clinical Model*.

See [Alerts Detailed Clinical Model Specification \[DH2016e\]](#) for more information.

4.1 Purpose

To emphasise information pertaining to the subject's language and communication needs that can be used to aid a care provider in the provision of care to the subject.

4.2 COMMUNICATION ALERT

Identification

Label	Interpreter Required Alert
Metadata Type	Data Group
Identifier	DG-17026
OID	1.2.36.1.2001.1001.101.102.17026

Definition


Definition	Information about language, or languages, spoken by the subject of care, when a need for an interpreter has been identified.
Definition Source	Australian Digital Health Agency
Synonymous Names	Warning
Scope	Captures details about language, or languages, preferred by the subject of care for communicating with care providers, when an interpreter is needed.
Scope Source	Australian Digital Health Agency
Notes	Inclusion of this data group indicates that interpreter services are required.

Usage





Misuse	Use when an interpreter is not required.
---------------	--






Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL DETAIL	0..1

Children

Data Type	Name	Occurrences
	Alert Description	1..1
	Preferred Language	1..*
	Alert Note	0..0
	REPORTER	0..0

Data Type	Name	Occurrences
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Communication Alert Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

4.3 Alert Description

Identification

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

Definition


Definition	Details of the alert.
Definition Source	Australian Digital Health Agency
Synonymous Names	Warning Description
Context	Used to identify to the referral receiver whether an interpreter should be organised.
Context Source	Australian Digital Health Agency
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ¹ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Conditions of Use	The value of this item SHALL be an implementation-specific value equivalent to “Interpreter Required”.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodeableText .
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Interpreter Required Alert (COMMUNICATION ALERT)	1..1

¹ <http://www.hl7.org/oid/index.cfm>

4.4 Preferred Language

Identification

Label	Preferred Language
Metadata Type	Data Element
Identifier	DE-21136
OID	1.2.36.1.2001.1001.101.103.21136

Definition


Definition	Language that the subject prefers to use for communication.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	Identifies the language spoken by the subject to help when organising the interpreter services.
Context Source	Australian Digital Health Agency
Notes	Values can be derived from an agreed data set such as 1267.0 - Australian Standard Classification of Languages (ASCL), 2011 [ABS2011] .
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ² with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodeableText .
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Interpreter Required Alert (COMMUNICATION ALERT)	1..*

² <http://www.hl7.org/oid/index.cfm>

4.5 Communication Alert Instance Identifier

Identification

Label	Communication Alert Instance Identifier
Metadata Type	Data Element
Identifier	DE-17029
OID	1.2.36.1.2001.1001.101.103.17029

Definition


Definition	Globally unique identifier for each instance of a <i>Communication Alert</i> administrative entry.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Interpreter Required Alert (COMMUNICATION ALERT)	0..1

4.6 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.17026
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Interpreter Required Alert (COMMUNICATION ALERT)	1..1

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5 Other Alerts Detailed Clinical Model

This chapter describes a reuse of version 4.1 of the *Alert* Detailed Clinical Model.

See [Alerts Detailed Clinical Model Specification \[DH2016e\]](#) for more information.

5.1 Purpose

To emphasise information pertaining to the subject that may:

- need special consideration by a care provider before making a decision about his or her actions to avert an unfavourable event;
- need consideration or action by a care provider or facility in relation to the care and safety of the subject, staff or other individuals; and
- notify the care provider of special circumstances that may be relevant in delivering care or interacting with the subject.

5.2 Misuse

Not to be used for recording adverse reactions.

Not to be used to record alert information about language and communication - use the *Communication Alert* DCM.

5.3 ALERT

Identification


Label	Other Alerts
Metadata Type	Data Group
Identifier	DG-15518
OID	1.2.36.1.2001.1001.101.102.15518

Definition







Definition	Information warning that special consideration or action is required when providing care to, or interacting with, the subject.
Definition Source	Australian Digital Health Agency
Synonymous Names	Warning








Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SERVICE REFERRAL DETAIL	0..*

Children

Data Type	Name	Occurrences
	Alert Type	1..1
	Alert Description	1..1
	Effective Period	0..0
	DateTime Reviewed	0..0
	Active Status	0..0
	Alert Certainty	0..0
	Alert Note	0..0
	DateTime Reported	0..0

Data Type	Name	Occurrences
	Information Provided by	0..0
	REPORTER	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Alert Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

5.4 Alert Type

Identification

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

Definition

Definition	Category of alert.
Definition Source	Australian Digital Health Agency
Synonymous Names	Warning type Alert class
Notes	This can be useful for filtering alerts.
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ¹ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.


Usage

Examples	<ol style="list-style-type: none"> 1) Administrative 2) Clinical or medical 3) Home environment 4) Infection risk 5) Safety and security 6) Special mental health 7) Special needs and/or preferences 8) Psychosocial
Exceptional Values	Absent values are PROHIBITED .

¹ <http://www.hl7.org/oid/index.cfm>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Other Alerts (ALERT)	1..1

5.5 Alert Description

Identification

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

Definition

Definition	Details of the alert.
Definition Source	Australian Digital Health Agency
Synonymous Names	Warning Description
Notes	The core part of the alert.
Data Type	CodeableText
Value Domain	<i>Not specified.</i>

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

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


Usage

Examples	<ol style="list-style-type: none"> 1) Animals present at subject's home 2) Anaesthetic risk 3) Pacemaker present 4) Custody proceedings 5) AVO in place
Exceptional Values	Absent values are PROHIBITED .

² <http://www.hl7.org/oid/index.cfm>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Other Alerts (ALERT)	1..1

5.6 Alert Instance Identifier

Identification

Label	Alert Instance Identifier
Metadata Type	Data Element
Identifier	DE-17015
OID	1.2.36.1.2001.1001.101.103.17015

Definition


Definition	Globally unique identifier for each instance of an <i>Alert</i> evaluation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Other Alerts (ALERT)	0..1

5.7 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.15518
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Other Alerts (ALERT)	1..1

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6 Current Service Detailed Clinical Model

This chapter describes a reuse of version 5.2 of the *Requested Service (Action)* Detailed Clinical Model.

See [Requested Service Detailed Clinical Model Specification \[DH2017k\]](#) for more information.

6.1 Purpose

To describe services requested for, or provided to, the subject.

6.2 Use

Use to record a group of one or more services that are to be provided in the future (e.g. referral) or a group of services that have already been provided. All services would have the same value for other data elements such as *Service Category* and *Service Booking Status*.

Use when the initiating provider knows precisely what is required by the service and when the requesting provider has and wishes to exercise the authority (and expertise) to decide exactly what action will be done. For example, an aged care patient might need to have meals on wheels arranged as well as assistance with house cleaning. In this scenario, it would be expected that values would be provided for both *Service Category* and *Service Description*. Other data elements may not be relevant in this scenario, such as *Request Validity Period*.

Use when the initiating provider defers to the expertise of the referred-to provider. This is used when the initiating provider is seeking another provider or organisation to use their own expertise or authority to determine the specific action to take, for example, when referring to an orthopaedic surgeon for management of advanced knee osteoarthritis. The referral requests an assessment by the surgeon and any consequential management that the surgeon determines. The referrer may query whether a total knee replacement is required, but that decision is left to the surgeon. In this scenario, it would be expected that values would only optionally need to be provided for *Service Description*. Other data elements would likely be included in such a request, such as *Request Validity Period*.

Use in relation to services that have already occurred where it can be recorded that an individual is having or has had a number of services. In this scenario, certain data elements may not be necessary, such as some of the details about the original referral that instigated the service (or services). For example, *Request Urgency* and *Request Validity Period*.

6.3 Misuse

Not to be used to specify medication prescriptions.

6.4 REQUESTED SERVICE

Identification

Label	Current Service
Metadata Type	Data Group
Identifier	DG-20158
OID	1.2.36.1.2001.1001.101.102.20158

Definition


Definition	Details of the services provided to the subject of care.
Definition Source	Australian Digital Health Agency
Synonymous Names	Provided Service

Usage




Conditions of Use	Each instance of this data group SHALL contain at least one instance of: <ul style="list-style-type: none"> • Service Category, or • Service Description.
Conditions of Use Source	Australian Digital Health Agency
Misuse	Use to record a service that has not yet been provided or is not currently being provided.

























Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	CURRENT SERVICES	1..*

Children

Data Type	Name	Occurrences
	Reason for Service	0..0
	Reason for Service Description	0..0
	Service Category	0..1

Data Type	Name	Occurrences
	Service Description	0..1
	Intent of Request	0..0
	Request Urgency	0..0
	Request Urgency Notes	0..0
	DateTime Service Scheduled	0..0
	Service Commencement Window	0..0
	Service Booking Status	1..1
	Service Comment	0..1
	Supplementary Information to Follow	0..0
	Supplementary Information Expected	0..0
	Subject of Care Instruction Description	0..0
	REPORTER	0..0
	SERVICE REQUESTER	0..0
	SERVICE PROVIDER	1..1
 	Request Validity Period	0..0
	Request Identifier (Instruction Identifier)	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
 	Requested Service DateTime	1..1
	Requested Service Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

6.5 Service Category

Identification

Label	Service Category
Metadata Type	Data Element
Identifier	DE-17021
OID	1.2.36.1.2001.1001.101.103.17021

Definition


Definition	Specialty of the services requested or provided.
Definition Source	Australian Digital Health Agency
Synonymous Names	Specialty
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ¹ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	<ol style="list-style-type: none"> 1) Gynaecology 2) Paediatric Cardiology 3) Podiatry 4) Disability supported accommodation
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Current Service (REQUESTED SERVICE)	0..1

¹ <http://www.hl7.org/oid/index.cfm>

6.6 Service Description

Identification

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

Definition

Definition	Description of the services requested or provided.
Definition Source	Australian Digital Health Agency
Synonymous Names	Service Requested Arranged Service Description
Context	Used to identify clinical services (e.g. diagnostic procedures, clinical procedures and clinical management) and non-clinical services (e.g. community care services).
Context Source	Australian Digital Health Agency
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ² with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.


Usage

Examples	<ol style="list-style-type: none"> 1) Dialysis 2) Adjustment of heart failure/hypertensive medications 3) Adjust INR to therapeutic range 4) Elective orthopaedic surgery for TKR 5) Ultrasound pelvis 6) Full blood count
Exceptional Values	Absent values are PROHIBITED .

² <http://www.hl7.org/oid/index.cfm>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Current Service (REQUESTED SERVICE)	0..1

6.7 Service Booking Status

Identification

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

Definition


Definition	Indication of the status of the requested or provided services.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	Provides the meaning for the date recorded in <i>Requested Service DateTime</i> data element; for example, whether it is the date that the service is first requested, the date that the booking was made, or the date that the service was supplied.
Context Source	Australian Digital Health Agency
Data Type	CodedText
Value Domain	Service Booking Status Values

Usage

Conditions of Use	The value of this item SHALL be "EVN, Event".
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodedText .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Current Service (REQUESTED SERVICE)	1..1

6.8 Service Booking Status Values

Identification

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

Definition


Definition	Set of values that indicate the status of the requested or provided services.
Definition Source	Australian Digital Health Agency

Value Domain

Source	HL7 v3 CDA: Act.moodCode.	
Permissible Values	APT, Appointment	Planned act for specific time and place
	ARQ, Appointment Request	Request for Booking of an Appointment
	EVN, Event	Service actually happens or happened or is ongoing
	RQO, Request	Request or Order for a service

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Service Booking Status	1..1

6.9 Service Comment

Identification

Label	Service Comment
Metadata Type	Data Element
Identifier	DE-17035
OID	1.2.36.1.2001.1001.101.103.17035

Definition


Definition	Additional narrative about the services that is not captured in other fields.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Current Service (REQUESTED SERVICE)	0..1

6.10 SERVICE PROVIDER

Identification

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

Definition

Definition	Provider of the service.
Definition Source	Australian Digital Health Agency
Synonymous Names	Service Agency

Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [DH2017a]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <p>Obligation and occurrence constraints:</p> <ul style="list-style-type: none"> • LOCATION OF PARTICIPATION is PROHIBITED. • ENTITLEMENT is PROHIBITED. • Qualifications is PROHIBITED. <p>Other constraints:</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to “Service Provider”. • Role SHOULD have a value representing the type of Facility e.g. Hospital, Clinic, Community Service Centre, Home care/housekeeping assistance. • AUSTRALIAN OR INTERNATIONAL ADDRESS SHALL be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as an ORGANISATION. <p>Terms used in obligation and occurrence constraints are explained in Appendix D, Specification Guide for Use.</p>
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Current Service (REQUESTED SERVICE)	1..1

6.11 Requested Service DateTime

Identification

Label	Requested Service DateTime
Metadata Type	Data Element
Identifier	DE-16635
OID	1.2.36.1.2001.1001.101.103.16635

Definition


Definition	Period or date (and optionally time) of completion of the <i>Requested Service</i> action.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	For supply of a service, this is the period during which the service is supplied or the date, and optionally time, of completion of supply of service.
Data Type	DateTime TimeInterval

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for DateTime , and TimeInterval .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Current Service (REQUESTED SERVICE)	1..1

6.12 Requested Service Instance Identifier

Identification

Label	Requested Service Instance Identifier
Metadata Type	Data Element
Identifier	DE-16716
OID	1.2.36.1.2001.1001.101.103.16716

Definition


Definition	Globally unique identifier for each instance of a <i>Requested Service</i> action.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Current Service (REQUESTED SERVICE)	0..1

6.13 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.20158
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Current Service (REQUESTED SERVICE)	1..1

7 Exclusion Statement - Adverse Reactions Detailed Clinical Model

This chapter describes a reuse of version 1.4 of the *Exclusion Statement - Adverse Reactions* Detailed Clinical Model.

See [Adverse Reaction Detailed Clinical Model Specification \[DH2016g\]](#) for more information.

7.1 Purpose

To positively record the absence or exclusion of any adverse reactions within the health record.

7.2 Use

Use to record the positive exclusion or absence of adverse reactions within the health record. This Detailed Clinical Model (DCM) avoids the need to use terminology to express negation about any item within the health record.

It is important to note that the Exclusion Statement information is time-specific. Its validity may not extend beyond the point in time when the information is recorded. The patient should always be asked to verify previous statements about adverse reactions to a substance.

7.3 EXCLUSION STATEMENT - ADVERSE REACTIONS

Identification


Label	EXCLUSION STATEMENT - ADVERSE REACTIONS
Metadata Type	Data Group
Identifier	DG-16137
OID	1.2.36.1.2001.1001.101.102.16137

Definition










Definition	Statements about adverse reactions that need to be positively recorded as absent or excluded.
Definition Source	openEHR Foundation
Scope	To positively record the absence or exclusion of any adverse reactions within the health record.
Scope Source	openEHR Foundation


Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Global Statement	1..1
	No Known Adverse Reaction to	0..0
	No Known Allergic Reaction to	0..0
	No Known Hypersensitivity Reaction to	0..0
	No Known Intolerance to	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Exclusion Statement - Adverse Reactions Instance Identifier	0..0
	RELATED INFORMATION	0..0

Data Type	Name	Occurrences
	Detailed Clinical Model Identifier	1..1

7.4 Global Statement

Identification

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

Definition


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

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodedText .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - ADVERSE REACTIONS	1..1

7.5 Global Statement Values

Identification

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

Definition


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

Value Domain

Source	Australian Digital Health Agency	
Permissible Values	01, None known	No information about adverse reactions to any substance is known.
	02, Not asked	No information about adverse reactions to any substance is available because the patient was not asked or was not able to be asked.
	03, None supplied	No information about adverse reactions to any substance is supplied.
	Please see Appendix B, Known Issues .	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Global Statement	1..1

7.6 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16137
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - ADVERSE REACTIONS	1..1

8 Adverse Reaction Detailed Clinical Model

This chapter describes a reuse of version 5.3 of the *Adverse Reaction* Detailed Clinical Model.

See [Adverse Reaction Detailed Clinical Model Specification \[DH2016g\]](#) for more information.

8.1 Purpose

To record health information that will inform a clinical assessment of the predisposition of an individual for a future reaction to a substance, class of substance or agent.

To record information about events of exposure to a substance, building up a persisting and evolving summary over time.

To record information about any adverse reaction, including:

- immune mediated reactions Types I-IV (including allergic reactions and hypersensitivities), and
- non-immune mediated reactions (including pseudo-allergic reactions, side-effects, intolerances, drug toxicities [e.g. Gentamicin induced ototoxicity], drug-drug interactions, food-drug interactions, drug-disease contraindications and idiosyncratic reactions).

8.2 Use

Use to record all information about adverse reactions (including allergic reactions) that are required to support direct clinical care of an individual, safe exchange of information about adverse reactions and to enable computerised knowledge-based activities such as clinical decision support and alerts.

Use to provide a single place within the health record to record a range of clinical statements about adverse reactions, including:

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

It can also be used to record an individual's reflections on their adverse reactions.

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

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

In addition, it is anticipated that in some very specific clinical situations, such as immunologist assessment or use in clinical trials, more information about the adverse reaction may be required.

The act of recording an adverse reaction in the health record implies there is a potential hazard for the individual if they are exposed to the same substance or agent in the future; a relative contraindication. If a clinician considers that it is not safe for the individual to be deliberately re-exposed to the substance or agent again, for example, following a manifestation of anaphylaxis, the Absolute Contraindication data flag should be recorded as "true". Note: Conversely, a statement about severity of predisposition (with possible values such as mild, moderate and severe) has deliberately not been modelled explicitly. Predicting or estimating the grade of possible severity of a future reaction is not safe to

record and persist in data, except where it is absolutely clear that the risk of deliberate re-exposure is unacceptable and highly likely to cause significant harm, such as a previous manifestation of anaphylaxis, and in this case the Absolute Contraindication data flag should be used.

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

- statements about previous clinical manifestations following exposure;
- source of the information or reporter; and
- a flag for absolute contraindication.

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

8.3 Misuse

Not to be used for recording the absence (or negative presence) of a reaction to 'any substances' or to identified substances – use the EVALUATION.exclusion family of data groups to express a positive statement of exclusion.

Not to be used for recording that no information could be obtained about the adverse reaction status of a patient. Use the EVALUATION.absent_information family of data group to record a positive statement of absent information about adverse reactions could be obtained; for example, if a non-cooperative patient refuses to answer questions.

Not to be used to record adverse events, including failures of clinical process, interventions or products. For example: abnormal use or mistakes or errors made in administration of an agent or substance; mislabelling; harm or injury caused by an intervention or procedure; overdose, etc.

Not to be used for recording alerts.

8.4 ADVERSE REACTION

Identification

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

Definition


Definition	Harmful or undesirable effect associated with exposure to any substance or agent.
Definition Source	Australian Digital Health Agency
Scope	Substances and agents include medication at therapeutic or sub-therapeutic doses, food, plants, animals, venom from insect stings and glycoprotein from animals such as cats.
Scope Source	Australian Digital Health Agency

Usage







Misuse	Not to be used to record drug interactions.
---------------	---







Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Substance/Agent	1..1
	Absolute Contraindication	0..0
	Adverse Reaction Comment	0..0
	REACTION EVENT	0..1
	Reaction Reported	0..0
	Adverse Reaction Report	0..0

Data Type	Name	Occurrences
	Supporting Clinical Record Information	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Adverse Reaction Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

8.5 Substance/Agent

Identification

Label	Substance/Agent
Metadata Type	Data Element
Identifier	DE-15521
OID	1.2.36.1.2001.1001.101.103.15521

Definition


Definition	Identification of a substance, agent, or a class of substance, that is considered to be responsible for the adverse reaction.
Definition Source	Australian Digital Health Agency
Synonymous Names	Agent Substance
Notes	An agent can be a substance such as food, drug or an environmental allergen.
Data Type	CodeableText
Value Domain	Substance/Agent Values

Usage

Examples	<ol style="list-style-type: none"> 1) Animal protein 2) Latex 3) Peanut 4) Penicillin 5) Bee venom
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	ADVERSE REACTION	1..1

8.6 Substance/Agent Values

Identification

Label	Substance/Agent Values
Metadata Type	Value Domain
Identifier	VD-15521
OID	1.2.36.1.2001.1001.101.104.15521

Definition


Definition	Set of values for an agent or substance causing an adverse reaction.
Definition Source	Australian Digital Health Agency

Value Domain

Source	Australian Digital Health Agency
Permissible Values	<p>The permissible values are the members of the following reference sets.</p> <p>From SNOMED CT-AU:</p> <ul style="list-style-type: none"> • 142321000036106 <i>Adverse reaction agent reference set</i> • 32570211000036100 <i>Substance foundation reference set</i> <p>From AMT:</p> <ul style="list-style-type: none"> • 929360061000036106 <i>Medicinal product reference set</i> • 929360081000036101 <i>Medicinal product pack reference set</i> • 929360071000036103 <i>Medicinal product unit of use reference set</i> • 929360021000036102 <i>Trade product reference set</i> • 929360041000036105 <i>Trade product pack reference set</i> • 929360031000036100 <i>Trade product unit of use reference set</i> • 929360051000036108 <i>Containerized trade product pack reference set</i>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Substance/Agent	1..1

8.7 REACTION EVENT

Identification

Label	REACTION EVENT
Metadata Type	Data Group
Identifier	DG-16474
OID	1.2.36.1.2001.1001.101.102.16474

Definition


Definition	Details about each adverse reaction event.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Usage





Conditions of Use	Each instance of this data group SHALL contain at least one instance of: <ul style="list-style-type: none"> • Manifestation, or • Reaction Type.
Conditions of Use Source	Australian Digital Health Agency



Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	ADVERSE REACTION	0..1

Children

Data Type	Name	Occurrences
	Specific Substance/Agent	0..0
	Manifestation	0..*
	Reaction Type	0..1
	Adverse Reaction Certainty	0..0

Data Type	Name	Occurrences
	Reaction Description	0..0
	Reaction Onset Date	0..0
	Duration of Reaction	0..0
	Additional Reaction Detail (ANATOMICAL LOCATION)	0..0
	Exposure Description	0..0
	Earliest Exposure	0..0
	Duration of Exposure	0..0
	ADDITIONAL EXPOSURE DETAIL	0..0
	Clinical Management Description	0..0
	Multimedia	0..0
	Reporting Details	0..0
	Adverse Reaction Event Comment	0..0

8.8 Manifestation

Identification

Label	Manifestation
Metadata Type	Data Element
Identifier	DE-15564
OID	1.2.36.1.2001.1001.101.103.15564

Definition


Definition	Presentation or exhibition of signs and symptoms of the adverse reaction expressed as a single word, phrase or brief description.
Definition Source	Australian Digital Health Agency
Synonymous Names	Reaction
Notes	<p>The clinical manifestation (signs, symptoms, severity or certainty) of the adverse reaction are relevant as they contribute towards the decision as to the immediacy and extent of treatment to be provided, as determined by a healthcare provider.</p> <p>Given that an adverse reaction has occurred, it is important to determine the manifestations of that reaction.</p>
Data Type	CodeableText
Value Domain	Clinical Manifestation Values

Usage

Examples	<ol style="list-style-type: none"> 1) Itchy eyes 2) Dysphagia 3) Tinnitus 4) Nausea 5) Rash
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REACTION EVENT	0..*

8.9 Clinical Manifestation Values

Identification

Label	Clinical Manifestation Values
Metadata Type	Value Domain
Identifier	VD-15564
OID	1.2.36.1.2001.1001.101.104.15564

Definition


Definition	Set of values for recording clinical manifestation of an adverse reaction.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
Permissible Values	<p>The permissible values are the members of the following SNOMED CT reference sets:</p> <ul style="list-style-type: none"> • 142341000036103 <i>Clinical manifestation reference set</i> • 32570071000036102 <i>Clinical finding foundation reference set</i>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Manifestation	1..1

8.10 Reaction Type

Identification

Label	Reaction Type
Metadata Type	Data Element
Identifier	DE-15554
OID	1.2.36.1.2001.1001.101.103.15554

Definition


Definition	Type of reaction, as determined by the clinician.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	This field is used to identify the type of adverse reaction as determined by: <ul style="list-style-type: none"> • the signs and symptoms experienced by the subject of care; • information provided by a relevant individual; • previously documented history; and • clinical assessment by a healthcare provider.
Context Source	Australian Digital Health Agency
Data Type	CodedText
Value Domain	Adverse Reaction Type Values

Usage

Conditions of Use	The value of this item SHOULD NOT be “Non-allergic reaction”.
	The value of this item SHALL NOT be “Drug interaction” or any of its children.
Conditions of Use Source	Australian Digital Health Agency
Examples	<ol style="list-style-type: none"> 1) Allergic reaction 2) Food intolerance 3) Hypersensitivity reaction 4) Medication side-effect
Exceptional Values	Absent values are PROHIBITED .
	Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REACTION EVENT	0..1

8.11 Adverse Reaction Type Values

Identification

Label	Adverse Reaction Type Values
Metadata Type	Value Domain
Identifier	VD-15554
OID	1.2.36.1.2001.1001.101.104.15554
External Identifier	SNOMED CT-AU Concept Id: 11000036103 <i>Adverse reaction type reference set</i>

Definition


Definition	Set of values for the type of adverse reaction.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
---------------	--------------

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
 001011001	Reaction Type	1..1

8.12 Adverse Reaction Instance Identifier

Identification

Label	Adverse Reaction Instance Identifier
Metadata Type	Data Element
Identifier	DE-16697
OID	1.2.36.1.2001.1001.101.103.16697

Definition


Definition	Globally unique identifier for each instance of an <i>Adverse Reaction</i> evaluation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	ADVERSE REACTION	0..1

8.13 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.15517
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	ADVERSE REACTION	1..1

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9 Exclusion Statement - Medications Detailed Clinical Model

This chapter describes a reuse of version 1.4 of the *Exclusion Statement - Medications Detailed Clinical Model*.

See [Medication Instruction and Action Detailed Clinical Model Specification \[DH2016k\]](#) for more information.

9.1 Purpose

To positively record the absence or exclusion of any medication use within the health record.

9.2 Use

Use to record the positive exclusion or absence of medication use within the health record. This detailed clinical model (DCM) avoids the need to use terminology to express negation about any item within the health record.

This DCM is only to be used to record 'point in time' or event-based information. It is not to be used for a persistent storage of information as the patient should always be questioned about current or past medication use prior to initiation of any treatment or management plan.

9.3 EXCLUSION STATEMENT - MEDICATIONS

Identification


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

Definition









Definition	Statement to positively assert that the patient has not been prescribed or is not taking certain medication.
Definition Source	openEHR Foundation
Scope	To positively record the absence or exclusion of any medication use within the health record.
Scope Source	openEHR Foundation

Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Global Statement	1..1
	Not Currently Taking	0..0
	Not Ever Taken	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Exclusion Statement - Medications Instance Identifier	0..0
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

9.4 Global Statement

Identification

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

Definition


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

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodedText .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - MEDICATIONS	1..1

9.5 Global Statement Values

Identification

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

Definition


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

Value Domain

Source	Australian Digital Health Agency	
Permissible Values	01, None known	No information about adverse reactions to any substance is known.
	02, Not asked	No information about adverse reactions to any substance is available because the patient was not asked or was not able to be asked.
	03, None supplied	No information about adverse reactions to any substance is supplied.
	Please see Appendix B, Known Issues .	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Global Statement	1..1

9.6 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16136
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - MEDICATIONS	1..1

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10 Known Medication Detailed Clinical Model

This chapter describes a reuse of version 3.4 of the *Medication Instruction* Detailed Clinical Model.

See [Medication Instruction and Action Detailed Clinical Model Specification \[DH2016k\]](#) for more information.

10.1 Purpose

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

10.2 Use

Use for recording instructions to dispense, administer or use a medicine, vaccine or other therapeutic good. This medication instruction can be used in many circumstances including: a record in a progress note; an item in a medication list, prescription or drug chart (to be dispensed or administered); or in a summary document such as a discharge summary or a referral for care. The instruction may be complex and involve more than one activity, such as in the case of a Prednisolone reducing dose regimen, or multiple medications as components of the same order. This would include a written order by a physician, dentist, nurse practitioner, or other designated health professional for a medication to be dispensed and administered to a patient.

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

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

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

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

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

The content is potentially complex. Where the content is reusable in other contexts, especially the paired *Medication Action* (for recording dispensing, administration etc.) the content has been specified in reusable data groups. For example: the *AMOUNT OF MEDICATION* data group contains detail about medication dose; the *TIMING* data group contains detail about structured dose timing; the *MEDICATION ADMINISTRATION* data group contains structure around administration for both the order and the action; and the *CHEMICAL DESCRIPTION OF MEDICATION* data group describes the specific ingredients within a medicine. All of these data groups together are required to make up the total maximal dataset for a reusable medication instruction.

10.3 Misuse

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

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

10.4 MEDICATION INSTRUCTION

Identification


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

Definition



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

























Relationships




Parents

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

Children

Data Type	Name	Occurrences
	Therapeutic Good Identification	1..1
	Additional Therapeutic Good Detail	0..0

Data Type	Name	Occurrences
	Directions	1..1
	Formula	0..0
	Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)	0..0
	Dose Description	0..0
	Structured Dose (AMOUNT OF MEDICATION)	0..0
	Timing (MEDICATION TIMING)	0..0
	Additional Instruction	0..0
	Clinical Indication	0..1
	Administration Details (MEDICATION ADMINISTRATION)	0..0
	Medication Instruction Comment	0..1
	DISPENSING	0..0
	Change Type	0..0
	Change Status	0..0
	Change Description	0..0
	Change or Recommendation Reason	0..0
	Indication for Authorised Use	0..0
	Medication Instruction ID	0..0
	Concession Benefit	0..0
	DateTime Medication Instruction Written	0..0
	Administrative Manufacturer Code	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Medication Instruction Narrative	0..0
	DateTime Medication Instruction Expires	0..0

Data Type	Name	Occurrences
	Medication Instruction Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

10.5 Therapeutic Good Identification

Identification

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

Definition

Definition	Medicine, vaccine or other therapeutic good being ordered for, administered to or used by the subject.
Definition Source	Australian Digital Health Agency
Synonymous Names	Item Name
Context	This includes medications and medical devices. It includes drugs, appliances, dressings, and reagents.
Context Source	Australian Digital Health Agency
Notes	<p>Identifies a therapeutic good, which is broadly defined as a good which is represented in any way to be, or is likely to be taken to be, for therapeutic use (unless specifically excluded or included under Section 7 of the <i>Therapeutic Goods Act 1989</i>).</p> <p>Therapeutic use means use in or in connection with:</p> <ul style="list-style-type: none"> • preventing, diagnosing, curing or alleviating a disease, ailment, defect or injury; or • influencing, inhibiting or modifying a physiological process; or • testing the susceptibility of persons to a disease or ailment; or • influencing, controlling or preventing conception; or • testing for pregnancy; or • replacement or modification of parts of the anatomy. <p>From the <i>Therapeutic Goods Act 1989</i> [TGA1989a].</p> <p>The formal definition of a therapeutic good is given in Section 3 of the <i>Therapeutic Goods Act 1989</i>.</p>
Data Type	CodeableText
Value Domain	Medicines Terminology


Usage

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

	<p>When an AMT value is not available, a value from another registered code set MAY be used. The code set SHALL be publicly available. A registered code set is one that has been registered through the HL7 code set registration procedure with an appropriate object identifier (OID).</p> <p>For items without an AMT code (including some extemporaneous preparations), a text description is suitable. For a medication, this SHALL include the name of the medication (brand name or generic name equivalent), the strength and, where appropriate, the dose form.</p>
Conditions of Use	Australian Digital Health Agency
Source	
Examples	<p>Some examples of AMT ConceptIDs and their AMT Preferred Terms are:</p> <ol style="list-style-type: none"> 1) 79115011000036100 <i>paracetamol 500 mg + codeine phosphate hemihydrate 30 mg tablet</i> 2) 79240011000036102 <i>paracetamol 500 mg + codeine phosphate hemihydrate 30 mg tablet, 20</i> 3) 835991000168101 <i>Panadeine Forte uncoated tablet, 20</i> 4) 835831000168109 <i>Panadeine Forte uncoated tablet</i> 5) 836001000168100 <i>Panadeine Forte uncoated tablet, 20, blister pack</i> 6) 51295011000036108 <i>bandage compression 10 cm x 3.5 m high stretch bandage, 1</i> 7) 48667011000036100 <i>Eloflex (2480) 10 cm x 3.5 m high stretch bandage</i> 8) 825471000168107 <i>Engerix-B Paediatric 10 microgram/0.5 mL injection suspension, 0.5 mL syringe</i>
Misuse	Detailing the formula of a compounded (extemporaneous) medication.
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	1..1

10.6 Medicines Terminology

Identification

Label	Medicines Terminology
Metadata Type	Value Domain
Identifier	VD-16115
OID	1.2.36.1.2001.1001.101.104.16115

Definition


Definition	Set of values used to refer to medicines and other therapeutic goods.
Definition Source	Australian Digital Health Agency
Notes	An explanation of AMT concepts can be found in Australian Medicines Terminology v3 Model - Editorial Rules v2.0 [NEHT2014ag] .

Value Domain

Source	Australian Medicines Terminology
Permissible Values	<p>The permissible values are the members of the following seven AMT reference sets:</p> <ul style="list-style-type: none"> 929360061000036106 <i>Medicinal product reference set</i> 929360081000036101 <i>Medicinal product pack reference set</i> 929360071000036103 <i>Medicinal product unit of use reference set</i> 929360021000036102 <i>Trade product reference set</i> 929360041000036105 <i>Trade product pack reference set</i> 929360031000036100 <i>Trade product unit of use reference set</i> 929360051000036108 <i>Containerized trade product pack reference set</i>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Therapeutic Good Identification	1..1

10.7 Directions

Identification

Label	Directions
Metadata Type	Data Element
Identifier	DE-16429
OID	1.2.36.1.2001.1001.101.103.16429

Definition


Definition	Complete narrative description of how much, when and how to use the medicine, vaccine or other therapeutic good.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	It is essential that when the <i>Directions</i> data element is used together with structured information components such as <i>Ingredients and Form</i> and <i>Structured Dose</i> in clinical records or prescriptions, the contents of <i>Directions</i> not contradict the contents of these structured information components.
Data Type	Text

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	1..1

10.8 Clinical Indication

Identification

Label	Clinical Indication
Metadata Type	Data Element
Identifier	DE-10141
OID	1.2.36.1.2001.1001.101.103.10141

Definition


Definition	Reason for ordering the medicine, vaccine or other therapeutic good.
Definition Source	Australian Digital Health Agency
Synonymous Names	Reason for Prescribing
Notes	The clinical justification (e.g. specific therapeutic effect intended) for this subject of care's use of the therapeutic good.
Data Type	Text

Usage

Examples	1) Long-term maintenance treatment of bronchospasm and dyspnoea.
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	0..1

10.9 Medication Instruction Comment

Identification

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

Definition


Definition	Additional information that may be needed to ensure the continuity of supply, rationale for current dose and timing, or safe and appropriate use.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	<ol style="list-style-type: none"> 1) Patient requires an administration aid. 2) Portable Pulse Oximeter measurement to be taken by clipping the sensor onto the tip of a finger. 3) Consulted prescriber concerning dose.
Misuse	Use for information that could be recorded as structured data.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	0..1

10.10 Medication Instruction Instance Identifier

Identification

Label	Medication Instruction Instance Identifier
Metadata Type	Data Element
Identifier	DE-16713
OID	1.2.36.1.2001.1001.101.103.16713

Definition


Definition	Globally unique object identifier for each instance of a <i>Medication Instruction</i> instruction.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	0..1

10.11 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniqueIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16211
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	1..1

11 Problem/Diagnosis Detailed Clinical Model

This chapter describes a reuse of version 5.3 of the *Problem/Diagnosis* Detailed Clinical Model.

See [Medical History Detailed Clinical Model Specification \[DH2016j\]](#) for more information.

11.1 Purpose

To record details about a problem or diagnosis by a clinician.

11.2 Use

Use to record detailed information about problems or diagnoses recognised by a clinician. There are many uses including: recording a diagnosis during an encounter; populating a problem list or a summary statement, such as a discharge summary.

Use to record all problems or diagnoses, including those with context-specific qualifiers such as past or present, primary or secondary, active or inactive etc. These qualifiers can be documented separately and included in the *Status* data component, because their use varies in different settings.

11.3 Misuse

Not to be used to record differential diagnoses - use the *Differential Diagnosis* DCM (to be published).

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

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

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

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

11.4 PROBLEM/DIAGNOSIS

Identification


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

Definition






Definition	Health condition that, as determined by a clinician, may have impact on the physical, mental or social well-being of a person. A diagnosis is determined by scientific evaluation of pathological and pathophysiological findings identified from the patient's clinical history, family history, physical examination and diagnostic investigations.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	The problems and diagnoses that form part of the past and current medical history of the subject of care.
Scope Source	Australian Digital Health Agency
Notes	An account of relevant identified health related problems as reported by a healthcare provider. This can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status as assessed by a healthcare provider.
















Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Problem/Diagnosis Identification	1..1
	Clinical Description	0..0
	Severity	0..0
	Date of Onset	0..1
	Age at Onset	0..0

Data Type	Name	Occurrences
	ANATOMICAL LOCATION	0..0
	Occurrence Summary (PROBLEM/DIAGNOSIS OCCURRENCE SUMMARY)	0..0
	RELATED ITEMS	0..0
	Date of Resolution/Remission	0..1
	Age at Resolution/Remission	0..0
	Diagnostic Criteria	0..0
	Clinical Stage/Grade	0..0
	Problem/Diagnosis Comment	0..1
	Link to Supporting Clinical Evidence	0..0
	Status	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Problem/Diagnosis Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

11.5 Problem/Diagnosis Identification

Identification

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

Definition


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

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodeableText .
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	1..1

11.6 Problem/Diagnosis Reference Set

Identification

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

Definition


Definition	Terminology to support the recording of health problems or diagnoses experienced by a subject of care for medical records within Australia.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
---------------	--------------

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
 001011001	Problem/Diagnosis Identification	1..1

11.7 Date of Onset

Identification

Label	Date of Onset
Metadata Type	Data Element
Identifier	DE-15507
OID	1.2.36.1.2001.1001.101.103.15507

Definition


Definition	Estimated or actual date the problem or diagnosis began, as indicated or identified by the clinician.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	DateTime

Usage

Conditions of Use	<i>Date of Onset</i> SHALL NOT include a time component.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for DateTime .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

11.8 Date of Resolution/Remission

Identification

Label	Date of Resolution/Remission
Metadata Type	Data Element
Identifier	DE-15510
OID	1.2.36.1.2001.1001.101.103.15510

Definition


Definition	Estimated or actual date the problem or diagnosis resolved or went into remission, as indicated or identified by the clinician.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	DateTime

Usage

Conditions of Use	<i>Date of Resolution/Remission</i> SHALL NOT include a time component.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for <i>DateTime</i> .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

11.9 Problem/Diagnosis Comment

Identification

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

Definition


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

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

11.10 Problem/Diagnosis Instance Identifier

Identification

Label	Problem/Diagnosis Instance Identifier
Metadata Type	Data Element
Identifier	DE-16702
OID	1.2.36.1.2001.1001.101.103.16702

Definition


Definition	Globally unique identifier for each instance of a <i>Problem/Diagnosis</i> evaluation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

11.11 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.15530
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	1..1

12 Procedure Detailed Clinical Model

This chapter describes a reuse of version 4.3 of the *Procedure (Action)* Detailed Clinical Model.

See [Medical History Detailed Clinical Model Specification \[DH2016j\]](#) for more information.

12.1 Purpose

To record information about the activities required to carry out a procedure, including the planning, scheduling, performance, suspension, cancellation, documentation and completion.

12.2 Use

Use to record information about the activities required to carry out a procedure, including the planning, scheduling, performance, suspension, cancellation, documentation and completion.

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

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

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

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

Recording information using this *Procedure* DCM indicates that some sort of activity has actually occurred; this will usually be the procedure itself but may be a failed attempt or another activity such as postponing the procedure.

12.3 Misuse

Not to be used to record details about related DCMs, such as use of imaging guidance during the procedure or collection of tissue samples for analysis - use a specific DCM for this purpose.

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

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

12.4 PROCEDURE

Identification

Label	PROCEDURE
Metadata Type	Data Group
Identifier	DG-15514
OID	1.2.36.1.2001.1001.101.102.15514

Definition


Definition	Clinical activity carried out for therapeutic, evaluative, investigative, screening or diagnostic purposes.
Definition Source	Australian Digital Health Agency
Synonymous Names	Clinical Intervention
Scope	The procedures that form part of the past and current medical history of the subject of care.
Scope Source	Australian Digital Health Agency

Usage




Misuse	Recording details about related activities such as use of imaging guidance during the procedure or collection of tissue samples for analysis - use specific DCMs for these purposes.
	Recording a whole operation or procedure report.
	Recording an observation such as a pathology test result or an imaging test.












Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Procedure Name	1..1
	Procedure Description	0..0
	Procedure Reason	0..0

Data Type	Name	Occurrences
	ANATOMICAL LOCATION	0..0
	Procedure Detail	0..0
	Multimedia	0..0
	Procedure Comment	0..1
	DEVICE	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Procedure DateTime	1..1
	Procedure Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

12.5 Procedure Name

Identification

Label	Procedure Name
Metadata Type	Data Element
Identifier	DE-15579
OID	1.2.36.1.2001.1001.101.103.15579

Definition


Definition	Name of the procedure (to be) performed.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	Procedure Foundation Reference Set

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodeableText .
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	1..1

12.6 Procedure Foundation Reference Set

Identification

Label	Procedure Foundation Reference Set
Metadata Type	Value Domain
Identifier	VD-16580
OID	1.2.36.1.2001.1001.101.104.16580
External Identifier	SNOMED CT-AU Concept Id: 32570141000036105 <i>Procedure foundation reference set</i>

Definition


Definition	Broadest possible terminology to support the recording of clinical interventions in Australian digital health implementations.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
 001011001	Procedure Name	1..1

12.7 Procedure Comment

Identification

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

Definition


Definition	Additional narrative about the procedure not captured in other fields.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	0..1

12.8 Procedure DateTime

Identification

Label	Procedure DateTime
Metadata Type	Data Element
Identifier	DE-16475
OID	1.2.36.1.2001.1001.101.103.16475

Definition


Definition	Date, and optionally time, of the <i>Procedure</i> action.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This is expected to be the start date and time (where time is available) for the procedure, but may be the date of completion or the time period of the action.
Data Type	TimeInterval

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for TimeInterval .
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	1..1

12.9 Procedure Instance Identifier

Identification

Label	Procedure Instance Identifier
Metadata Type	Data Element
Identifier	DE-16561
OID	1.2.36.1.2001.1001.101.103.16561

Definition


Definition	Globally unique identifier for each instance of a <i>Procedure</i> action.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	0..1

12.10 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.15514
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	1..1

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13 Uncategorised Medical History Item Detailed Clinical Model

This chapter describes a reuse of version 2.1 of the *Uncategorised Medical History Item Detailed Clinical Model*.

See [Medical History Detailed Clinical Model Specification \[DH2016j\]](#) for more information.

13.1 Purpose

To record an entry in a medical history when it cannot be determined whether the entry is a *Procedure* or is a *Problem/Diagnosis*.

13.2 Use

Use to record an item that is known to be a Procedure or a Problem/Diagnosis but that cannot be explicitly categorised as one or the other. This covers cases where the source system cannot automatically classify an entry as a Problem/Diagnosis or a Procedure, including cases where:

- the coding system used for medical history item cannot structurally support adequate concept classification; and
- the medical history item is maintained as free text and thus has never been classified.

Since it is not known whether an *Uncategorised Medical History Item* entry is conceptually a procedure or a problem/diagnosis, exclusion statements cannot be used when an *Uncategorised Medical History Item* entry is present, as the entry may, in fact, be a procedure or a problem/diagnosis.

13.3 Misuse

Misuses of this DCM include:

- using it when the item is known to be neither a Procedure nor a Problem/Diagnosis; and
- using it when the item can be identified as either a Procedure or a Problem/Diagnosis.

13.4 UNCATEGORISED MEDICAL HISTORY ITEM

Identification

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

Definition


Definition	Medical history entry that has not been categorised as either <i>Procedure</i> or <i>Problem/Diagnosis</i> .
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	For exchanging medical history items from clinical information systems that do not separate procedure and problem/diagnosis data in their data store.
Scope Source	Australian Digital Health Agency
Assumptions	Every entry in a person's medical history is either a procedure or a problem/diagnosis.
Assumptions Source	Australian Digital Health Agency

Usage



Misuse	<p>Misuses of this data group include:</p> <ul style="list-style-type: none"> • using it when the item is known to be neither a <i>Procedure</i> nor <i>Problem/Diagnosis</i>; and • using it when the item can be identified as either a <i>Procedure</i> or <i>Problem/Diagnosis</i>.
---------------	---







Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Medical History Item Description	1..1
	Medical History Item TimeInterval	0..1

Data Type	Name	Occurrences
	Medical History Item Comment	0..1
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Uncategorised Medical History Item Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

13.5 Medical History Item Description

Identification

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

Definition


Definition	Full description of the problem, diagnosis or procedure as a medical history item.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	<ol style="list-style-type: none"> 1) Hypercholesterolaemia 2) Left total knee replacement 3) Right Lower Lobe pneumonia
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	1..1

13.6 Medical History Item TimeInterval

Identification

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

Definition


Definition	Date range during which the problem or diagnosis applied or the procedure occurred.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	TimeInterval

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for TimeInterval .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	0..1

13.7 Medical History Item Comment

Identification

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

Definition


Definition	Additional narrative about the problem, diagnosis or procedure.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	0..1

13.8 Uncategorized Medical History Item Instance Identifier

Identification

Label	Uncategorised Medical History Item Instance Identifier
Metadata Type	Data Element
Identifier	DE-16479
OID	1.2.36.1.2001.1001.101.103.16479

Definition


Definition	Globally unique identifier for each instance of an <i>Uncategorised Medical History Item</i> evaluation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	0..1

13.9 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16627
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	1..1

14 Pathology Test Result Detailed Clinical Model

This chapter describes a reuse of version 3.3 of the *Pathology Test Result* Detailed Clinical Model.

See [Pathology Test Result Detailed Clinical Model Specification \[DH2017I\]](#) for more information.

14.1 Purpose

To record the findings and interpretation of pathology tests performed on tissues and body fluids. This is typically done in a laboratory, but may be done in other environments, such as at the point of care.

14.2 Use

Use to record any pathology test result, including the result of a test on a specimen taken as part of a composite procedure or operation.

Multi-analyte panels can be represented using templates or specialised DCMs.

More complex tests, such as histopathology or microbiology, should be represented using specialised DCMs where additional report content is required.

The content of instances of this DCM will normally be reported back to the requesting clinician as one component within the context of an overall structured document.

14.3 Misuse

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

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

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

14.4 PATHOLOGY TEST RESULT

Identification


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

Definition








Definition	Result of a laboratory test which may be used to record a single valued test but will often be specialised or templated to represent multiple value or 'panel' tests.
Definition Source	Australian Digital Health Agency
Synonymous Names	Lab Test Pathology Biochemistry Haematology Microbiology Immunology














Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DIAGNOSTIC INVESTIGATIONS	0..*

Children

Data Type	Name	Occurrences
	Pathology Test Result Name	1..1
	Diagnostic Service	0..1
	Test Specimen Detail (SPECIMEN)	1..*
	Overall Pathology Test Result Status	1..1
	Clinical Information Provided	0..1
	Result Group (PATHOLOGY TEST RESULT GROUP)	0..*
	Pathological Diagnosis	0..*

Data Type	Name	Occurrences
 T	Conclusion (Pathology Test Conclusion)	0..1
	Test Result Representation	0..1
 T	Test Comment	0..1
	RECEIVING LABORATORY	0..0
	TEST REQUEST DETAILS	0..*
 T	Test Procedure	0..0
	REPORTING PATHOLOGIST	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Observation DateTime	1..1
	Pathology Test Result Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

14.5 Pathology Test Result Name

Identification

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

Definition


Definition	Identification of the pathology test performed, sometimes including specimen type.
Definition Source	Australian Digital Health Agency
Notes	<p>The test name can refer to a single test, for example Glycosylated Haemoglobin (HbA1c), or to a test group such as electrolytes, Full Blood Count (FBC) or coagulation tests.</p> <p>When a <i>Pathology Test Result</i> record contains only a single individual test, this name may be the same as the name of the individual test.</p>
Data Type	CodeableText
Value Domain	Pathology Test Result Name Values

Usage

Examples	<ol style="list-style-type: none"> 1) Sputum microscopy and culture 2) FBC 3) Serum bilirubin 4) HbA1c
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	1..1

14.6 Pathology Test Result Name Values

Identification

Label	Pathology Test Result Name Values
Metadata Type	Value Domain
Identifier	VD-11017
OID	1.2.36.1.2001.1001.101.104.11017

Definition


Definition	Set of values for the names of pathology tests requested or performed.
Definition Source	Australian Digital Health Agency
Notes	<p>A pathology test may be performed on a pathology specimen or a person.</p> <p>The codes recommended for pathology terminology by the Royal College of Pathologists of Australasia (RCPA) are listed in the latest version of <i>RCPA - Pathology Terminology and Information Models</i>, which is available from the RCPA tab at https://www.healthterminologies.gov.au/ncts/#/access (accessed 9 January 2017).</p>

Value Domain

Source	Australian Digital Health Agency
Permissible Values	The permissible values are the codes recommended for pathology terminology by the RCPA.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Pathology Test Result Name	1..1

14.7 Diagnostic Service

Identification

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

Definition


Definition	Diagnostic service that performs the examination.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	Diagnostic Service Values

Usage

Examples	<ol style="list-style-type: none"> 1) Microbiology 2) Haematology
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..1

14.8 Diagnostic Service Values

Identification

Label	Diagnostic Service Values
Metadata Type	Value Domain
Identifier	VD-16148
OID	1.2.36.1.2001.1001.101.104.16148
External Identifier	2.16.840.1.113883.12.74

Definition


Definition	Set of values for the type of diagnostic service.
Definition Source	Australian Digital Health Agency

Value Domain

Source	HL7 Table 0074 (Diagnostic service section ID)
---------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
 001011001	Diagnostic Service	1..1

14.9 SPECIMEN

Identification


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

Definition









Definition	Details about specimens to which this test result refers.
Definition Source	Australian Digital Health Agency
Synonymous Names	Laboratory Specimen Sample Collection
Notes	Do not include specimens described in <i>PATHOLOGY TEST RESULT GROUP</i> .


Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	1..*

Children

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

Data Type	Name	Occurrences
	IDENTIFIERS	0..1

14.10 Specimen Tissue Type

Identification

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

Definition

Definition	Type of specimen to be collected.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This is the actual specimen being submitted to the laboratory for analysis.
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ¹ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.


Usage

Examples	<ol style="list-style-type: none"> 1) Venous blood 2) Prostate tissue, left base 3) Urine 4) Sputum 5) Scraping 6) Catheter tip 7) Single core (yellow-tan) liver tissue
-----------------	---

¹ <http://www.hl7.org/oid/index.cfm>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Test Specimen Detail (SPECIMEN)	0..1

14.11 Collection Procedure

Identification

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

Definition


Definition	Method of collection to be used.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ² with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	<ol style="list-style-type: none"> 1) Venepuncture 2) Biopsy 3) Resection
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Test Specimen Detail (SPECIMEN)	0..1

² <http://www.hl7.org/oid/index.cfm>

14.12 ANATOMICAL LOCATION

Identification

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

Definition


Definition	Details about the anatomical locations to which this examination result refers.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Usage





Conditions of Use	Each instance of this data group SHALL contain exactly one SPECIFIC LOCATION or exactly one Anatomical Location Description .
	This data group SHALL NOT contain both an instance of SPECIFIC LOCATION and an instance of Anatomical Location Description .
Conditions of Use Source	Australian Digital Health Agency


Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Test Specimen Detail (SPECIMEN)	0..*

Children

Data Type	Name	Occurrences
	SPECIFIC LOCATION	0..1
	RELATIVE LOCATION	0..0
	Anatomical Location Description	0..1
	Visual Markings/Orientation	0..0

Data Type	Name	Occurrences
	Anatomical Location Image	0..*

14.13 SPECIFIC LOCATION

Identification


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

Definition





Definition	Specific and identified anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..1

Children

Data Type	Name	Occurrences
	Anatomical Location Name	0..1
	Side	0..1
	Numerical Identifier	0..0
	Anatomical Plane	0..0

14.14 Anatomical Location Name

Identification

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

Definition


Definition	Name of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	Body Structure Foundation Reference Set

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SPECIFIC LOCATION	0..1

14.15 Body Structure Foundation Reference Set

Identification

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

Definition


Definition	Set of values for named anatomical locations.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
---------------	--------------

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
 001011001	Anatomical Location Name	1..1

14.16 Side

Identification

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

Definition


Definition	Laterality of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	Laterality
Data Type	CodedText
Value Domain	Laterality Reference Set

Usage

Examples	<ol style="list-style-type: none"> 1) Right 2) Left 3) Bilateral
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SPECIFIC LOCATION	0..1

14.17 Laterality Reference Set

Identification

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

Definition


Definition	Set of values for identifying the laterality of an anatomical location.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
---------------	--------------

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
 001011001	Side	1..1

14.18 Anatomical Location Description

Identification

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

Definition


Definition	Description of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..1

14.19 Anatomical Location Image

Identification

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

Definition


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

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for EncapsulatedData .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..*

14.20 PHYSICAL PROPERTIES OF AN OBJECT

Identification


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

Definition






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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Test Specimen Detail (SPECIMEN)	0..*

Children

Data Type	Name	Occurrences
	Name (Physical Object Name)	0..0
	Weight	0..1
	DIMENSIONS	0..1
	Description (Object Description)	0..1
	Image	0..1

14.21 Weight

Identification

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

Definition


Definition	Property of a body – commonly, but inadequately, defined as the quantity of matter in it – to which its inertia is ascribed, and expressed as the weight of the body divided by the acceleration due to gravity.
Definition Source	Macquarie Dictionary (2010)
Synonymous Names	
Data Type	Quantity

Usage

Conditions of Use	This data element SHALL NOT be included if Volume is included.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Quantity .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..1

14.22 DIMENSIONS

Identification


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

Definition








Definition	Dimensions of the object.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..1

Children

Data Type	Name	Occurrences
	Diameter	0..0
	Circumference	0..0
	Length	0..0
	Breadth	0..0
	Depth	0..0
	Area	0..0
	Volume	0..1

14.23 Volume

Identification

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

Definition


Definition	Size, measure or amount of anything in three dimensions; space occupied by a body or substance measured in cubic units.
Definition Source	Macquarie Dictionary (2010)
Synonymous Names	
Data Type	Quantity

Usage

Conditions of Use	This data element SHALL NOT not be included if Weight is included.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Quantity .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DIMENSIONS	0..1

14.24 Object Description

Identification

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

Definition


Definition	Description of other physical characteristics of the object.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..1

14.25 Image

Identification

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

Definition


Definition	Picture of the object.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	EncapsulatedData

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for EncapsulatedData .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..1

14.26 COLLECTION AND HANDLING

Identification


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

Definition








Definition	Collection and handling requirements.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Test Specimen Detail (SPECIMEN)	0..1

Children

Data Type	Name	Occurrences
	Potential Risk / Biohazard	0..0
	Sampling Preconditions	0..1
	Number of Containers	0..0
	Collection Procedure Details	0..0
	Transport Medium	0..0
	Testing Method	0..0
	DEVICE	0..0

14.27 Sampling Preconditions

Identification

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

Definition


Definition	Conditions to be met before the sample should be taken.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	Can also be used to document any known deviations from collection or handling instructions, or any special instructions on the handling or immediate processing of the sample.
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ³ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	<ol style="list-style-type: none"> 1) centrifuge on receipt 2) fasting 3) full bladder 4) sterile field 5) patient was not fasted
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	COLLECTION AND HANDLING	0..1

³ <http://www.hl7.org/oid/index.cfm>

14.28 HANDLING AND PROCESSING

Identification


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

Definition





Definition	Workflow of specimen processing or handling.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Test Specimen Detail (SPECIMEN)	1..1

Children

Data Type	Name	Occurrences
	Collection DateTime	1..1
	Collection Setting	0..1
	Date and Time of Receipt (DateTime Received)	0..1
	Date and Time Processed (DateTime Processed)	0..0

14.29 Collection DateTime

Identification

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

Definition


Definition	Date, and optionally time, of collection.
Definition Source	Australian Digital Health Agency
Synonymous Names	Collected Date/Time
Data Type	DateTime

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for DateTime .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	HANDLING AND PROCESSING	1..1

14.30 Collection Setting

Identification

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

Definition


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

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	HANDLING AND PROCESSING	0..1

14.31 DateTime Received

Identification

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

Definition


Definition	Date and time that the sample was received at the laboratory.
Definition Source	Australian Digital Health Agency
Synonymous Names	Received Date/Time
Notes	This provides a point-in-time reference to link result data to request data, and a point-in-time reference within a health record that the clinician may refer to.
Data Type	DateTime

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for DateTime .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	HANDLING AND PROCESSING	0..1

14.32 IDENTIFIERS

Identification


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

Definition






Definition	Sample identifications.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Test Specimen Detail (SPECIMEN)	0..1

Children

Data Type	Name	Occurrences
	Specimen Identifier	0..1
	Parent Specimen Identifier	0..1
	Container Identifier	0..1
	Specimen Collector Identifier	0..0
	SPECIMEN COLLECTOR DETAILS	0..0

14.33 Specimen Identifier

Identification

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

Definition


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

Usage

Conditions of Use	Each specimen SHOULD have an identifier.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelyIdentifier .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IDENTIFIERS	0..1

14.34 Parent Specimen Identifier

Identification

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

Definition


Definition	Unique identifier of the parent specimen where the specimen is split into sub-samples.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IDENTIFIERS	0..1

14.35 Container Identifier

Identification

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

Definition


Definition	Unique identifier given to the container in which the specimen is transported or processed.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IDENTIFIERS	0..1

14.36 Overall Pathology Test Result Status

Identification

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

Definition


Definition	Status of the pathology test result as a whole.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodedText
Value Domain	Pathology Test Result Status Values

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodedText .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	1..1

14.37 Pathology Test Result Status Values

Identification

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

Definition

Definition	Set of values for the pathology test result status.
Definition Source	Australian Digital Health Agency
Notes	<p>The <i>HL7 Table 0085 - Observation result status codes interpretation</i> is intended to be used at the result or record level, while the <i>HL7 Table 0123 - Result status</i> is intended to be used for the overall report status.</p> <p>Having to source values from two HL7 tables and determine which one to apply in a situation is a potential cause of confusion. Consequently we provide a value set that is applicable across report level and individual result level status values. The single value set has been assessed to be adequate for the My Health Record-based use cases. This approach reduces the chances of confusion and errors in the use of status values.</p>

Value Domain


Source	NCTIS Pathology Test Result Status Values	
Permissible Values	1, Registered	No result yet available.
	2, Interim	This is an initial or interim result: data may be missing or verification has not been performed.
	3, Final	The result is complete and verified by the responsible pathologist.
	4, Amended	The result has been modified subsequent to being Final, and is complete and verified by the responsible pathologist.
	5, Cancelled/Aborted	The result is unavailable because the test was not started or not completed.
	Values sourced by the Agency from <i>HL7 Table 0085 - Observation result status codes interpretation</i> , <i>HL7 Table 0123 - Result status</i> and other sources.	

Usage

Conditions of Use	In situations where <i>NCTIS Pathology Test Result Status Values</i> is not available, <i>HL7 v2.x Table 0123 (Result status)</i> [OID:2.16.840.1.113883.12.123] MAY be used.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Overall Pathology Test Result Status	1..1

14.38 Clinical Information Provided

Identification

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

Definition


Definition	Description or summary of relevant, prior clinical information that may help in determining the test(s) to be performed, or interpreting the result when compiling or reading the report.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This would typically be a summarised restatement of any clinical information provided by the original requester of the test for any of the following reasons:</p> <ul style="list-style-type: none"> • to justify the request; • to help the pathologist or laboratory scientist determine whether a better test should be performed; • to help the pathologist or laboratory scientist determine whether any additional tests are needed; and • to help interpret the result when reporting or reading the report.
Data Type	Text

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..1

14.39 PATHOLOGY TEST RESULT GROUP

Identification


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

Definition




Definition	Group of results that form all or part of a recognisable pathology test.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	Results may be grouped by specimen, or by some other name or code to describe what binds all the results together.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..*

Children

Data Type	Name	Occurrences
	Pathology Test Result Group Name	1..1
	Result (INDIVIDUAL PATHOLOGY TEST RESULT)	1..*
	Result Group Specimen Detail (SPECIMEN)	0..1

14.40 Pathology Test Result Group Name

Identification

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

Definition


Definition	Name of a group of pathology test results.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	Pathology Test Result Name Values

Usage

Examples	<ol style="list-style-type: none"> 1) Full blood count 2) Liver function tests
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group (PATHOLOGY TEST RESULT GROUP)	1..1

14.41 INDIVIDUAL PATHOLOGY TEST RESULT

Identification


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

Definition






Definition	Specific detailed result of a pathology test, including both the value of the result item, and additional information that may be useful for clinical interpretation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Many specific data items that pathology labs report as part of a clinical service are treated as results; results are not confined to measurements. Individual results are identified by <i>Individual Pathology Test Result Name</i>.</p> <p>If a result is not grouped with others, it is recorded as the only result in a nameless result group.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group (PATHOLOGY TEST RESULT GROUP)	1..*

Children

Data Type	Name	Occurrences
	Individual Pathology Test Result Name	1..1
	Result Value (INDIVIDUAL PATHOLOGY TEST RESULT VALUE)	0..1
	Individual Pathology Test Result Comment	0..*
	Individual Pathology Test Result Reference Range Guidance	0..1
	Individual Pathology Test Result Status	1..1

14.42 Individual Pathology Test Result Name

Identification

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

Definition


Definition	Name of an individual pathology test result.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	Individual Pathology Test Result Name Values

Usage

Examples	<ol style="list-style-type: none"> 1) Serum glucose level 2) Haemoglobin concentration 3) Hepatitis B surface antibody titre 4) Prothrombin time
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result (INDIVIDUAL PATHOLOGY TEST RESULT)	1..1

14.43 Individual Pathology Test Result Name Values

Identification

Label	Individual Pathology Test Result Name Values
Metadata Type	Value Domain
Identifier	VD-16571
OID	1.2.36.1.2001.1001.101.104.16571

Definition


Definition	Set of values for the names of individual pathology tests performed.
Definition Source	Australian Digital Health Agency
Notes	<p>A pathology test may be performed on a pathology specimen or a person.</p> <p>The codes recommended for pathology terminology by the Royal College of Pathologists of Australasia (RCPA) are listed in the latest version of <i>RCPA - Pathology Terminology and Information Models</i>, which is available from the RCPA tab at https://www.healthterminologies.gov.au/ncts/#/access (accessed 9 January 2017).</p>

Value Domain

Source	Australian Digital Health Agency
Permissible Values	The permissible values are the codes recommended for pathology terminology by the RCPA.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Individual Pathology Test Result Name	1..1

14.44 INDIVIDUAL PATHOLOGY TEST RESULT VALUE

Identification


Label	Result Value
Metadata Type	Data Group
Identifier	DG-11023
OID	1.2.36.1.2001.1001.101.102.11023

Definition



Definition	Value of the result, with reference range information.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result (INDIVIDUAL PATHOLOGY TEST RESULT)	0..1

Children

Data Type	Name	Occurrences
	Individual Pathology Test Result Value	1..1
	Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS)	0..1

14.45 Individual Pathology Test Result Value

Identification

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

Definition


Definition	Actual value of the result.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Most result values will be numerical measurements, but others may be coded concepts or free text.</p> <p>It is recommended that data types without units, e.g. Text or Integer, are avoided where possible so that machine-level semantic interoperability is not compromised.</p>
Data Type	Any

Usage

Examples	<p>1) 140</p> <p>2) ++</p> <p>3) Neg</p>
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Value (INDIVIDUAL PATHOLOGY TEST RESULT VALUE)	1..1

14.46 REFERENCE RANGE DETAILS

Identification


Label	Individual Pathology Test Result Value Reference Ranges
Metadata Type	Data Group
Identifier	DG-16325
OID	1.2.36.1.2001.1001.101.102.16325

Definition



Definition	Reference ranges applicable to the <i>Individual Pathology Test Result Value</i> .
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	A reference range is particular to the patient and context, e.g. sex, age, and any other factor that affects ranges. May be used to represent normal, therapeutic, dangerous, critical and other such clinical ranges.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Value (INDIVIDUAL PATHOLOGY TEST RESULT VALUE)	0..1

Children

Data Type	Name	Occurrences
	Normal Status	0..1
	REFERENCE RANGE	0..*

14.47 Normal Status

Identification

Label	Normal Status
Metadata Type	Data Element
Identifier	DE-11028
OID	1.2.36.1.2001.1001.101.103.11028

Definition

Definition	Indication of the degree of diagnostically significant abnormality of the value, based on available clinical information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Available clinical information includes the reference range.</p> <p>The term “normal” is not statistical normality, but rather what would normally be considered healthy for the individual concerned. As such, this data element represents the health risk for the individual, which is indicated by the observation or measurement and the nature and criticality of that health risk.</p>
Data Type	CodeableText
Value Domain	<p><i>Not specified.</i></p> <p>In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure⁴ with an appropriate object identifier (OID), and SHALL be publicly available.</p> <p>When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.</p>


Usage

Examples	<ol style="list-style-type: none"> 1) Below normal 2) Above normal 3) Critically low 4) Critically high
-----------------	---

⁴ <http://www.hl7.org/oid/index.cfm>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS)	0..1

14.48 REFERENCE RANGE

Identification

Label	REFERENCE RANGE
Metadata Type	Data Group
Identifier	DG-11024
OID	1.2.36.1.2001.1001.101.102.11024

Definition


Definition	Named range to be associated with any quantity datum.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Usage



Conditions of Use	If this data group occurs more than once, its contents SHOULD include all of the ranges in a single set.
	All reference ranges SHALL come from the one set of reference ranges.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS)	0..*

Children

Data Type	Name	Occurrences
	Reference Range Meaning	1..1
	Reference Range	1..1

14.49 Reference Range Meaning

Identification

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

Definition


Definition	Term whose value indicates the meaning of this range.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ⁵ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	<ol style="list-style-type: none"> 1) Normal 2) Critical 3) Therapeutic
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERENCE RANGE	1..1

⁵ <http://www.hl7.org/oid/index.cfm>

14.50 Reference Range

Identification

Label	Reference Range
Metadata Type	Data Element
Identifier	DE-11024
OID	1.2.36.1.2001.1001.101.103.11024

Definition


Definition	Data range for the associated <i>Reference Range Meaning</i> data element.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	QuantityRange

Usage

Examples	<ul style="list-style-type: none"> 1) 15 - 58 g/L 2) < 15 mmol/L 3) 2.5 - 3.5 kg 4) 23 - 45 cm
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERENCE RANGE	1..1

14.51 Individual Pathology Test Result Comment

Identification

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

Definition


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

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result (INDIVIDUAL PATHOLOGY TEST RESULT)	0..*

14.52 Individual Pathology Test Result Reference Range Guidance

Identification

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

Definition


Definition	Additional advice on the applicability of the reference range.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result (INDIVIDUAL PATHOLOGY TEST RESULT)	0..1

14.53 Individual Pathology Test Result Status

Identification

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

Definition


Definition	Status of an individual pathology test result.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Allows a report with more than one result to be issued and allows each result to have a different status associated with it.</p> <p>The status of a result is included in the report to inform the requester or receiver whether it is final or there is more to expect, or whether amendments have been made. This may be of use to the clinician in deciding how to respond to the report.</p>
Data Type	CodedText
Value Domain	Pathology Test Result Status Values

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodedText .
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result (INDIVIDUAL PATHOLOGY TEST RESULT)	1..1

14.54 SPECIMEN

Identification


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

Definition









Definition	Details about the individual specimen to which these result group test results refer, where testing of multiple specimens is required.
Definition Source	Australian Digital Health Agency
Synonymous Names	Laboratory Specimen Sample Collection


Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group (PATHOLOGY TEST RESULT GROUP)	0..1

Children

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

Data Type	Name	Occurrences
	IDENTIFIERS	0..1

14.55 Specimen Tissue Type

Identification

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

Definition

Definition	Type of specimen to be collected.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This is the actual specimen being submitted to the laboratory for analysis.
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ⁶ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.


Usage

Examples	<ol style="list-style-type: none"> 1) Venous blood 2) Prostate tissue, left base 3) Urine 4) Sputum 5) Scraping 6) Catheter tip 7) Single core (yellow-tan) liver tissue
-----------------	---

⁶ <http://www.hl7.org/oid/index.cfm>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group Specimen Detail (SPECIMEN)	0..1

14.56 Collection Procedure

Identification

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

Definition


Definition	Method of collection to be used.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ⁷ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	<ol style="list-style-type: none"> 1) Venepuncture 2) Biopsy 3) Resection
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group Specimen Detail (SPECIMEN)	0..1

⁷ <http://www.hl7.org/oid/index.cfm>

14.57 ANATOMICAL LOCATION

Identification

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

Definition


Definition	Details about the anatomical locations to which this examination result refers.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Usage





Conditions of Use	Each instance of this data group SHALL contain exactly one SPECIFIC LOCATION or exactly one Anatomical Location Description .
	This data group SHALL NOT contain both an instance of SPECIFIC LOCATION and an instance of Anatomical Location Description .
Conditions of Use Source	Australian Digital Health Agency


Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group Specimen Detail (SPECIMEN)	0..*

Children

Data Type	Name	Occurrences
	SPECIFIC LOCATION	0..1
	RELATIVE LOCATION	0..0
	Anatomical Location Description	0..1
	Visual Markings/Orientation	0..0

Data Type	Name	Occurrences
	Anatomical Location Image	0..*

14.58 SPECIFIC LOCATION

Identification


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

Definition





Definition	Specific and identified anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..1

Children

Data Type	Name	Occurrences
	Anatomical Location Name	0..1
	Side	0..1
	Numerical Identifier	0..0
	Anatomical Plane	0..0

14.59 Anatomical Location Name

Identification

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

Definition


Definition	Name of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	Body Structure Foundation Reference Set

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SPECIFIC LOCATION	0..1

14.60 Body Structure Foundation Reference Set

Identification

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

Definition


Definition	Set of values for named anatomical locations.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
---------------	--------------

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Location Name	1..1

14.61 Side

Identification

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

Definition


Definition	Laterality of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	Laterality
Data Type	CodedText
Value Domain	Laterality Reference Set

Usage

Examples	<ol style="list-style-type: none"> 1) Right 2) Left 3) Bilateral
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SPECIFIC LOCATION	0..1

14.62 Laterality Reference Set

Identification

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

Definition


Definition	Set of values for identifying the laterality of an anatomical location.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
---------------	--------------

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Side	1..1

14.63 Anatomical Location Description

Identification

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

Definition


Definition	Description of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..1

14.64 Anatomical Location Image

Identification

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

Definition


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

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for EncapsulatedData .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..*

14.65 PHYSICAL PROPERTIES OF AN OBJECT

Identification


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

Definition






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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group Specimen Detail (SPECIMEN)	0..*

Children

Data Type	Name	Occurrences
	Name (Physical Object Name)	0..0
	Weight	0..1
	DIMENSIONS	0..1
	Description (Object Description)	0..1
	Image	0..1

14.66 Weight

Identification

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

Definition


Definition	Property of a body – commonly, but inadequately, defined as the quantity of matter in it – to which its inertia is ascribed, and expressed as the weight of the body divided by the acceleration due to gravity.
Definition Source	Macquarie Dictionary (2010)
Synonymous Names	
Data Type	Quantity

Usage

Conditions of Use	This data element SHALL NOT be included if Volume is included.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Quantity .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..1

14.67 DIMENSIONS

Identification


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

Definition








Definition	Dimensions of the object.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..1

Children

Data Type	Name	Occurrences
	Diameter	0..0
	Circumference	0..0
	Length	0..0
	Breadth	0..0
	Depth	0..0
	Area	0..0
	Volume	0..1

14.68 Volume

Identification

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

Definition


Definition	Size, measure or amount of anything in three dimensions; space occupied by a body or substance measured in cubic units.
Definition Source	Macquarie Dictionary (2010)
Synonymous Names	
Data Type	Quantity

Usage

Conditions of Use	This data element SHALL NOT not be included if Weight is included.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Quantity .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DIMENSIONS	0..1

14.69 Object Description

Identification

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

Definition


Definition	Description of other physical characteristics of the object.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..1

14.70 Image

Identification

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

Definition


Definition	Picture of the object.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	EncapsulatedData

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for EncapsulatedData .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..1

14.71 COLLECTION AND HANDLING

Identification


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

Definition








Definition	Collection and handling requirements.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group Specimen Detail (SPECIMEN)	0..1

Children

Data Type	Name	Occurrences
	Potential Risk / Biohazard	0..0
	Sampling Preconditions	0..1
	Number of Containers	0..0
	Collection Procedure Details	0..0
	Transport Medium	0..0
	Testing Method	0..0
	DEVICE	0..0

14.72 Sampling Preconditions

Identification

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

Definition


Definition	Conditions to be met before the sample should be taken.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	Can also be used to document any known deviations from collection or handling instructions, or any special instructions on the handling or immediate processing of the sample.
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ⁸ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	<ol style="list-style-type: none"> 1) centrifuge on receipt 2) fasting 3) full bladder 4) sterile field 5) patient was not fasted
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	COLLECTION AND HANDLING	0..1

⁸ <http://www.hl7.org/oid/index.cfm>

14.73 HANDLING AND PROCESSING

Identification


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

Definition





Definition	Workflow of specimen processing or handling.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group Specimen Detail (SPECIMEN)	1..1

Children

Data Type	Name	Occurrences
	Collection DateTime	1..1
	Collection Setting	0..1
	Date and Time of Receipt (DateTime Received)	0..1
	Date and Time Processed (DateTime Processed)	0..0

14.74 Collection DateTime

Identification

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

Definition


Definition	Date, and optionally time, of collection.
Definition Source	Australian Digital Health Agency
Synonymous Names	Collected Date/Time
Data Type	DateTime

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for DateTime .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	HANDLING AND PROCESSING	1..1

14.75 Collection Setting

Identification

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

Definition


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

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	HANDLING AND PROCESSING	0..1

14.76 DateTime Received

Identification

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

Definition


Definition	Date and time that the sample was received at the laboratory.
Definition Source	Australian Digital Health Agency
Synonymous Names	Received Date/Time
Notes	This provides a point-in-time reference to link result data to request data, and a point-in-time reference within a health record that the clinician may refer to.
Data Type	DateTime

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for DateTime .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	HANDLING AND PROCESSING	0..1

14.77 IDENTIFIERS

Identification


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

Definition






Definition	Sample identifications.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group Specimen Detail (SPECIMEN)	0..1

Children

Data Type	Name	Occurrences
	Specimen Identifier	0..1
	Parent Specimen Identifier	0..1
	Container Identifier	0..1
	Specimen Collector Identifier	0..0
	SPECIMEN COLLECTOR DETAILS	0..0

14.78 Specimen Identifier

Identification

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

Definition


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

Usage

Conditions of Use	Each specimen SHOULD have an identifier.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IDENTIFIERS	0..1

14.79 Parent Specimen Identifier

Identification

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

Definition


Definition	Unique identifier of the parent specimen where the specimen is split into sub-samples.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IDENTIFIERS	0..1

14.80 Container Identifier

Identification

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

Definition


Definition	Unique identifier given to the container in which the specimen is transported or processed.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IDENTIFIERS	0..1

14.81 Pathological Diagnosis

Identification

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

Definition


Definition	Single word, phrase or brief description representing the diagnostic statement as asserted by the reporting pathologist.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ⁹ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..*

⁹ <http://www.hl7.org/oid/index.cfm>

14.82 Pathology Test Conclusion

Identification

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

Definition


Definition	Concise and clinically contextualised narrative interpretation of the pathology test results.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..1

14.83 Test Result Representation

Identification

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

Definition


Definition	Rich text representation of the entire result as issued by the diagnostic service.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>The report is a verbatim copy of the report as issued. The results reported may also, or instead, be supplied in a machine-readable structured form. As some structured pathology information is unable to be stored and displayed correctly by receiving systems at this time, some structured pathology information (such as microbiology results) is sent in the same way as free text or images.</p> <p>Resistance to structured formatting has been expressed in some quarters. These concerns may be due to the perceived difficulty in ensuring the results are maintained in their entirety as intended by the reporting provider. The nature and intent of DCMs to constrain information and provide context may help to alleviate this problem. In the meantime, the <i>Pathology Test Result data group</i> represents the non-numerical pathology results as a single data element.</p>
Data Type	EncapsulatedData

Usage

Conditions of Use	Multiple formats are allowed but they SHALL be semantically equivalent.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for EncapsulatedData .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..1

14.84 Test Comment

Identification

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

Definition


Definition	Additional narrative about the test that is not captured in other fields.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..1

14.85 TEST REQUEST DETAILS

Identification


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

Definition






Definition	Details concerning a single requested pathology test.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	Usually there is one test request for each result, however, in some circumstances multiple test requests may be represented using a single <i>Pathology Test Result</i> .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..*

Children

Data Type	Name	Occurrences
	Requester Order Identifier	0..0
	Test Requested Name	0..*
	REQUESTER	0..0
	Receiver Order Identifier	0..0
	Laboratory Test Result Identifier	0..1

14.86 Test Requested Name

Identification

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

Definition


Definition	Identification of the pathology test that was requested.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	Pathology Test Result Name Values

Usage

Conditions of Use	This data element SHOULD NOT be used if its value is equal to the value of the Pathology Test Result Name data element.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodeableText .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	TEST REQUEST DETAILS	0..*

14.87 Laboratory Test Result Identifier

Identification

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

Definition


Definition	Identifier given to the laboratory test result of a pathology investigation.
Definition Source	Australian Digital Health Agency
Synonymous Names	Lab Number
Notes	Assigning an identification code to a result allows the result to be linked to a request in the laboratory.
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier.
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	TEST REQUEST DETAILS	0..1

14.88 Observation DateTime

Identification

Label	Observation DateTime
Metadata Type	Data Element
Identifier	DE-15561
OID	1.2.36.1.2001.1001.101.103.15561

Definition

Definition	Date, and optionally time, when an observation is clinically significant to the condition of the subject of the observation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Assumptions	For an observation based on a specimen the clinically significant time will have the same value as the time of collection of the specimen.
Assumptions Source	Australian Digital Health Agency
Notes	<p>Clinical Semantics of Event Time. (Section 8.2.3.3 of <i>EHR Information Model [OEHR2008a]</i>)</p> <p>In most cases, the times recorded in [an <i>Observation DateTime</i> data element] can be thought of as “the times when the observed phenomena were true”. For example, if a pulse of 88bpm is recorded for 12/feb/2005 12:44:00, this is the time at which the heart rate (for which pulse is a surrogate) existed. In such cases, the <i>sample</i> time, and the <i>measuring</i> time are one and the same.</p> <p>However in cases where the time of sampling is different from that of measurement, the semantics are more subtle. There are two cases. The first is where a sample is taken (e.g. a tissue sample in a needle biopsy), and is tested later on, but from the point of view of the test, the time delay makes no difference. This might be because the sample was immediately preserved (e.g. freezing, placed in a sterile ... transport container), or because even if it decays in some way, it makes no difference to the test (e.g. bacteria may die, but this makes no difference to [an] analysis, as long as the biological matter is not physically destroyed).</p> <p>The second situation is when the sample does decay in some way, and the delay is relevant. Most such cases are in pathology tests, where presence of live biological organisms (e.g. anaerobic bacteria) is being measured. The sample time (or ‘collection’ time) must be recorded. Depending on when the test is done, the results may be interpreted differently.</p> <p>The key question is: what is the meaning of the [data element] in these situations? It is tempting to say that [its value is] (as in other cases) just the [time] of the actual act of observation, e.g. microscopy, chromatography etc. However, there are two problems with this. Firstly, and most importantly, all physical samples must be understood as being <i>indirect surrogates for some aspect of the patient state at the time of sampling</i>, which cannot be observed by direct, instantaneous means in the way a pulse can be taken. This means that no matter when the laboratory work is done, the time to which the result applies is the <i>sample</i> time. It is up to the laboratory to take into account time delays and effects of decay of samples in order to provide a test result which correctly indicates the state of the patient at the time of sampling. The common sense of this is clear when one considers the extreme case where the patient is in a coma or dead (possibly for reasons completely unrelated to the problem being tested for) by the time laboratory testing actually occurs; however, the test result indicates the situation at the point in time when the sample was taken, i.e. when the patient was alive. The second reason is that some kinds of testing are themselves lengthy. For example fungal specimens require 4-6 weeks to confirm a</p>


Data Type	<p>negative result; checks will be made on a daily or weekly basis to find positive growth. However, the result data reported by the laboratory (and therefore the structure of the Observation) is not related to the timing of the laboratory testing; it is reported as being the result for the time of collection of the specimen from the patient.</p> <p>The meaning therefore of the [data element] is always the time of sampling. Where delays between sample and measurement times exist and are significant, they are [modelled explicitly].</p> <p>DateTime</p>
------------------	---

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for DateTime .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	1..1

14.89 Pathology Test Result Instance Identifier

Identification

Label	Pathology Test Result Instance Identifier
Metadata Type	Data Element
Identifier	DE-16714
OID	1.2.36.1.2001.1001.101.103.16714

Definition


Definition	Globally unique identifier for each instance of a <i>Pathology Test Result</i> observation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	0..1

14.90 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16144
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PATHOLOGY TEST RESULT	1..1

15 Imaging Examination Result Detailed Clinical Model

This chapter describes a reuse of version 3.2 of the *Imaging Examination Result* Detailed Clinical Model.

See [Imaging Examination Result Detailed Clinical Model Specification \[DH2016m\]](#) for more information.

15.1 Purpose

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

15.2 Use

Use to record all results related to the diagnostic imaging aspects of any imaging examinations performed.

Use to record the imaging examination components (only) of a more complex procedure, including those that may have been undertaken under imaging guidance.

More complex procedures (such as echocardiograms or bone density scans) may be represented using templates or specialised archetypes where additional report content is appropriate.

The content of instances of this DCM will normally be reported back to the requesting clinician as one component within the context of an overall report.

15.3 Misuse

Not to be used to record non-imaging examination findings or activities. For example, when imaging is performed as part of a procedure, the information related to the procedure shall be recorded using the Procedure archetype for the operative findings. This archetype will only be used to record the findings from the imaging.

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

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

15.4 IMAGING EXAMINATION RESULT

Identification


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

Definition




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






Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DIAGNOSTIC INVESTIGATIONS	0..*

Children

Data Type	Name	Occurrences
	Examination Result Name (Imaging Examination Result Name)	1..1
	Imaging Modality	0..1
	Anatomical Site (ANATOMICAL LOCATION)	0..*

Data Type	Name	Occurrences
	Anatomical Region	0..0
	Imaging Examination Result Status	1..1
	Clinical Information Provided	0..1
	Findings	0..1
	Result Group (IMAGING EXAMINATION RESULT GROUP)	0..*
	Radiological Diagnosis	0..0
	Conclusion (Imaging Examination Conclusion)	0..0
	Examination Result Representation	0..1
	Examination Comment	0..0
	RECEIVING IMAGING SERVICE	0..0
	EXAMINATION REQUEST DETAILS	0..*
	Examination Procedure	0..0
	COMPARED IMAGE DETAILS	0..0
	REPORTING RADIOLOGIST	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Observation DateTime	1..1
	Imaging Examination Result Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

15.5 Imaging Examination Result Name

Identification

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

Definition


Definition	Identification of the imaging examination or procedure performed, typically including modality and anatomical location (including laterality).
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ¹ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	<ol style="list-style-type: none"> 1) CT chest and abdomen 2) Ultrasound plantar fascia
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	1..1

¹ <http://www.hl7.org/oid/index.cfm>

15.6 Imaging Modality

Identification

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

Definition

Definition	Imaging method used to perform the examination.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	For identification or description of the diagnostic imaging modalities that are: <ul style="list-style-type: none"> • available for request; or • used in reporting.
Context Source	Australian Digital Health Agency
Notes	The imaging method, including the electro-magnetic energy type, applied to produce diagnostic quality images of body structures or internal organs performed during a diagnostic imaging procedure. If the modality is specified by a code in <i>Examination Result Name</i> , then this field is not required.
Data Type	CodeableText
Value Domain	<i>Not specified.</i> In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ² with an appropriate object identifier (OID), and SHALL be publicly available. When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.


Usage

Examples	<ol style="list-style-type: none"> 1) X-ray 2) CT scan 3) MRI 4) PET scan
-----------------	---

² <http://www.hl7.org/oid/index.cfm>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..1

15.7 ANATOMICAL LOCATION

Identification

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

Definition


Definition	Details about the anatomical locations to which this examination result refers.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Usage





Conditions of Use	Each instance of this data group SHALL contain exactly one SPECIFIC LOCATION or exactly one Anatomical Location Description .
	This data group SHALL NOT contain both an instance of SPECIFIC LOCATION and an instance of Anatomical Location Description .
Conditions of Use Source	Australian Digital Health Agency


Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..*

Children

Data Type	Name	Occurrences
	SPECIFIC LOCATION	0..1
	RELATIVE LOCATION	0..0
	Anatomical Location Description	0..1
	Visual Markings/Orientation	0..0

Data Type	Name	Occurrences
	Anatomical Location Image	0..*

15.8 SPECIFIC LOCATION

Identification


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

Definition





Definition	Specific and identified anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..1

Children

Data Type	Name	Occurrences
	Anatomical Location Name	0..1
	Side	0..1
	Numerical Identifier	0..0
	Anatomical Plane	0..0

15.9 Anatomical Location Name

Identification

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

Definition


Definition	Name of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	Body Structure Foundation Reference Set

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SPECIFIC LOCATION	0..1

15.10 Body Structure Foundation Reference Set

Identification

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

Definition


Definition	Set of values for named anatomical locations.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
---------------	--------------

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Location Name	1..1

15.11 Side

Identification

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

Definition


Definition	Laterality of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	Laterality
Data Type	CodedText
Value Domain	Laterality Reference Set

Usage

Examples	<ol style="list-style-type: none"> 1) Right 2) Left 3) Bilateral
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SPECIFIC LOCATION	0..1

15.12 Laterality Reference Set

Identification

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

Definition


Definition	Set of values for identifying the laterality of an anatomical location.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
---------------	--------------

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Side	1..1

15.13 Anatomical Location Description

Identification

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

Definition


Definition	Description of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..1

15.14 Anatomical Location Image

Identification

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

Definition


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

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for EncapsulatedData .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..*

15.15 Imaging Examination Result Status

Identification

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

Definition


Definition	Status of the examination result as a whole.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodedText
Value Domain	Imaging Examination Result Status Values

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodedText .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	1..1

15.16 Imaging Examination Result Status Values

Identification

Label	Imaging Examination Result Status Values
Metadata Type	Value Domain
Identifier	VD-16501
OID	1.2.36.1.2001.1001.101.104.16501

Definition

Definition	Set of values for the imaging examination result status.
Definition Source	Australian Digital Health Agency
Notes	<p>The <i>HL7 Table 0085 - Observation result status codes interpretation</i> is intended to be used at the result or record level, while the <i>HL7 Table 0123 - Result status</i> is intended to be used for the overall report status.</p> <p>Having to source values from two HL7 tables and determine which one to apply in a situation is a potential cause of confusion. Consequently we provide a value set that is applicable across report level and individual result level status values. The single value set has been assessed to be adequate for the My Health Record-based use cases. This approach reduces the chances of confusion and errors in the use of status values.</p>

Value Domain


Source	NCTIS Imaging Examination Result Status Values	
Permissible Values	1, Registered	No result yet available.
	2, Interim	This is an initial or interim result: data may be missing or verification has not been performed.
	3, Final	The result is complete and verified by the responsible radiologist.
	4, Amended	The result has been modified subsequent to being Final, and is complete and verified by the radiologist.
	5, Cancelled/Aborted	The result is not available because the examination was not started or completed.
	Values sourced by the Agency from <i>HL7 Table 0085 - Observation result status codes interpretation</i> , <i>HL7 Table 0123 - Result status</i> and other sources.	

Usage

Conditions of Use	In situations where <i>NCTIS Imaging Examination Status Values</i> is not available, <i>HL7 v2.x Table 0123 (Result status)</i> [OID:2.16.840.1.113883.12.123] MAY be used.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Imaging Examination Result Status	1..1

15.17 Clinical Information Provided

Identification

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

Definition


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

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..1

15.18 Findings

Identification

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

Definition


Definition	Clinical assessment and opinion based on one or more observations and examinations.
Definition Source	Australian Digital Health Agency
Synonymous Names	Results Observational Findings Results/Observation
Data Type	Text

Usage

Examples	<ol style="list-style-type: none"> 1) Extensive diverticular disease of the sigmoid colon is demonstrated throughout its length. 2) The gallbladder shows a diffuse thickening with fatty infiltration of the gallbladder wall. 3) The heart size is within normal limits.
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..1

15.19 IMAGING EXAMINATION RESULT GROUP

Identification


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

Definition




Definition	Group of structured results.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	Results may be grouped by anatomical location or by some other name or code to describe what binds all the results together.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..*

Children

Data Type	Name	Occurrences
	Imaging Examination Result Group Name	1..1
	Result (INDIVIDUAL IMAGING EXAMINATION RESULT)	1..*
	Anatomical Site (ANATOMICAL LOCATION)	0..1

15.20 Imaging Examination Result Group Name

Identification

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

Definition


Definition	Name of a group of structured results.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ³ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group (IMAGING EXAMINATION RESULT GROUP)	1..1

³ <http://www.hl7.org/oid/index.cfm>

15.21 INDIVIDUAL IMAGING EXAMINATION RESULT

Identification


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

Definition




Definition	Specific detailed result of an imaging examination, including both the value of the result item and additional information that may be useful for clinical interpretation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	Results include whatever specific data items imaging services report as part of the clinical service; it may include measurements. These are often referred to as structured findings.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group (IMAGING EXAMINATION RESULT GROUP)	1..*

Children

Data Type	Name	Occurrences
	Individual Imaging Examination Result Name	1..1
	Result Value (IMAGING EXAMINATION RESULT VALUE)	0..1
	Result Comment	0..*

15.22 Individual Imaging Examination Result Name

Identification

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

Definition


Definition	Name of a specific detailed result.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ⁴ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	<ol style="list-style-type: none"> 1) Cardiac ejection fraction 2) Bone density
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result (INDIVIDUAL IMAGING EXAMINATION RESULT)	1..1

⁴ <http://www.hl7.org/oid/index.cfm>

15.23 IMAGING EXAMINATION RESULT VALUE

Identification


Label	Result Value
Metadata Type	Data Group
Identifier	DG-11023
OID	1.2.36.1.2001.1001.101.102.11023

Definition





Definition	Value of the result, with reference range information.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result (INDIVIDUAL IMAGING EXAMINATION RESULT)	0..1

Children

Data Type	Name	Occurrences
  	Result Value (Imaging Examination Result Value)	1..1
	Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS)	0..1

15.24 Imaging Examination Result Value

Identification

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

Definition


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

Usage

Examples	1) Within the lumbar spine (L2-L4), the bone mineral density = 1.121g/cm2. This value corresponds to a Z score of 0.5 and a T score of -0.6.
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Value (IMAGING EXAMINATION RESULT VALUE)	1..1

15.25 Result Value Values

Identification

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

Definition

Definition	Set of values for <i>Imaging Examination Result Value</i> .
Definition Source	Australian Digital Health Agency
Notes	The choice of appropriate code set depends on the information to be coded.

Value Domain


Source	Australian Digital Health Agency
---------------	----------------------------------

Usage

Conditions of Use	Any code set used SHALL be a registered code set, i.e. registered through the HL7 code set registration procedure with an appropriate object identifier (OID), and SHALL be publicly available.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Value (Imaging Examination Result Value)	1..1

15.26 REFERENCE RANGE DETAILS

Identification


Label	Imaging Examination Result Value Reference Ranges
Metadata Type	Data Group
Identifier	DG-16325
OID	1.2.36.1.2001.1001.101.102.16325

Definition



Definition	Reference ranges applicable to the <i>Imaging Examination Result Value</i> .
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>A reference range is particular to the patient and context, e.g. sex, age, and any other factor that affects ranges.</p> <p>May be used to represent normal, therapeutic, dangerous, critical and other such clinical ranges.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Value (IMAGING EXAMINATION RESULT VALUE)	0..1

Children

Data Type	Name	Occurrences
	Normal Status	0..1
	REFERENCE RANGE	0..*

15.27 Normal Status

Identification

Label	Normal Status
Metadata Type	Data Element
Identifier	DE-11028
OID	1.2.36.1.2001.1001.101.103.11028

Definition


Definition	Indication of the degree of diagnostically significant abnormality of the value, based on available clinical information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Available clinical information includes the reference range.</p> <p>The term “normal” is not statistical normality, but rather what would normally be considered healthy for the individual concerned. As such, this data element represents the health risk for the individual, which is indicated by the observation or measurement and the nature and criticality of that health risk.</p>
Data Type	CodeableText
Value Domain	<p><i>Not specified.</i></p> <p>In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure⁵ with an appropriate object identifier (OID), and SHALL be publicly available.</p> <p>When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.</p>

Usage

Examples	<ol style="list-style-type: none"> 1) Normal 2) Abnormal
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS)	0..1

⁵ <http://www.hl7.org/oid/index.cfm>

15.28 REFERENCE RANGE

Identification

Label	REFERENCE RANGE
Metadata Type	Data Group
Identifier	DG-11024
OID	1.2.36.1.2001.1001.101.102.11024

Definition


Definition	Named range to be associated with any quantity datum.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Usage



Conditions of Use	If this data group occurs more than once, its contents SHOULD include all of the ranges in a single set.
	All reference ranges SHALL come from the one set of reference ranges.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS)	0..*

Children

Data Type	Name	Occurrences
	Reference Range Meaning	1..1
	Reference Range	1..1

15.29 Reference Range Meaning

Identification

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

Definition


Definition	Term whose value indicates the meaning of this range.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ⁶ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	<ol style="list-style-type: none"> 1) Normal 2) Mildly abnormal 3) Moderately abnormal 4) Severely abnormal
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERENCE RANGE	1..1

⁶ <http://www.hl7.org/oid/index.cfm>

15.30 Reference Range

Identification

Label	Reference Range
Metadata Type	Data Element
Identifier	DE-11024
OID	1.2.36.1.2001.1001.101.103.11024

Definition


Definition	Data range for the associated <i>Reference Range Meaning</i> data element.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	QuantityRange

Usage

Examples	<ul style="list-style-type: none"> 1) 4.2-5.9 2) 6.0-6.3 3) 6.4-6.8 4) >= 6.9
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REFERENCE RANGE	1..1

15.31 Result Comment

Identification

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

Definition


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

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result (INDIVIDUAL IMAGING EXAMINATION RESULT)	0..*

15.32 ANATOMICAL LOCATION

Identification

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

Definition


Definition	Details about the individual anatomical location to which these result group examination results refer, where finer-grained representation of <i>Anatomical Location</i> is required.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Usage





Conditions of Use	Each instance of this data group SHALL contain exactly one SPECIFIC LOCATION or exactly one Anatomical Location Description .
	This data group SHALL NOT contain both an instance of SPECIFIC LOCATION and an instance of Anatomical Location Description .
Conditions of Use Source	Australian Digital Health Agency


Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Result Group (IMAGING EXAMINATION RESULT GROUP)	0..1

Children

Data Type	Name	Occurrences
	SPECIFIC LOCATION	0..1
	RELATIVE LOCATION	0..0
	Anatomical Location Description	0..1
	Visual Markings/Orientation	0..0

Data Type	Name	Occurrences
	Anatomical Location Image	0..*

15.33 SPECIFIC LOCATION

Identification


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

Definition





Definition	Specific and identified anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..1

Children

Data Type	Name	Occurrences
	Anatomical Location Name	0..1
	Side	0..1
	Numerical Identifier	0..0
	Anatomical Plane	0..0

15.34 Anatomical Location Name

Identification

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

Definition


Definition	Name of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	Body Structure Foundation Reference Set

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SPECIFIC LOCATION	0..1

15.35 Body Structure Foundation Reference Set

Identification

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

Definition


Definition	Set of values for named anatomical locations.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
 001011001	Anatomical Location Name	1..1

15.36 Side

Identification

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

Definition


Definition	Laterality of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	Laterality
Data Type	CodedText
Value Domain	Laterality Reference Set

Usage

Examples	<ol style="list-style-type: none"> 1) Right 2) Left 3) Bilateral
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SPECIFIC LOCATION	0..1

15.37 Laterality Reference Set

Identification

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

Definition


Definition	Set of values for identifying the laterality of an anatomical location.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
---------------	--------------

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Side	1..1

15.38 Anatomical Location Description

Identification

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

Definition


Definition	Description of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..1

15.39 Anatomical Location Image

Identification

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

Definition


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

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for EncapsulatedData.
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Anatomical Site (ANATOMICAL LOCATION)	0..*

15.40 Examination Result Representation

Identification

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

Definition


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

Usage

Conditions of Use	Multiple formats are allowed but they SHALL be semantically equivalent.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for EncapsulatedData .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..1

15.41 EXAMINATION REQUEST DETAILS

Identification


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

Definition








Definition	Details concerning a single requested examination.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	Usually there is one examination request for each result; however in some circumstances multiple examination requests may be represented using a single <i>Imaging Examination Result</i> .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..*

Children

Data Type	Name	Occurrences
	Requester Order Identifier	0..0
	Examination Requested Name	0..*
	REQUESTER	0..0
	Receiver Order Identifier	0..0
	DICOM Study Identifier	0..1
	Report Identifier	0..1
	IMAGE DETAILS	0..*

15.42 Examination Requested Name

Identification

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

Definition


Definition	Identification of the imaging examination which was requested.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ⁷ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Conditions of Use	This data element SHOULD NOT be used if its value is equal to the value of the <i>Imaging Examination Result Name</i> data element.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodeableText .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXAMINATION REQUEST DETAILS	0..*

⁷ <http://www.hl7.org/oid/index.cfm>

15.43 DICOM Study Identifier

Identification

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

Definition


Definition	Unique identifier of this study allocated by the imaging service.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXAMINATION REQUEST DETAILS	0..1

15.44 Report Identifier

Identification

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

Definition


Definition	Local identifier given to the imaging examination report.
Definition Source	Australian Digital Health Agency
Synonymous Names	Diagnostic Imaging Report Identifier
Assumptions	The value of <i>Report Identifier</i> is intended for machine or computer consumption. It does not need to be used or consumed by the human user, e.g. reporting provider or the recipient of a test report.
Assumptions Source	Australian Digital Health Agency
Notes	This is a unique identifier of a diagnostic imaging procedure (or study) report. A local identifier can be made globally unique by giving it a context. The context may be identified by a globally unique identifier of the system which produces the local identifier.
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXAMINATION REQUEST DETAILS	0..1

15.45 IMAGE DETAILS

Identification


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

Definition







Definition	Images referenced or provided to assist clinical understanding of the examination.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	If the attached image is in DICOM (Digital Imaging and Communications in Medicine) format, all fields below the image should be populated so that the values are available to software that does not process DICOM images.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXAMINATION REQUEST DETAILS	0..*

Children

Data Type	Name	Occurrences
	Image Identifier	0..1
	DICOM Series Identifier	0..1
	Image View Name	0..1
	Subject Position	0..1
	Image DateTime	0..1
	Image	0..1

15.46 Image Identifier

Identification

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

Definition


Definition	Unique identifier of this image allocated by the imaging service.
Definition Source	Australian Digital Health Agency
Synonymous Names	Diagnostic Image Identifier
Context	The <i>Image Identifier</i> value uniquely identifies an image object (DICOM or non-DICOM image). This allows software to easily determine if an image is already present, rather than having to compare a large number of (DICOM/image) tags.
Context Source	Australian Digital Health Agency
Assumptions	It is assumed that the diagnostic imaging information system or Picture Archive and Communicating System (PACS) generates a unique identifier for each diagnostic image produced from the test procedure performed.
Assumptions Source	Australian Digital Health Agency
Notes	This is often the DICOM image instance UID. To ensure global uniqueness, the <i>Image Identifier</i> value may have to be used or associated with the unique "Organisation identifier" value.
Data Type	UniquelyIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelyIdentifier .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGE DETAILS	0..1

15.47 DICOM Series Identifier

Identification

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

Definition


Definition	Unique identifier of this series allocated by the imaging service.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGE DETAILS	0..1

15.48 Image View Name

Identification

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

Definition


Definition	Name of the imaging view.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ⁸ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	1) Lateral 2) Antero-posterior (AP)
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGE DETAILS	0..1

⁸ <http://www.hl7.org/oid/index.cfm>

15.49 Subject Position

Identification

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

Definition


Definition	Description of the subject's position when the imaging examination was performed.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ⁹ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGE DETAILS	0..1

⁹ <http://www.hl7.org/oid/index.cfm>

15.50 Image DateTime

Identification

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

Definition


Definition	Date, and optionally time, the imaging examination was performed.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	DateTime

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for DateTime .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGE DETAILS	0..1

15.51 Image

Identification

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

Definition


Definition	Attached or referenced image of a current view.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	EncapsulatedData

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for EncapsulatedData .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGE DETAILS	0..1

15.52 Observation DateTime

Identification

Label	Observation DateTime
Metadata Type	Data Element
Identifier	DE-15561
OID	1.2.36.1.2001.1001.101.103.15561

Definition

Definition	Date, and optionally time, when an observation is clinically significant to the condition of the subject of the observation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Assumptions	For an observation based on a specimen the clinically significant time will have the same value as the time of collection of the specimen.
Assumptions Source	Australian Digital Health Agency
Notes	<p>Clinical Semantics of Event Time. (Section 8.2.3.3 of <i>EHR Information Model [OEHR2008a]</i>)</p> <p>In most cases, the times recorded in [an <i>Observation DateTime</i> data element] can be thought of as “the times when the observed phenomena were true”. For example, if a pulse of 88bpm is recorded for 12/feb/2005 12:44:00, this is the time at which the heart rate (for which pulse is a surrogate) existed. In such cases, the <i>sample</i> time, and the <i>measuring</i> time are one and the same.</p> <p>However in cases where the time of sampling is different from that of measurement, the semantics are more subtle. There are two cases. The first is where a sample is taken (e.g. a tissue sample in a needle biopsy), and is tested later on, but from the point of view of the test, the time delay makes no difference. This might be because the sample was immediately preserved (e.g. freezing, placed in a sterile ... transport container), or because even if it decays in some way, it makes no difference to the test (e.g. bacteria may die, but this makes no difference to [an] analysis, as long as the biological matter is not physically destroyed).</p> <p>The second situation is when the sample does decay in some way, and the delay is relevant. Most such cases are in pathology tests, where presence of live biological organisms (e.g. anaerobic bacteria) is being measured. The sample time (or ‘collection’ time) must be recorded. Depending on when the test is done, the results may be interpreted differently.</p> <p>The key question is: what is the meaning of the [data element] in these situations? It is tempting to say that [its value is] (as in other cases) just the [time] of the actual act of observation, e.g. microscopy, chromatography etc. However, there are two problems with this. Firstly, and most importantly, all physical samples must be understood as being <i>indirect surrogates for some aspect of the patient state at the time of sampling</i>, which cannot be observed by direct, instantaneous means in the way a pulse can be taken. This means that no matter when the laboratory work is done, the time to which the result applies is the <i>sample</i> time. It is up to the laboratory to take into account time delays and effects of decay of samples in order to provide a test result which correctly indicates the state of the patient at the time of sampling. The common sense of this is clear when one considers the extreme case where the patient is in a coma or dead (possibly for reasons completely unrelated to the problem being tested for) by the time laboratory testing actually occurs; however, the test result indicates the situation at the point in time when the sample was taken, i.e. when the patient was alive. The second reason is that some kinds of testing are themselves lengthy. For example fungal specimens require 4-6 weeks to confirm a</p>


Data Type	<p>negative result; checks will be made on a daily or weekly basis to find positive growth. However, the result data reported by the laboratory (and therefore the structure of the Observation) is not related to the timing of the laboratory testing; it is reported as being the result for the time of collection of the specimen from the patient.</p> <p>The meaning therefore of the [data element] is always the time of sampling. Where delays between sample and measurement times exist and are significant, they are [modelled explicitly].</p> <p>DateTime</p>
------------------	---

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for DateTime .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	1..1

15.53 Imaging Examination Result Instance Identifier

Identification

Label	Imaging Examination Result Instance Identifier
Metadata Type	Data Element
Identifier	DE-16715
OID	1.2.36.1.2001.1001.101.103.16715

Definition


Definition	Globally unique identifier for each instance of an <i>Imaging Examination Result</i> observation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniqueIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniqueIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..1

15.54 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16145
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	1..1

16 Pending Diagnostic Investigation Detailed Clinical Model

This chapter describes a reuse of version 5.2 of the *Requested Service (Action) Detailed Clinical Model*.

See [Requested Service Detailed Clinical Model Specification \[DH2017k\]](#) for more information.

16.1 Purpose

To describe services requested for, or provided to, the subject.

16.2 Use

Use to record a group of one or more services that are to be provided in the future (e.g. referral) or a group of services that have already been provided. All services would have the same value for other data elements such as *Service Category* and *Service Booking Status*.

Use when the initiating provider knows precisely what is required by the service and when the requesting provider has and wishes to exercise the authority (and expertise) to decide exactly what action will be done. For example, an aged care patient might need to have meals on wheels arranged as well as assistance with house cleaning. In this scenario, it would be expected that values would be provided for both *Service Category* and *Service Description*. Other data elements may not be relevant in this scenario, such as *Request Validity Period*.

Use when the initiating provider defers to the expertise of the referred-to provider. This is used when the initiating provider is seeking another provider or organisation to use their own expertise or authority to determine the specific action to take, for example, when referring to an orthopaedic surgeon for management of advanced knee osteoarthritis. The referral requests an assessment by the surgeon and any consequential management that the surgeon determines. The referrer may query whether a total knee replacement is required, but that decision is left to the surgeon. In this scenario, it would be expected that values would only optionally need to be provided for *Service Description*. Other data elements would likely be included in such a request, such as *Request Validity Period*.

Use in relation to services that have already occurred where it can be recorded that an individual is having or has had a number of services. In this scenario, certain data elements may not be necessary, such as some of the details about the original referral that instigated the service (or services). For example, *Request Urgency* and *Request Validity Period*.

16.3 Misuse

Not to be used to specify medication prescriptions.

16.4 REQUESTED SERVICE

Identification

Label	Pending Diagnostic Investigation
Metadata Type	Data Group
Identifier	DG-20158
OID	1.2.36.1.2001.1001.101.102.20158

Definition


Definition	Diagnostic investigation that has been requested for the patient, but has not yet been carried out, or for which the results are not yet available.
Definition Source	Australian Digital Health Agency
Synonymous Names	Arranged Service
Notes	<p>This item does not include the results of diagnostic investigation orders.</p> <p>This item is not be used to record requests for diagnostic investigations recorded in <i>Pathology Test Result</i> or <i>Imaging Examination Result</i>.</p> <p>If the service provision has not been confirmed then recording the service date and provider is optional.</p>

Usage




Misuse	Recording a requested service that is not a diagnostic service.
---------------	---























Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	DIAGNOSTIC INVESTIGATIONS	0..*

Children

Data Type	Name	Occurrences
	Reason for Service	0..1
	Reason for Service Description	0..1
	Service Category	0..0

Data Type	Name	Occurrences
	Service Description	1..1
	Intent of Request	0..0
	Request Urgency	0..0
	Request Urgency Notes	0..0
	DateTime Service Scheduled	0..1
	Service Commencement Window	0..1
	Service Booking Status	1..1
	Service Comment	0..1
	Supplementary Information to Follow	0..0
	Supplementary Information Expected	0..0
	Subject of Care Instruction Description	0..*
	REPORTER	0..0
	SERVICE REQUESTER	0..0
	SERVICE PROVIDER	0..1
	Request Validity Period	0..0
	Request Identifier (Instruction Identifier)	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Requested Service DateTime	1..1
	Requested Service Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

16.5 Reason for Service

Identification

Label	Reason for Service
Metadata Type	Data Element
Identifier	DE-20172
OID	1.2.36.1.2001.1001.101.103.20172

Definition

Definition	Reason for the services being requested or provided.
Definition Source	Australian Digital Health Agency
Synonymous Names	Reason for Requesting Service Service Reason Referral Reason
Context	Used to communicate information about the reason for services; for example, reason for requesting admission if the subject was referred to the organisation, or for requesting services (by the healthcare provider) to be provided to the subject after discharge from the healthcare facility. In a discharge summary, this data component captures information about reasons for requesting services (by the healthcare provider) to be provided to the subject after discharge from the healthcare facility.
Context Source	Australian Digital Health Agency
Data Type	CodeableText
Value Domain	<i>Not specified.</i> In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ¹ with an appropriate object identifier (OID), and SHALL be publicly available. When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.


Usage

Examples	1) To rule out ischaemic heart disease. 2) To rule out organic brain lesions.
-----------------	--

¹ <http://www.hl7.org/oid/index.cfm>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Pending Diagnostic Investigation (REQUESTED SERVICE)	0..1

16.6 Reason for Service Description

Identification

Label	Reason for Service Description
Metadata Type	Data Element
Identifier	DE-17030
OID	1.2.36.1.2001.1001.101.103.17030

Definition


Definition	Narrative about the reason for the services being requested or provided.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	Used to communicate to the referee information about the reasons for the referral, which may include information about the problems or issues experienced by the subject of care as identified by the referrer, clinical presentation, etc.
Context Source	Australian Digital Health Agency
Notes	<p>This data element is used when there is no coded information available in <i>Reason for Service</i>, or to provide additional information that the code cannot provide.</p> <p>In the referral scenario, it complements the structured information contained in the referral specification. The content in this data element may vary from a single line in simple cases to many paragraphs for more complex circumstances.</p>
Data Type	Text

Usage

Examples	<ol style="list-style-type: none"> 1) Thank you for seeing this 14-year-old schoolboy who fell whilst playing football at school yesterday. On examination he has a swollen painful R ankle and cannot bear weight on it today. I suspect he has a fracture of his right tibia and fibula. 2) Thank you for seeing this 43-year-old lady who has had 2 episodes of cholecystitis in the last month. She is currently well. Ultrasound of her abdomen done at the Public Hospital Emergency Department shows she has gall stones. She has private cover and wishes to see you to consider cholecystectomy at the Private Hospital. 3) Thank you for seeing this 88-year-old recently widowed woman. She was previously dependent upon her husband for help around the house for activities such as the heavy cleaning of the house and assistance with driving and shopping. Please arrange assistance for house cleaning and transportation to the local shops once a week.
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Pending Diagnostic Investigation (REQUESTED SERVICE)	0..1

16.7 Service Description

Identification

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

Definition

Definition	Description of the services requested or provided.
Definition Source	Australian Digital Health Agency
Synonymous Names	Service Requested Arranged Service Description
Context	Used to identify clinical services (e.g. diagnostic procedures, clinical procedures and clinical management) and non-clinical services (e.g. community care services).
Context Source	Australian Digital Health Agency
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ² with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.


Usage

Examples	<ol style="list-style-type: none"> 1) Dialysis 2) Adjustment of heart failure/hypertensive medications 3) Adjust INR to therapeutic range 4) Elective orthopaedic surgery for TKR 5) Ultrasound pelvis 6) Full blood count
Exceptional Values	Absent values are PROHIBITED .

² <http://www.hl7.org/oid/index.cfm>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Pending Diagnostic Investigation (REQUESTED SERVICE)	1..1

16.8 DateTime Service Scheduled

Identification

Label	DateTime Service Scheduled
Metadata Type	Data Element
Identifier	DE-16054
OID	1.2.36.1.2001.1001.101.103.16054

Definition


Definition	Date, and optionally time, at which the arranged services are scheduled to be provided.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	This data element is used to record the date, and optionally time, on which the service is actually performed or scheduled to be performed, depending on the value of <i>Service Booking Status</i> data element.
Context Source	Australian Digital Health Agency
Notes	For a request to supply a service, if the service provision has not been confirmed, the service date may be omitted. For supply of a service, this is the date, and optionally time, of completion of supply, and will have the same value as <i>Requested Service DateTime</i> data element.
Data Type	DateTime

Usage

Conditions of Use	This data element SHALL NOT be included if <i>Service Commencement Window</i> is included.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for <i>DateTime</i> .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Pending Diagnostic Investigation (REQUESTED SERVICE)	0..1

16.9 Service Commencement Window

Identification

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

Definition


Definition	Period of time during which it would be ideal for the subject to be seen, in the opinion of the requester.
Definition Source	Australian Digital Health Agency
Synonymous Names	Service Commences
Notes	Specifies the range of time within which the requesting provider is expecting the arranged service to be provided to the subject. It can be used as a means of conveying objective urgency.
Data Type	TimeInterval

Usage

Conditions of Use	This data element SHALL NOT be included if <i>DateTime Service Scheduled</i> is included.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for TimeInterval .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Pending Diagnostic Investigation (REQUESTED SERVICE)	0..1

16.10 Service Booking Status

Identification

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

Definition


Definition	Indication of the status of the requested or provided services.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	Provides the meaning for the date recorded in <i>Requested Service DateTime</i> data element; for example, whether it is the date that the service is first requested, the date that the booking was made, or the date that the service was supplied.
Context Source	Australian Digital Health Agency
Notes	Status value “EVN” would only be used in exceptional circumstances, for example a test has been carried out but the report is still not available.
Data Type	CodedText
Value Domain	Service Booking Status Values

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for CodedText .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Pending Diagnostic Investigation (REQUESTED SERVICE)	1..1

16.11 Service Booking Status Values

Identification

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

Definition


Definition	Set of values that indicate the status of the requested or provided services.
Definition Source	Australian Digital Health Agency

Value Domain

Source	HL7 v3 CDA: Act.moodCode.	
Permissible Values	APT, Appointment	Planned act for specific time and place
	ARQ, Appointment Request	Request for Booking of an Appointment
	EVN, Event	Service actually happens or happened or is ongoing
	RQO, Request	Request or Order for a service

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Service Booking Status	1..1

16.12 Service Comment

Identification

Label	Service Comment
Metadata Type	Data Element
Identifier	DE-17035
OID	1.2.36.1.2001.1001.101.103.17035

Definition


Definition	Additional narrative about the services that is not captured in other fields.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Pending Diagnostic Investigation (REQUESTED SERVICE)	0..1

16.13 Subject of Care Instruction Description

Identification

Label	Subject of Care Instruction Description
Metadata Type	Data Element
Identifier	DE-10146
OID	1.2.36.1.2001.1001.101.103.10146

Definition


Definition	Instructions, advice or information that has been given to the subject from a care provider in relation to the requested services.
Definition Source	Australian Digital Health Agency
Synonymous Names	Patient Instructions
Context	Used in service request scenario only. In the context of referral, the information includes instructions about clinical procedures requested for the subject.
Context Source	Australian Digital Health Agency
Data Type	Text

Usage

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

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Pending Diagnostic Investigation (REQUESTED SERVICE)	0..*

16.14 SERVICE PROVIDER

Identification

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

Definition

Definition	Provider (individual or organisation) to whom the subject of care is being referred.
Definition Source	Australian Digital Health Agency
Synonymous Names	Referred to Provider Referred to Referee
Scope	A service request would normally be sent to an authorised healthcare provider, but could go directly to a carer or to a representative of an organisation to provide services, other than those normally deemed to be healthcare services, such as a Child Protection Agency, Police, etc.
Scope Source	Australian Digital Health Agency
Notes	This does not have to be a person and, in particular, does not have to be a healthcare provider. Types of provider include: <ul style="list-style-type: none"> • a clinician; • human services provider; and • a service at an organisation.

Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [DH2017a]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <p>Obligation and occurrence constraints:</p> <ul style="list-style-type: none"> • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or an ORGANISATION. <p>SERVICE PROVIDER as a PERSON</p> <p>Additional obligation and occurrence constraints when the service provider is a person (PERSON OR ORGANISATION OR DEVICE is instantiated as a PERSON):</p> <ul style="list-style-type: none"> • Participation Period is PROHIBITED. • LOCATION OF PARTICIPATION is PROHIBITED. • Entity Identifier is ESSENTIAL. • Relationship to Subject of Care is PROHIBITED.
--------------------------	---

- EMPLOYMENT DETAIL is **ESSENTIAL**.
- EMPLOYER ORGANISATION is **ESSENTIAL**.
- EMPLOYER ORGANISATION.Entity Identifier is **ESSENTIAL**.
- EMPLOYER ORGANISATION.ELECTRONIC COMMUNICATION DETAIL is **ESSENTIAL**.
- DEMOGRAPHIC DATA is **PROHIBITED**.

Other constraints:

- Participation Type **SHALL** have an implementation-specific value equivalent to "Referee".
- Role **SHOULD** have a value chosen from [1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 \[ABS2009\]](#). However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and is publicly available **MAY** be used.
- The value of ADDRESS.Address Purpose **SHALL** be "B" (Business).
- The value of ELECTRONIC COMMUNICATION DETAIL.Electronic Communication Usage Code **SHALL** be "B" (Business).
- AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.
- PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.

SERVICE PROVIDER as an ORGANISATION

Additional obligation and occurrence constraints when the service provider is an organisation (PERSON OR ORGANISATION OR DEVICE is instantiated as an ORGANISATION):

- Participation Period is **PROHIBITED**.
- LOCATION OF PARTICIPATION is **PROHIBITED**.
- Entity Identifier is **ESSENTIAL**.
- ELECTRONIC COMMUNICATION DETAIL is **ESSENTIAL**.
- ENTITLEMENT is **PROHIBITED**.
- Qualifications is **PROHIBITED**.

Other constraints:

- Participation Type **SHALL** have an implementation-specific value equivalent to "Referee".
- Role **SHOULD** have a value representing the type of Facility e.g. Hospital, Clinic, Community Service Centre, Home care/housekeeping assistance.
- AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.
- PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as an ORGANISATION.


Terms used in obligation and occurrence constraints are explained in [Appendix D, Specification Guide for Use](#).

**Conditions of Use
Source**

Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Pending Diagnostic Investigation (REQUESTED SERVICE)	0..1

16.15 Requested Service DateTime

Identification

Label	Requested Service DateTime
Metadata Type	Data Element
Identifier	DE-16635
OID	1.2.36.1.2001.1001.101.103.16635

Definition


Definition	Period or date (and optionally time) of completion of the <i>Requested Service</i> action.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>The status of the request changes on this date, and optionally time, or at the end of this period.</p> <p>For a service request, this is the date, and optionally time, of the request. There is no point in recording the period during which the request is created.</p> <p>For supply of a service, this is the period during which the service is supplied or the date, and optionally time, of completion of supply of service.</p>
Data Type	DateTime TimeInterval

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for DateTime , and TimeInterval .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Pending Diagnostic Investigation (REQUESTED SERVICE)	1..1

16.16 Requested Service Instance Identifier

Identification

Label	Requested Service Instance Identifier
Metadata Type	Data Element
Identifier	DE-16716
OID	1.2.36.1.2001.1001.101.103.16716

Definition


Definition	Globally unique identifier for each instance of a <i>Requested Service</i> action.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Pending Diagnostic Investigation (REQUESTED SERVICE)	0..1

16.17 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix D, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.20158
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Pending Diagnostic Investigation (REQUESTED SERVICE)	1..1

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17 UML Class Diagrams

The following figures represent the data hierarchy using UML 2.0 class diagrams. The diagrams display data groups, sections, structured documents and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes; data groups, sections and structured documents are displayed as classes; their label names are represented as association role names. Association role names are only displayed if they differ from the associated class name. When a data element has a choice of data types, the data type of the attribute that represents it is an abstract interface class generalised from the individual data types. The diagrams show the data hierarchy excluding the details of participation. The default multiplicity is 1..1.

If a data element's label differs from its name, the label is the attribute name and the name is a stereotype of the attribute. If a data group's or section's label differs from its name, the label is the class name and the name is a stereotype of the class.

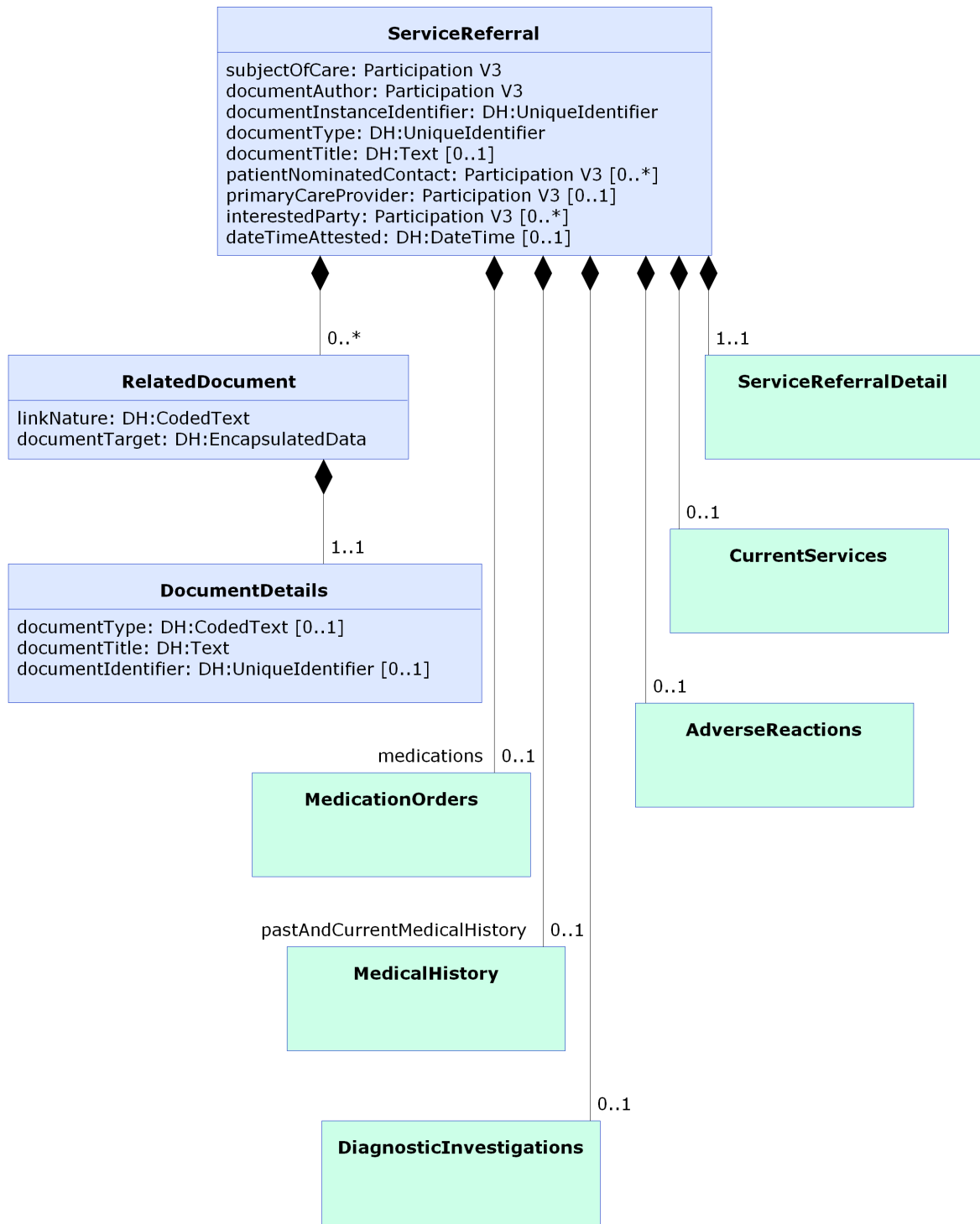


Figure 17.1. Service Referral



Figure 17.2. Service Referral Detail

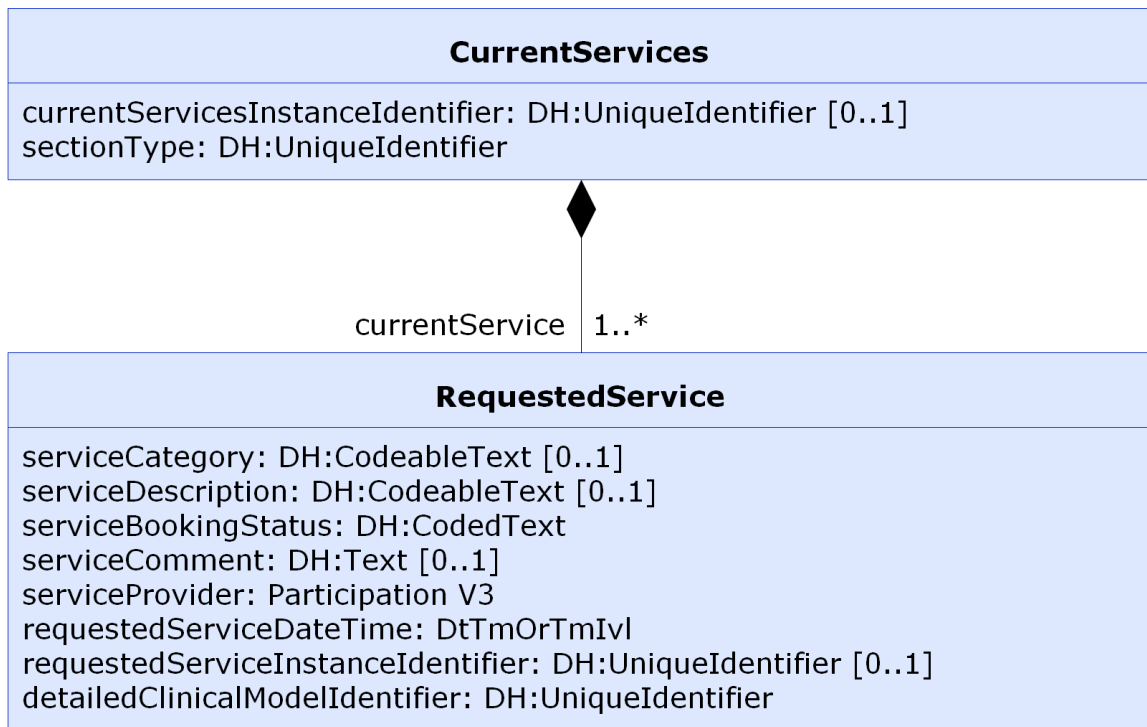


Figure 17.3. Current Services

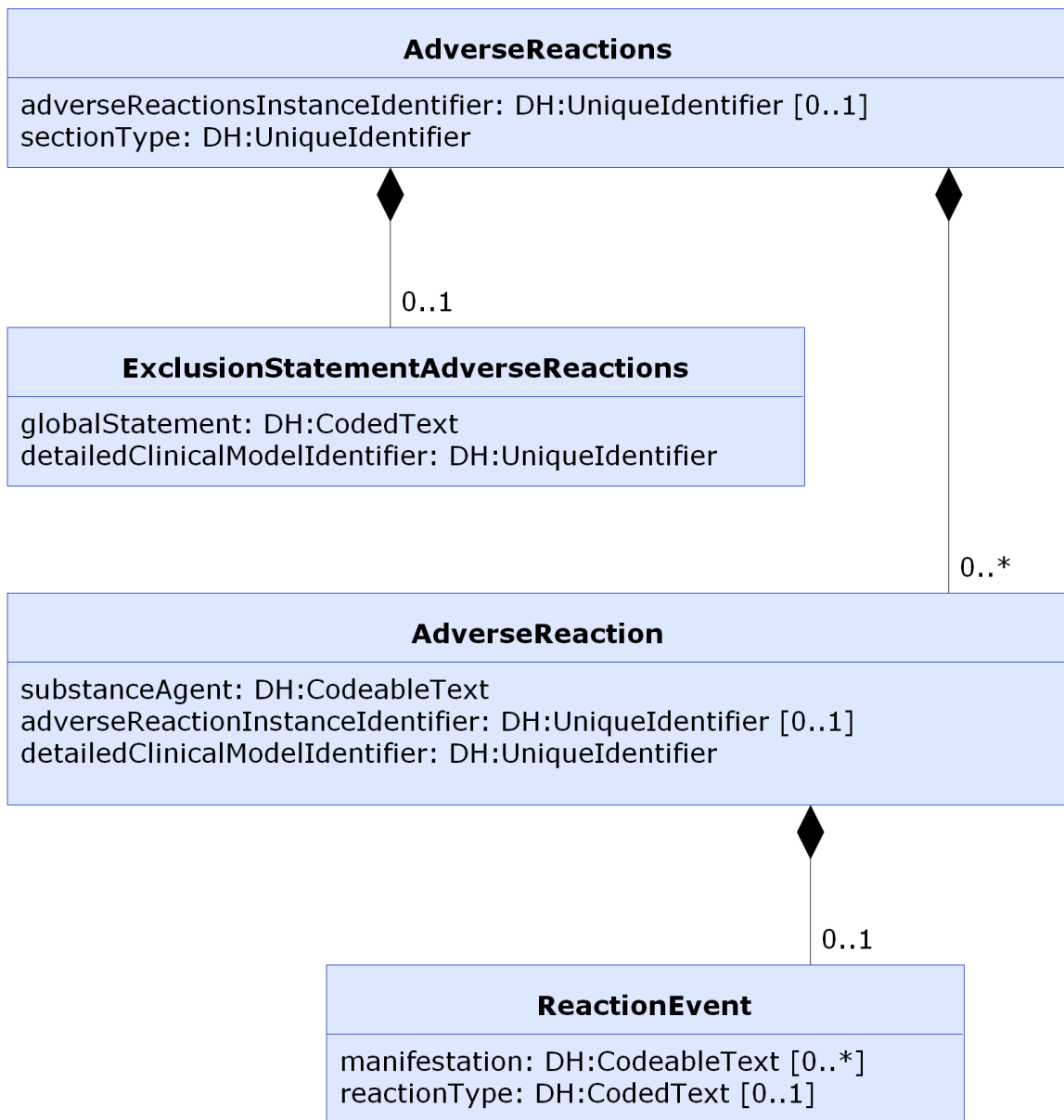


Figure 17.4. Adverse Reactions

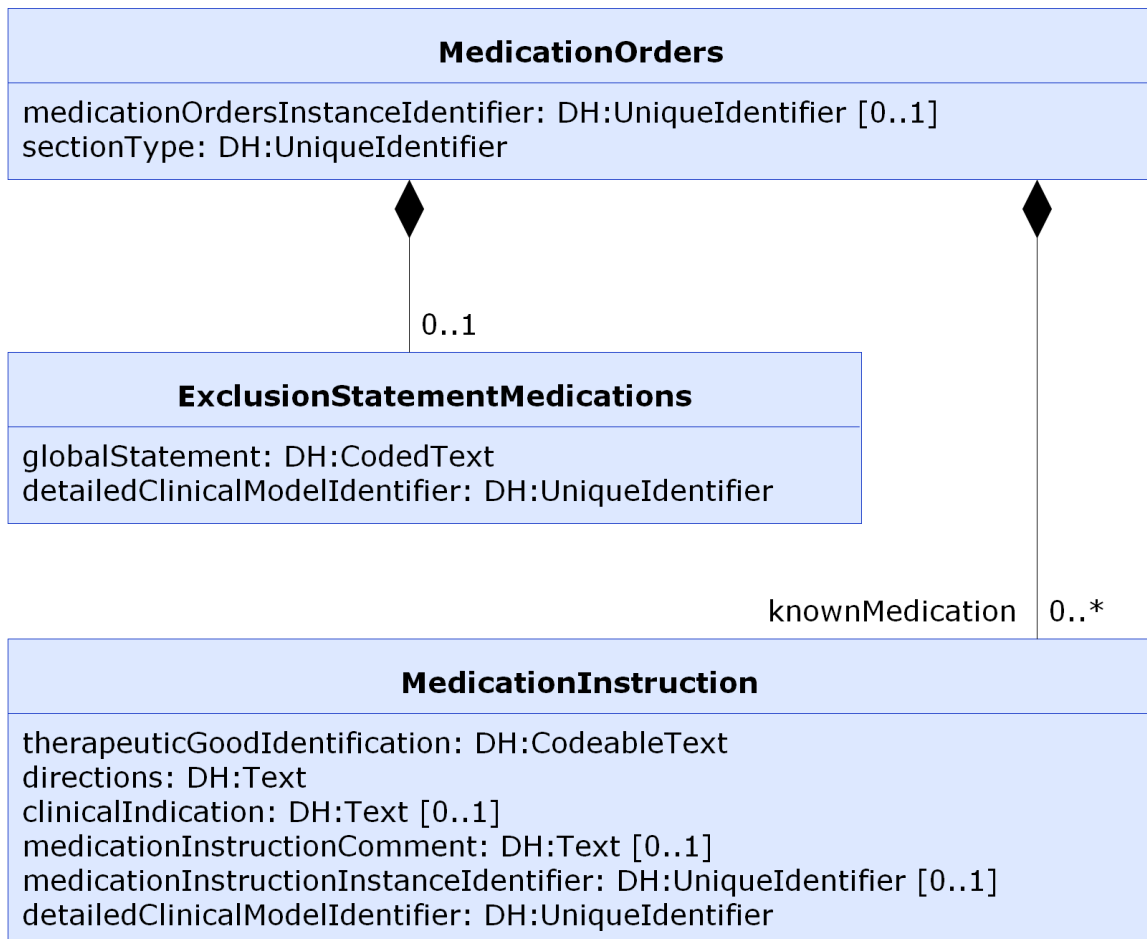


Figure 17.5. Medications

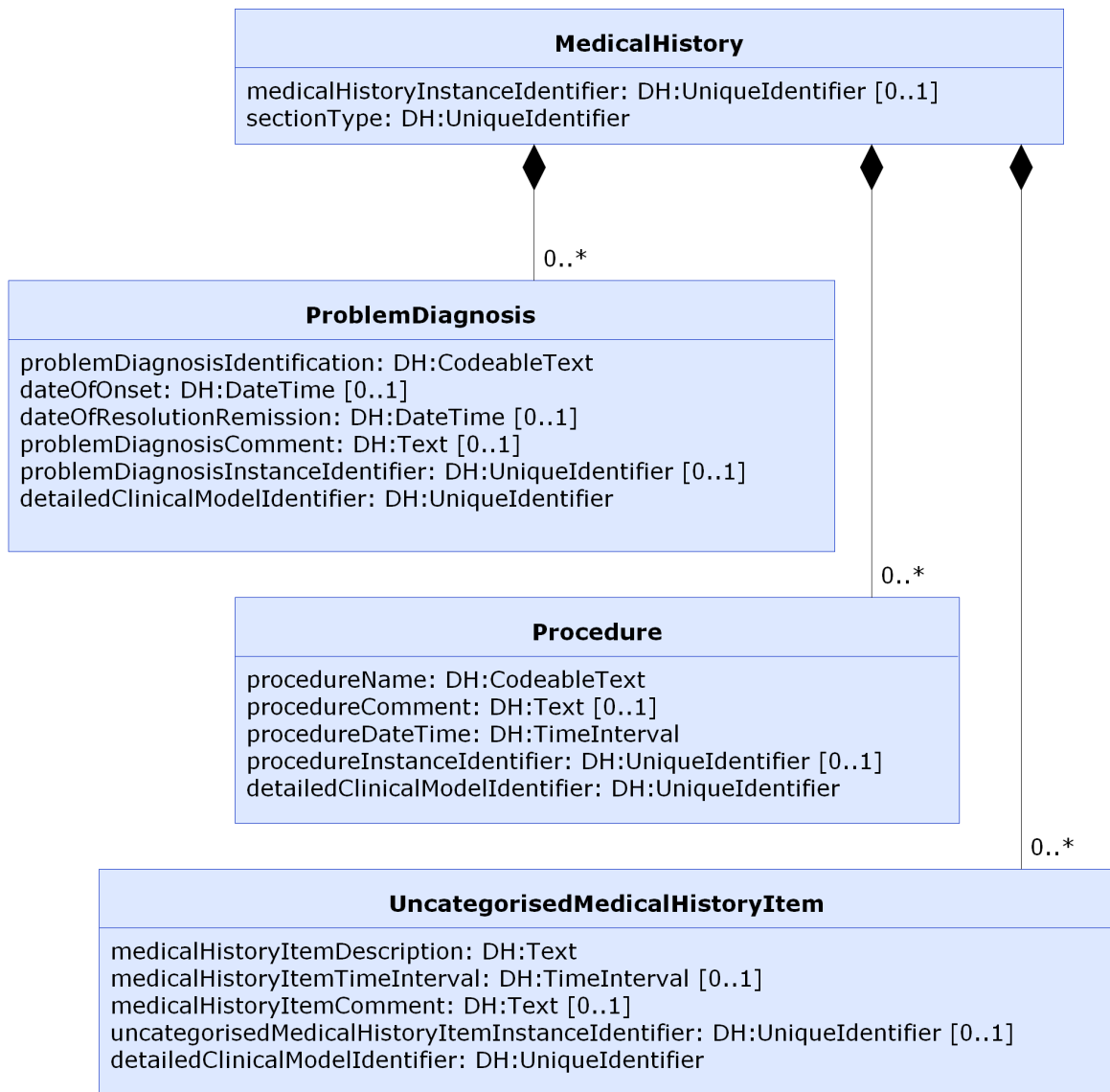


Figure 17.6. Past and Current Medical History

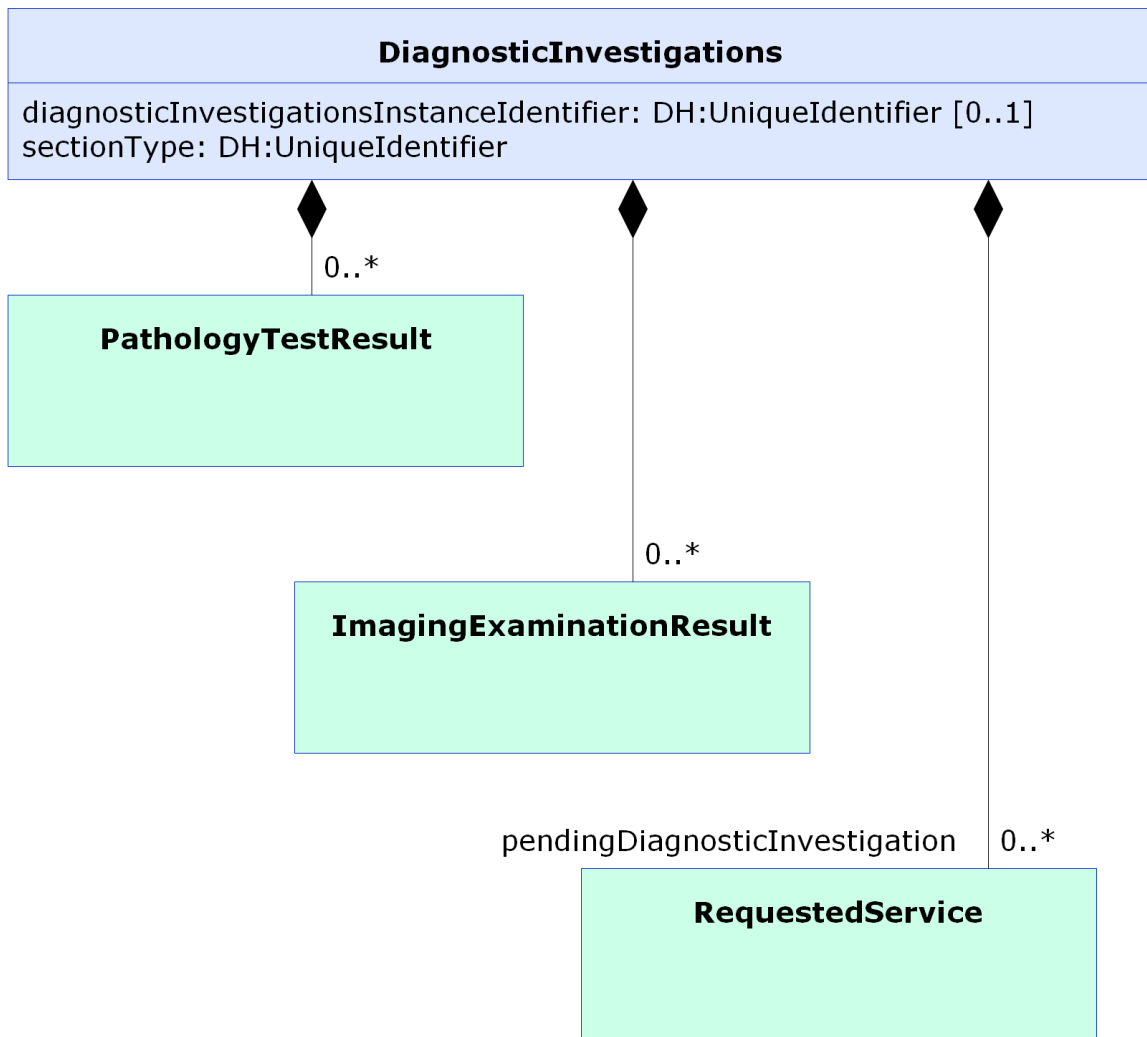


Figure 17.7. Diagnostic Investigations

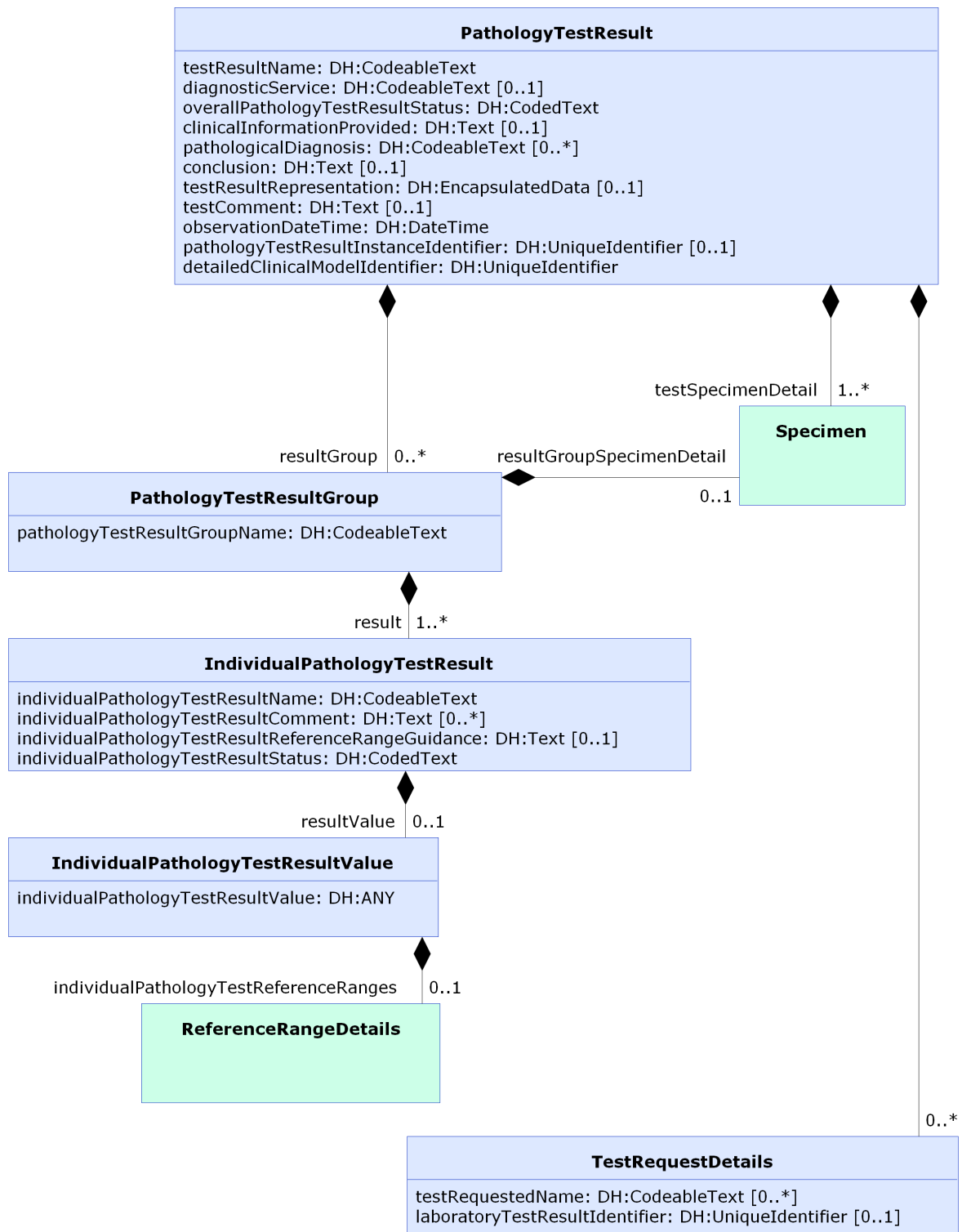


Figure 17.8. Pathology Test Result

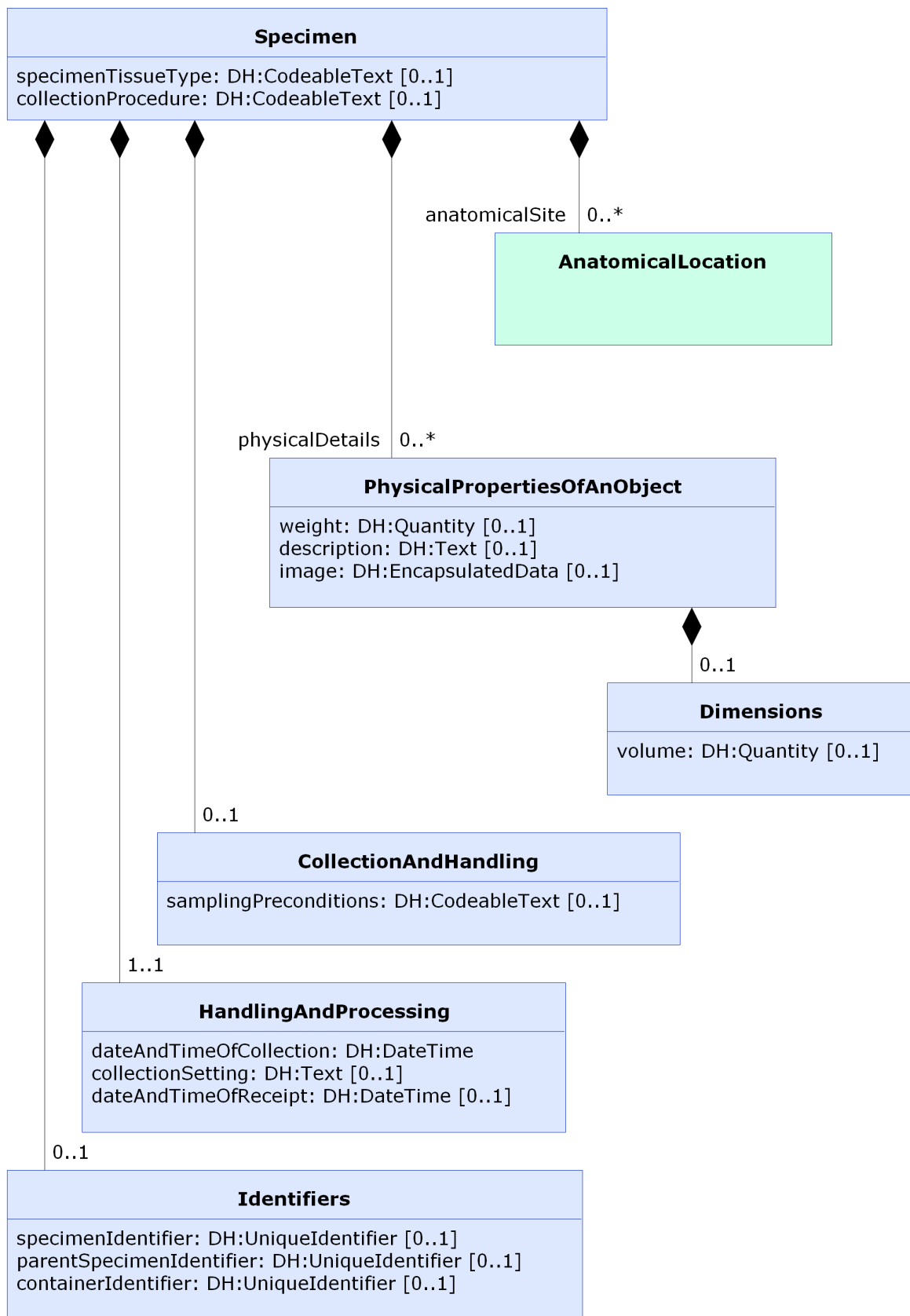


Figure 17.9. Specimen

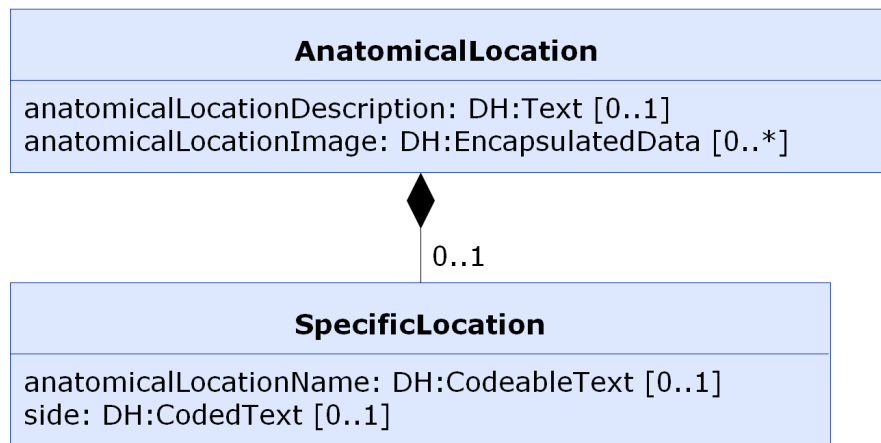
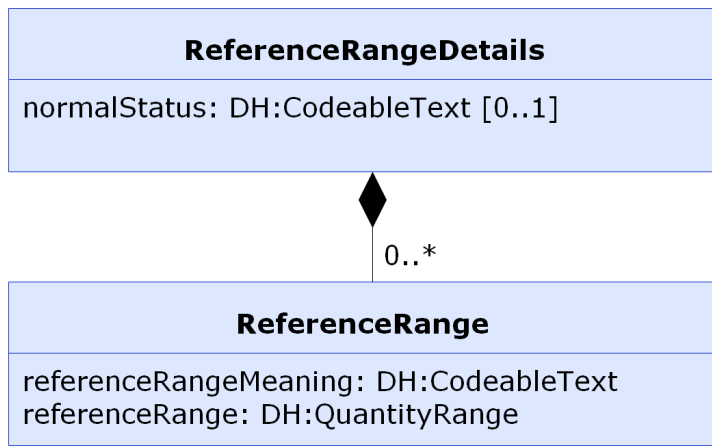


Figure 17.10. Reference Range Details and Anatomical Location

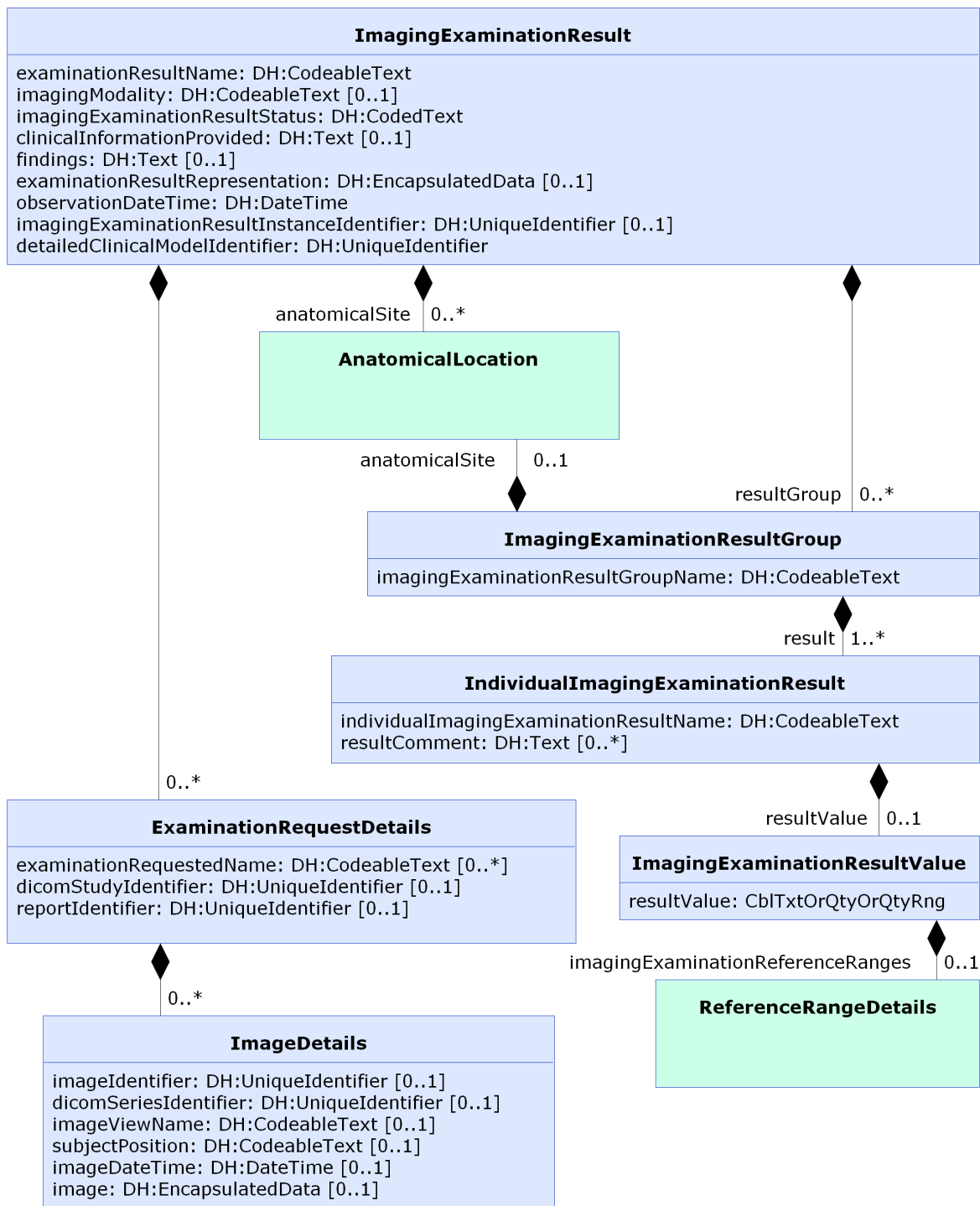


Figure 17.11. Imaging Examination Result

RequestedService
reasonForService: DH:CodeableText [0..1] reasonForServiceDescription: DH:Text [0..1] serviceDescription: DH:CodeableText dateTimeServiceScheduled: DH:DateTime [0..1] serviceCommencementWindow: DH:TimeInterval [0..1] serviceBookingStatus: DH:CodedText serviceComment: DH:Text [0..1] subjectOfCareInstructionDescription: DH:Text [0..*] serviceProvider: Participation V3 [0..1] requestedServiceDateTime: DtTmOrTmIvl requestedServiceInstanceIdentifier: DH:UniqueIdentifier [0..1] detailedClinicalModelIdentifier: DH:UniqueIdentifier

Figure 17.12. Pending Diagnostic Investigation

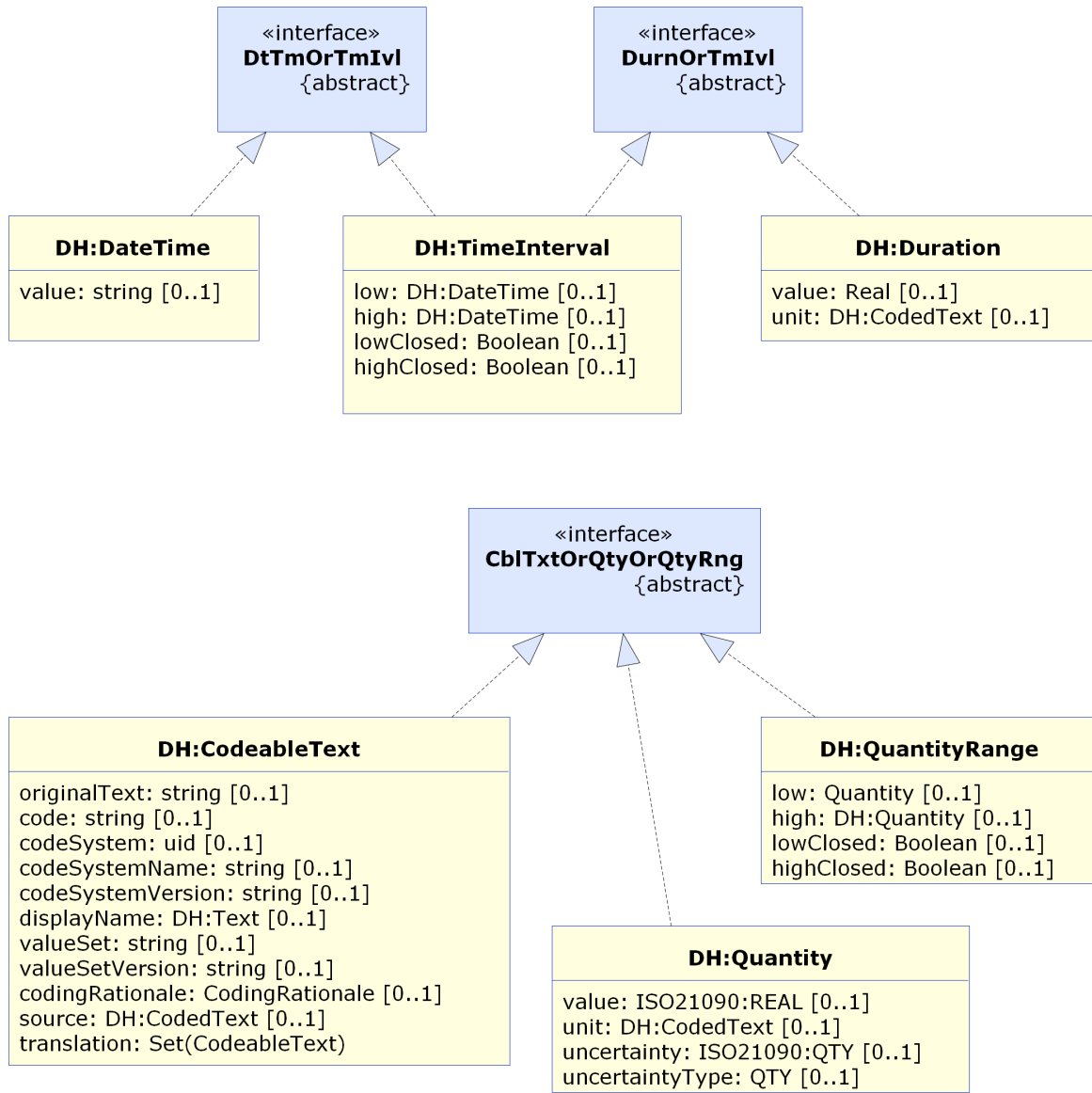


Figure 17.13. Compound Data Types

Appendix A. Mappings from Requirements

This appendix lists data elements from [Service Referral Information Requirements \[DH2018c\]](#) document and matches them to their associated data elements in this structured content specification (SCS) augmented with [Participation Data Specification \[DH2017a\]](#).

Data components are identified by their label, e.g. *Test Specimen Detail*, rather than by their name, e.g. *Specimen*.

The mapping table below includes links to the SCS data elements that are described in this document.

Some cells in the mapping table are empty. This indicates that the cell has the same value as the cell immediately above it.

In rows with N/A in the *Req No.* column, the *SCS Data Component* column contains one or more definitions of relevant abbreviations, e.g. "Subject of Care [SOC]".

In rows with an identifier in the *Req No.* column, the *SCS Data Component* column identifies one or more data components, to which the Requirement is mapped, unless it contains only notes in italics about the mapping.

Requirement Section	Data Item	Req No.	SCS Data Component
Referral detail	N/A	N/A	Service Referral Detail [SRD]
	Service referral detail section (mandatory)	027394	[SRD]
	Service requested (optional)	026867	[SRD] > Requested Service > Service Description [SRD] > Requested Service > Service Category
		026905	
	Referral reason (optional)	027397	[SRD] > Requested Service > Reason for Service [SRD] > Requested Service > Reason for Service Description
	Urgency (optional)	026868	[SRD] > Requested Service > Request Urgency
	Urgency notes (optional)	026869	[SRD] > Requested Service > Request Urgency Notes
	Referral validity duration (optional)	026668	[SRD] > Requested Service > Request Validity Period
	Need for interpreter services (optional)	026928	[SRD] > Interpreter Required Alert > Alert Description
	Preferred language (mandatory)	026850	[SRD] > Interpreter Required Alert > Preferred Language
		026930	
		027102	
	Date and time attested (optional)	027437	DateTime Attested
	Request Date and time (mandatory)	027463	Document Author > Participation Period
Current services	N/A	N/A	Current Services [CS]
	Current services section (optional)	026903	[CS]

Requirement Section	Data Item	Req No.	SCS Data Component
	Current service agency name (mandatory)	026884	[CS] > Current Service > Service Provider > Participant > Person or Organisation or Device > Person > Person Name
	Current service, service type (mandatory)	026882	[CS] > Current Service > Service Category [CS] > Current Service > Service Description
		026934	
	Current service comment (optional)	026888	[CS] > Current Service > Service Comment
Individual	N/A	N/A	Subject of Care [SOC] [SOC] > Participant > Person or Organisation or Device > Person [SOC > P > POD > P]
	Individual section (mandatory)	026788	[SOC]
	Individual identifier (mandatory)	027133	[SOC] > Participant > Entity Identifier
	Individual identifier Issuer (mandatory)	027136	
	Individual's title (optional)	022081	[SOC > P > POD > P] > Person Name > Name Title
	Individual's given name (optional)	023056	[SOC > P > POD > P] > Person Name > Given Name
	Individual's family name (mandatory)	023058	[SOC > P > POD > P] > Person Name > Family Name
	Individual's name suffix (optional)	023059	[SOC > P > POD > P] > Person Name > Name Suffix
	Individual's preferred name(s) (optional)	026840	[SOC > P > POD > P] > Person Name > Preferred Name Indicator
	Individual's sex (mandatory)	024032	[SOC > P > POD > P] > Demographic Data > Sex
		027859	
	Individual's date of birth (mandatory)	023060	[SOC > P > POD > P] > Demographic Data > Date of Birth Detail > Date of Birth
	Date of birth accuracy indicator (optional)	024026	[SOC > P > POD > P] > Demographic Data > Date of Birth Detail > Date of Birth Accuracy Indicator
		027005	
	Individual's address (mandatory)	024041	[SOC] > Participant > Address
		026640	
	Individual's postal address (optional)	026841	[SOC] > Participant > Address
	Individual's electronic communication details (optional)	024042	[SOC] > Participant > Electronic Communication Detail

Requirement Section	Data Item	Req No.	SCS Data Component
	Indigenous status (mandatory)	024033	[SOC > P > POD > P] > Demographic Data > Indigenous Status
	Individual's country of birth (optional)	026847	[SOC > P > POD > P] > Demographic Data > Country of Birth
		026927	
Entitlements	N/A	N/A	[SOC] > Participant > Entitlement
	Entitlement data (optional)	026802	
	Entitlement Type (mandatory)	026781	[SOC] > Participant > Entitlement > Entitlement Type
	Entitlement Number (mandatory)	026782	[SOC] > Participant > Entitlement > Entitlement Number
	Entitlement validity duration (optional)	026783	[SOC] > Participant > Entitlement > Entitlement Validity Duration
Nominated contacts	N/A	N/A	Patient Nominated Contact [PNC]
	Nominated contacts section (optional)	026789	[PNC]
	Nominated contact - person or organisation (mandatory)	026828	[PNC] > Participant > Person or Organisation or Device [PNC > P > POD]
Nominated contact - person	N/A	N/A	[PNC > P > POD] > Person [PNC > P > POD > P]
	Individual's title (optional)	022081	[PNC > P > POD > P] > Person Name > Name Title
	Individual's given name (optional)	023056	[PNC > P > POD > P] > Person Name > Given Name
	Individual's family name (mandatory)	023058	[PNC > P > POD > P] > Person Name > Family Name
	Individual's name suffix (optional)	023059	[PNC > P > POD > P] > Person Name > Name Suffix
	Relationship to individual (optional)	026773	[PNC > P > POD > P] > Relationship to Subject of Care
	Nominated contact's means of contacting (mandatory)	026803	[PNC] > Participant
	Nominated contact address (optional)	026774	[PNC] > Participant > Address
	Nominated contact electronic communication details (optional)	026775	[PNC] > Participant > Electronic Communication Detail
	Nominated contact role (optional)	026784	[PNC] > Role
	Nominated contact person identifier (mandatory)	026785	[PNC] > Participant

Requirement Section	Data Item	Req No.	SCS Data Component
	Organisation name (optional)	027155	[PNC > P > POD > P] > Employment Detail > Employer Organisation > Person or Organisation or Device > Organisation > Organisation Name
Nominated contact - organisation	N/A	N/A	[PNC > P > POD] > Organisation [PNC > P > POD > O]
	Organisation name (mandatory)	026776	[PNC > P > POD > O] > Organisation Name
	Organisation department / unit (optional)	026777	[PNC > P > POD > O] > Department/Unit
	Organisation identifier (optional)	026778	[PNC] > Participant > Entity Identifier
	Nominated contact address (optional)	026774	[PNC] > Participant > Address
	Nominated contact electronic communication details (optional)	026775	[PNC] > Participant > Electronic Communication Detail
	Nominated contact's means of contacting (mandatory)	026803	[PNC] > Participant
Document author	N/A	N/A	Document Author [DA] [DA] > Participant > Person or Organisation or Device > Person [DA > P > POD > P]
	Document author section (mandatory)	026790	[DA]
	Healthcare provider identifier (mandatory)	027110	[DA] > Participant > Entity Identifier
	Healthcare provider identifier issuer (mandatory)	027141	
	Healthcare organisation identifier (mandatory)	027111	[DA > P > POD > P] > Employment Detail > Employer Organisation > Entity Identifier
	Healthcare organisation identifier issuer (mandatory)	027144	
	Healthcare provider's title (optional)	023061	[DA > P > POD > P] > Person Name > Name Title
	Healthcare provider given name (optional)	023062	[DA > P > POD > P] > Person Name > Given Name

Requirement Section	Data Item	Req No.	SCS Data Component
	Healthcare provider family name (mandatory)	023064	[DA > P > POD > P] > Person Name > Family Name
	Healthcare provider name suffix (optional)	023065	[DA > P > POD > P] > Person Name > Name Suffix
	Healthcare provider organisation name (mandatory)	023070	[DA > P > POD > P] > Employment Detail > Employer Organisation > Person or Organisation or Device > Organisation > Organisation Name
	Healthcare provider individual's workplace address (optional)	024035	[DA] > Participant > Address
	Healthcare provider individual's workplace electronic communication details (optional)	024036	[DA] > Participant > Electronic Communication Details
	Healthcare provider employer organisation electronic communication detail (mandatory)	026805	[DA > P > POD > P] > Employment Detail > Employer Organisation > Electronic Communication Details
	Healthcare provider professional role (mandatory)	024040	[DA] > Role
	Healthcare organisation address (optional)	026799	[DA > P > POD > P] > Employment Detail > Employer Organisation > Address
Primary care provider	N/A	N/A	Primary Care Provider [PCP] [PCP] > Participant > Person or Organisation or Device [PCP > P > POD]
	Primary care provider section (optional)	026792	[PCP]
		026829	[PCP > P > POD]
Primary care provider - person	N/A	N/A	[PCP > P > POD] > Person [PCP > P > POD > P]
	Healthcare provider identifier (mandatory)	027110	[PCP] > Participant > Entity Identifier
	Healthcare provider identifier issuer (mandatory)	027141	
	Healthcare organisation identifier (mandatory)	027111	[PCP > P > POD > P] > Employment Detail > Employer Organisation > Entity Identifier

Requirement Section	Data Item	Req No.	SCS Data Component
	Healthcare organisation identifier issuer (mandatory)	027144	
	Healthcare provider's title (optional)	023061	[PCP > P > POD > P] > Person Name > Name Title
	Healthcare provider given name (optional)	023062	[PCP > P > POD > P] > Person Name > Given Name
	Healthcare provider family name (mandatory)	023064	[PCP > P > POD > P] > Person Name > Family Name
	Healthcare provider name suffix (optional)	023065	[PCP > P > POD > P] > Person Name > Name Suffix
	Healthcare provider organisation name (mandatory)	023070	[PCP > P > POD > P] > Employment Detail > Employer Organisation > Person or Organisation or Device > Organisation > Organisation Name
	Healthcare provider individual's workplace address (optional)	024035	[PCP] > Participant > Address
	Healthcare provider individual's workplace electronic communication details (optional)	024036	[PCP] > Participant > Electronic Communication Details
	Healthcare provider professional role (mandatory)	024040	[PCP] > Role
	Healthcare organisation address (optional)	026799	[PCP > P > POD > P] > Employment Detail > Employer Organisation > Address
	Healthcare organisation electronic communication details (optional)	026798	[PCP > P > POD > P] > Employment Detail > Employer Organisation > Electronic Communication Details
Primary care provider - organisation	N/A	N/A	[PCP > P > POD] > Organisation [PCP > P > POD > O]
	Organisation name (mandatory)	026776	[PCP > P > POD > O] > Organisation Name
	Healthcare organisation identifier (mandatory)	027111	[PCP] > Participant > Entity Identifier

Requirement Section	Data Item	Req No.	SCS Data Component
	Healthcare organisation identifier issuer (mandatory)	027144	
	Healthcare organisation address (optional)	026799	[PNC] > Participant > Address
	Healthcare organisation electronic communication details (optional)	026798	[PNC] > Participant > Electronic Communication Details
Referral receiver	N/A	N/A	[SRD] > Requested Service > Service Provider [SRD > RS > SP] [SRD > RS > SP] > Participant > Person or Organisation or Device [SRD > RS > SP > P > POD]
	Referral receiver section (optional)	028076	[SRD > RS > SP]
		028077	[SRD > RS > SP > P > POD]
Referral receiver - person	N/A	N/A	[SRD > RS > SP > P > POD] > Person [SRD > RS > SP > P > POD > P]
	Healthcare provider identifier (mandatory)	027110	[SRD > RS > SP > P > POD > P] > Participant > Entity Identifier
	Healthcare provider identifier issuer (mandatory)	027141	
	Healthcare organisation identifier (mandatory)	027111	[SRD > RS > SP > P > POD > P] > Employment Detail > Employer Organisation > Entity Identifier
	Healthcare organisation identifier issuer (mandatory)	027144	
	Healthcare provider's title (optional)	023061	[SRD > RS > SP > P > POD > P] > Person Name > Name Title
	Healthcare provider given name (optional)	023062	[SRD > RS > SP > P > POD > P] > Person Name > Given Title
	Healthcare provider family name (mandatory)	023064	[SRD > RS > SP > P > POD > P] > Person Name > Family Name
	Healthcare provider name suffix (optional)	023065	[SRD > RS > SP > P > POD > P] > Person Name > Name Suffix
	Healthcare provider organisation name (mandatory)	023070	[SRD > RS > SP > P > POD > P] > Employment Detail > Employer Organisation > Person or Organisation or Device > Organisation > Organisation Name

Requirement Section	Data Item	Req No.	SCS Data Component
	Healthcare provider individual's workplace address (optional)	024035	[SRD > RS > SP] > Participant > Address
	Healthcare provider individual's workplace electronic communication details (optional)	024036	[SRD > RS > SP] > Participant > Electronic Communication Details
	Healthcare provider employer organisation electronic communication detail (mandatory)	026805	[SRD > RS > SP > P > POD > P] > Employment Detail > Employer Organisation > Electronic Communication Details
	Healthcare organisation address (optional)	026799	[SRD > RS > SP > P > POD > P] > Employment Detail > Employer Organisation > Address
	Healthcare provider professional role (mandatory)	024040	[SRD > RS > SP] > Role
Referral receiver - organisation	N/A	N/A	[SRD > RS > SP > P > POD] > Organisation [SRD > RS > SP > P > POD > O]
	Organisation name (mandatory)	026776	[SRD > RS > SP > P > POD > O] > Organisation Name
	Organisation department / unit (optional)	026777	[SRD > RS > SP > P > POD > O] > Department/Unit
	Healthcare organisation identifier (mandatory)	027111	[SRD > RS > SP] > Participant > Entity Identifier
	Healthcare organisation identifier issuer (mandatory)	027144	
	Healthcare organisation address (optional)	026799	[SRD > RS > SP] > Participant > Address
	Healthcare organisation electronic communication details (mandatory)	026800	[SRD > RS > SP] > Participant > Electronic Communication Detail
Interested parties to receive correspondence	N/A	N/A	Interested Party [IP] [IP] > Participant > Person or Organisation or Device [IP > P > POD]
	Interested parties section (optional)	027103	[IP]

Requirement Section	Data Item	Req No.	SCS Data Component
	Interested parties - person or organisation (mandatory)	027104	[IP > P > POD]
Interested parties - person	N/A	N/A	[IP > P > POD] > Person [IP > P > POD > P]
	Healthcare provider identifier (mandatory)	027110	[IP] > Participant > Entity Identifier
	Healthcare provider identifier issuer (mandatory)	027141	
	Healthcare organisation identifier (mandatory)	027111	[IP > P > POD > P] > Employment Detail > Employer Organisation > Entity Identifier
	Healthcare organisation identifier issuer (mandatory)	027144	
	Healthcare provider's title (optional)	023061	[IP > P > POD > P] > Person Name > Name Title
	Healthcare provider given name (optional)	023062	[IP > P > POD > P] > Person Name > Given Name
	Healthcare provider family name (mandatory)	023064	[IP > P > POD > P] > Person Name > Family Name
	Healthcare provider name suffix (optional)	023065	[IP > P > POD > P] > Person Name > Name Suffix
	Healthcare provider organisation name (mandatory)	023070	[IP > P > POD > P] > Employment Detail > Employer Organisation > Person or Organisation or Device > Organisation > Organisation Name
	Healthcare provider individual's workplace address (optional)	024035	[IP] > Participant > Address
	Healthcare provider individual's workplace electronic communication details (optional)	024036	[IP] > Participant > Electronic Communication Details
	Healthcare provider employer organisation electronic communication detail (mandatory)	026805	[IP > P > POD > P] > Employment Detail > Employer Organisation > Electronic Communication Details

Requirement Section	Data Item	Req No.	SCS Data Component
	Healthcare organisation address (optional)	026799	[IP > P > POD > P] > Employment Detail > Employer Organisation > Address
	Healthcare provider professional role (mandatory)	024040	[IP] > Role
Interested parties - organisation	N/A	N/A	[IP > P > POD] > Organisation [IP > P > POD > O]
	Organisation name (mandatory)	026776	[IP > P > POD > O] > Organisation Name
	Healthcare organisation identifier (mandatory)	027111	[IP] > Participant > Entity Identifier
	Healthcare organisation identifier issuer (mandatory)	027144	
	Healthcare organisation address (optional)	026799	[IP] > Participant > Address
	Healthcare organisation electronic communication details (mandatory)	026800	[IP] > Participant > Electronic Communication Details
Alerts	N/A	N/A	Other Alerts [OA]
	Alert section (optional)	027114	[OA]
	Alert type (mandatory)	027115	[OA] > Alert Type
	Alert description (mandatory)	027116	[OA] > Alert Description
Current and past medical history	N/A	N/A	Past and Current Medical History [PCMH]
	Medical History section (optional)	027402	[PCMH]
Problems/Diagnoses	N/A	N/A	
	Problem/Diagnosis (optional)	026823	[PCMH] > Problem/Diagnosis [PCMH > PD]
	Problem/Diagnosis description (mandatory)	026818	[PCMH > PD] > Problem/Diagnosis Identification
		026820	
	Date of onset (optional)	026609	[PCMH > PD] > Date of Onset
	Date of resolution/remission (optional)	026610	[PCMH > PD] > Date of Resolution/Remission

Requirement Section	Data Item	Req No.	SCS Data Component
	Problem/Diagnosis comment (optional)	026669	[PCMH > PD] > Problem/Diagnosis Comment
Procedure	N/A	N/A	[PCMH] > Procedure [PCMH > P]
	Procedure (optional)	026821	
	Procedure name (mandatory)	026822	[PCMH > P] > Procedure Name
		026824	
	Date and time started (optional)	026672	[PCMH > P] > Procedure DateTime
	Procedure comment (optional)	026671	[PCMH > P] > Procedure Comment
Current medications	N/A	N/A	Medications [M]
	Current medication section (optional)	027403	[M]
Exclusion statement	N/A	N/A	[M] > Exclusion Statement - Medications [M > ESM]
	Exclusion statement - medications (mandatory)	027431	[M > ESM]
		027432	
Medications	N/A	N/A	[M] > Known Medication [M > KM]
	Therapeutic good identification (mandatory)	025175	[M > KM] > Therapeutic Good Identification
		027901	
	Medication directions (mandatory)	027416	[M > KM] > Directions
	Reason for therapeutic good/clinical indication (optional)	026588	[M > KM] > Clinical Indication
	Additional comments/medication instruction comment (optional)	026589	[M > KM] > Medication Instruction Comment
Adverse reactions	N/A	N/A	Adverse Reactions [AR]
	Adverse reactions section (optional)	026780	[AR]
Exclusion statement	N/A	N/A	[AR] > Exclusion Statement - Adverse Reactions [AR > ESAR]
	Exclusion statement - adverse reactions (mandatory)	027433	[AR > ESAR]
		027434	
Adverse reactions	N/A	N/A	[AR] > Adverse Reaction [AR > AR]

Requirement Section	Data Item	Req No.	SCS Data Component
	Substance/agent (mandatory)	026594	[AR > AR] > Substance/Agent
		026584	
	Reaction Description/Manifestation (optional)	026607	[AR > AR] > Reaction Event > Manifestation
		026565	
	Adverse reaction type (optional)	026595	[AR > AR] > Reaction Event > Reaction Type
		026593	
Diagnostic investigations	N/A	N/A	DIAGNOSTIC INVESTIGATIONS [DI] [DI] > PATHOLOGY TEST RESULT [DI > PTR] [DI] > IMAGING EXAMINATION RESULT [DI > IER] [DI] > Pending Diagnostic Investigation [DI > PDI]
	Diagnostic investigations section (optional)	026813	
	Investigation type (mandatory)	026814	Derived from type of data group = PATHOLOGY TEST RESULT or type of data group = IMAGING EXAMINATION RESULT or value of Pending Diagnostic Investigation > Service Description
	Investigation name (mandatory)	026815	Derived from type of data group = PATHOLOGY TEST RESULT or type of data group = IMAGING EXAMINATION RESULT or value of Pending Diagnostic Investigation > Service Description
	Result status (mandatory)	026816	[DI > PTR] > Overall Pathology Test Result Status [DI > IER] > Imaging Examination Result Status [DI > PDI] > Service Booking Status
	Result content (optional)	026817	[DI > PTR] > Test Result Representation
Attachments	N/A	N/A	Related Document [RD]
	Attachments section (optional)	027007	[RD]
	Attachment name (mandatory)	027008	[RD] > Document Details > Document Title
	Attachment document type (optional)	027435	[RD] > Document Details > Document Type
	Attachment identifier (optional)	027436	[RD] > Document Details > Document Identifier
Document control	N/A	N/A	<i>This is described in the CDA Implementation Guide</i>
	Document instance identifier (mandatory)	023067	Document Instance Identifier
	Document version number (mandatory)	023068	<i>This is managed in the implementation level (e.g. HL7 CDA.)</i>

Requirement Section	Data Item	Req No.	SCS Data Component
	Date and time of document creation (mandatory)	024025	<i>This is managed in the implementation level (e.g. HL7 CDA.)</i>
	Document type (mandatory)	024027	Document Type

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Appendix B. Known Issues

This appendix lists known issues with this specification at the time of publishing. We are working on solutions to these issues and encourage comments to help us develop these solutions.

Reference	Description
Links to external resources	Certain combinations of web browsers and PDF readers have problems opening URL links (usually found in reference sections) that span more than one line.
Interested Party - Person - identifiers	<p>The information requirements document mandates the inclusion of healthcare provider identifier and healthcare organisation identifier for a person who is an interested party to receive correspondence. The SCS model has them as optional.</p> <p>This requirement is best enforced in a conformance profile.</p>
Primary Care Provider - Person - identifiers	<p>The information requirements document mandates the inclusion of healthcare provider identifier and healthcare organisation identifier for a person who is a primary care provider. The SCS model has them as optional.</p> <p>This requirement is best enforced in a conformance profile.</p>
UML Class Diagram	The representation of data component names and labels with stereotypes and names is not good UML practice. It will be changed when a diagramming tool that supports an appropriate representation is adopted by the Agency.
Workplace address	Some requirements specify that provider addresses shall be workplace addresses. This SCS prohibits giving an address purpose of "Postal" in line with the information requirements. It has been suggested that the constraint should be to prohibit home addresses rather than to mandate business addresses.
Requested Service DateTime	<i>Requested Service DateTime</i> is mandatory in the DCM and therefore included in the <i>SERVICE REFERRAL DETAIL > Requested Service</i> and <i>Current Service</i> . There are no information requirements for such a date time nor is it expected that this content will always be available in the source system. This can be handled by using absent values.
Reference Range	This element is of data type <i>QuantityRange</i> . It is possible that the data type should be widened to allow a wider choice of data types.
Undefined Value Domains	<p>The following data elements lack a defined value domain: <i>Document Type</i>, <i>Reason for Service</i>, <i>Service Category</i>, <i>Service Description</i>, <i>Alert Description</i>, <i>Preferred Language</i>, <i>Alert Type</i>, <i>Specimen Tissue Type</i>, <i>Collection Procedure</i>, <i>Sampling Preconditions</i>, <i>Normal Status</i>, <i>Reference Range Meaning</i>, <i>Pathological Diagnosis</i>, <i>Imaging Examination Result Name</i>, <i>Imaging Modality</i>, <i>Imaging Examination Result Group Name</i>, <i>Individual Imaging Examination Result Name</i>, <i>Normal Status</i>, <i>Examination Requested Name</i>, <i>Image View Name</i>, and <i>Subject Position</i>.</p> <p>The Agency is in the process of developing national code sets for these items. In the meantime, you are free to use your own code set(s), providing any code set used SHALL be registered, i.e. registered through the HL7 code set registration procedure with an appropriate object identifier (OID), and SHALL be publicly available. Note that when national standard code set(s) do become available, they SHALL be used and the non-standard code sets SHALL be deprecated.</p>
Exclusion Statement detailed clinical models	<p>The Exclusion Statement detailed clinical models (DCMs):</p> <p><i>Exclusion Statement - Adverse Reactions</i> and <i>Exclusion Statement - Medications</i> are the subject of ongoing development and review. They will change in the future.</p> <p>This includes the values of <i>Global Statement Values</i>.</p>
Date of Onset and Date of Resolution/Remission	It is possible that <i>Date of Onset</i> and <i>Date of Resolution/Remission</i> should be considered as the start and end of a period. Resolution depends on whether a recurrent problem should be recorded as a single Problem/Diagnosis, or as a series of them.
Requested Service DCM	This detailed clinical model has been designed for point-in-time services, not recurring services.

Reference	Description
DateTime Service Scheduled and Requested Service DateTime	There is a strong overlap between <i>DateTime Service Scheduled</i> and <i>Requested Service DateTime</i> . In the future they might be merged into a single data element.
Pathology Test Result DCM	This structure has not been normalised, meaning that while some common groupings of information are easy, other groupings of information are very difficult. An example is that every Result is part of a Result Group. Another is that a specimen may be associated with a Result Group, but not a Result. The information model for this concept needs to be restructured, even if none of the data elements change.
14.22 DIMENSION 14.67 DIMENSIONS	There is no provision to include measurements other than volume, in particular for tissue specimens where at least length, width/breath and depth are required.
14.81 Pathological Diagnosis	A diagnosis typically has a diagnosis and a context (a qualification of the diagnosis, such as suggested, not seen). This specification allows diagnosis to be text or coded, but does not support recording diagnosis context when the diagnosis is coded.
14.83 Test Result Representation	There is no provision to include multiple formats for diagnostic service reports ((i.e. pdf, rtf, xhtml etc.) where each report contains the same content but the renderer can choose the format that they are best able to support when showing the content (depending on platform and tools available).
14.88 Observation DateTime	No guidance is provided on how the value of <i>Observation DateTime</i> is related to the value of specimen <i>Collection DateTime</i> (14.29 Collection DateTime and 14.74 Collection DateTime) when there is more than one instance of <i>Collection DateTime</i> . We seek feedback from early implementers.
15.40 Examination Result Representation	There is no provision to include multiple formats for diagnostic service reports ((i.e. pdf, rtf, xhtml etc.) where each report contains the same content but the renderer can choose the format that they are best able to support when showing the content (depending on platform and tools available).
14.29 Collection DateTime 14.74 Collection DateTime	<i>Collection DateTime</i> data element and its parent data group <i>HANDLING AND PROCESSING</i> should be optional as, for observations based on a specimen, the clinically significant time is held in the <i>Observation DateTime</i> data element.
Referrer	The referrer is not explicitly modelled, though the information is available as the <i>Document Author</i> is also the referrer. There is value in modelling the referrer as a separate data component to the author. This can be done using <i>Service Requester</i> in <i>Requested Service</i> , this approach is used in HL7 FHIR and may be used in a future version of this specification.

Reference	Description
Source in Value Domain	<p>Sometimes the Source row for a Value Domain does not contain the name of a terminology or vocabulary. This applies to the following value domains:</p> <ul style="list-style-type: none"> • Link Nature Values ISO 13606-3:2009 this is the specification that contains the vocabulary • Request Urgency Values Australian Digital Health Agency Agency specified list of values could be "NCTIS Request Urgency Values" • Global Statement Values Australian Digital Health Agency Agency specified list of values could be "NCTIS Global Statement Values" • Substance/Agent Values Australian Digital Health Agency Set of reference sets from more than one terminology could be "SNOMED CT-AU" as AMT is now part of SNOMED CT-AU • Pathology Test Result Name Values Australian Digital Health Agency Set of reference sets from more than one terminology could be "SNOMED CT and LOINC" • Individual Pathology Test Result Name Values Australian Digital Health Agency Set of reference sets from more than one terminology could be "SNOMED CT and LOINC" • Result Value Values Australian Digital Health Agency There is no defined set of values, just guidance on the choice
14.6 Pathology Test Result Name Values 14.43 Individual Pathology Test Result Name Values	<p>The codes recommended for pathology terminology by the RCPA are constituted by a number of reference sets and care should be taken to select the reference set(s) most appropriate for the context of use</p>
Alignment with the HL7TM Fast Healthcare Interoperability Resources (FHIR®) standard	<p>The concepts as modelled in this specification, and in particular participation, are not fully consistent with HL7 FHIR resources. Work is underway to address alignment to HL7 FHIR and is expected to result in adjustment to the structure of this model.</p>
Gender	<p>The model of participation referenced by this specification include a data component for sex but not a data component for gender. The preferred Australian Government approach is to collect and use gender information. Work is underway to address alignment with the government guidelines on sex and gender in Agency information models.</p>

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Appendix C. Change History

A list of normative and substantive informative changes since the previous version of this specification. A single change is likely to be listed multiple times, as changes are listed in order of appearance. For example, the addition of a data component will be recorded as both a change to the data hierarchy and the addition of a section.

Changes from version 1.0 published 27 June 2016.

Rebranding

Throughout the document there are various changes to rebrand the document from the National E-Health Transition Authority (NEHTA) to the Australian Digital Health Agency (the Agency). The changes include:

- Definition Source, Scope Source, Context Source, Condition of Use Source and Value Domain Source have been updated from “NEHTA” to “Australian Digital Health Agency”;
- references to “National E-Health Transition Authority” and “NEHTA” have been replaced with references to the “Australian Digital Health Agency” and “the Agency” respectively; and
- all NEHTA URLs have been updated to redirect to the Agency website.

2.3 SERVICE REFERRAL

The multiplicity range has changed from 1..1 to 0..1 for the following data components:

- *SERVICE PROVIDER*
- *Requested Service Instance Identifier* (thrice)
- *Communication Alert Instance Identifier*
- *Alert Instance Identifier*
- *Adverse Reaction Instance Identifier*
- *Medication Instruction Instance Identifier*
- *Problem/Diagnosis Instance Identifier*
- *Procedure Instance Identifier*
- *Uncategorised Medical History Item Instance Identifier*
- *Pathology Test Result Instance Identifier*
- *Imaging Examination Result Instance Identifier*

The multiplicity range has changed from 0..1 to 0..0 for the following data components:

- *Examination Comment*

2.4 SUBJECT OF CARE

The version of *Participation Data Specification* used has changed from v3.2 to v3.3.

2.5 DOCUMENT AUTHOR

The version of *Participation Data Specification* used has changed from v3.2 to v3.3.

2.17 PATIENT NOMINATED CONTACT

The version of *Participation Data Specification* used has changed from v3.2 to v3.3.

2.18 PRIMARY CARE PROVIDER

The version of *Participation Data Specification* used has changed from v3.2 to v3.3.

2.19 INTERESTED PARTY

The version of *Participation Data Specification* used has changed from v3.2 to v3.3.

3 Requested Service Detailed Clinical Model

The design is now based on Requested Service DCM v5.2.

3.4 REQUESTED SERVICE

The multiplicity range has changed for the following data component in the Children relationships table:

- SERVICE PROVIDER from 1..1 to 0..1
- Requested Service Instance Identifier from 1..1 to 0..1

3.15 SERVICE PROVIDER

The version of *Participation Data Specification* used has changed from v3.2 to v3.3.

3.18. Requested Service Instance Identifier

The multiplicity range has changed from 1..1 to 0..1.

4.2 COMMUNICATION ALERT

The multiplicity range has changed for the following data component in the Children relationships table:

- Communication Alert Instance Identifier from 1..1 to 0..1

4.5. Communication Alert Instance Identifier

The multiplicity range has changed from 1..1 to 0..1.

5.3 ALERT

The multiplicity range has changed for the following data component in the Children relationships table:

- Alert Instance Identifier from 1..1 to 0..1

5.6. Alert Instance Identifier

The multiplicity range has changed from 1..1 to 0..1.

6 Current Service Detailed Clinical Model

The design is now based on Requested Service DCM v5.2.

6.4 REQUESTED SERVICE

The multiplicity range has changed for the following data component in the Children relationships table:

- Requested Service Instance Identifier from 1..1 to 0..1

6.10 SERVICE PROVIDER

The version of *Participation Data Specification* used has changed from v3.2 to v3.3.

6.12. Requested Service Instance Identifier

The multiplicity range has changed from 1..1 to 0..1.

8.4 ADVERSE REACTION

Statement added that it is a misuse to record drug interactions with *Adverse Reaction*.

The multiplicity range has changed for the following data component in the Children relationships table:

- Adverse Reaction Instance Identifier from 1..1 to 0..1

8.10 Reaction Type

Condition of use added: The value of this item **SHOULD NOT** be “Non-allergic reaction”.

Condition of use added: The value of this item **SHALL NOT** be “Drug interaction” or any of its children.

8.12. Adverse Reaction Instance Identifier

The multiplicity range has changed from 1..1 to 0..1.

10.4 MEDICATION INSTRUCTION

The multiplicity range has changed for the following data component in the Children relationships table:

- Medication Instruction Instance Identifier from 1..1 to 0..1

10.5. Therapeutic Good Identification

Condition of use added: When an AMT value is not available, a value from another registered code set **MAY** be used. The code set **SHALL** be publicly available. A registered code set is one that has been registered through the HL7 code set registration procedure with an appropriate object identifier (OID).

10.10. Medication Instruction Instance Identifier

The multiplicity range has changed from 1..1 to 0..1.

11.4 PROBLEM/DIAGNOSIS

The multiplicity range has changed for the following data component in the Children relationships table:

- Problem/Diagnosis Instance Identifier from 1..1 to 0..1

11.10. Problem/Diagnosis Instance Identifier

The multiplicity range has changed from 1..1 to 0..1.

12.4 PROCEDURE

The multiplicity range has changed for the following data component in the Children relationships table:

- Procedure Instance Identifier from 1..1 to 0..1

12.9. Procedure Instance Identifier

The multiplicity range has changed from 1..1 to 0..1.

13.4 UNCATEGORISED MEDICAL HISTORY ITEM

The multiplicity range has changed for the following data component in the Children relationships table:

- Uncategorised Medical History Item Instance Identifier from 1..1 to 0..1

13.8. Uncategorised Medical History Item Instance Identifier

The multiplicity range has changed from 1..1 to 0..1.

14 Pathology Test Result Detailed Clinical Model

The design is now based on Pathology Test Result DCM v3.3.

14.4 PATHOLOGY TEST RESULT

The multiplicity range has changed for the following data component in the Children relationships table:

- Pathology Test Result Instance Identifier from 1..1 to 0..1

14.6. Pathology Test Result Name Values

The external identifier has been removed.

The permissible values are explicitly linked to the RCPA terminology.

14.43. Individual Pathology Test Result Name Values

The condition of use has been removed.

The permissible values are explicitly linked to the RCPA terminology.

14.89. Pathology Test Result Instance Identifier

The multiplicity range has changed from 1..1 to 0..1.

15.4 IMAGING EXAMINATION RESULT

The multiplicity range has changed for the following data component in the Children relationships table:

- Examination Comment from 0..1 to 0..0
- Imaging Examination Result Instance Identifier from 1..1 to 0..1

15.41 Examination Comment

This has been removed.

15.53. Imaging Examination Result Instance Identifier

The multiplicity range has changed from 1..1 to 0..1.

16 Pending Diagnostic Investigation Detailed Clinical Model

The design is now based on Requested Service DCM v5.2.

16.4 REQUESTED SERVICE

The multiplicity range has changed for the following data component in the Children relationships table:

- Requested Service Instance Identifier from 1..1 to 0..1

16.14 SERVICE PROVIDER

The version of *Participation Data Specification* used has changed from v3.2 to v3.3.

16.16. Requested Service Instance Identifier

The multiplicity range has changed from 1..1 to 0..1.

Appendix D. Specification Guide for Use

D.1 Overview

The participation data specification, each detailed clinical model (DCM) and each structured content specification (SCS) is designed on a shared basis for data interpretation. Each specifies rigorous business and technical definitions of data that systems may need to share. Each is intended to be a logical specification of the data to be persisted within or communicated between systems. They are also the foundation for the compliance, conformance, and declaration process. Our CDA implementation guides are guides to the implementation of HL7 CDA R2 messages based upon these DCMs and SCSs.

The participation data specification specifies data components that enable a recipient of a document to identify participations within their own systems. Participations record context-specific information about relationships between participants and healthcare events. As such, participations are only meaningful within the context in which they are used.

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

Each SCS describes a template of a [Structured Document](#). It specifies the data for a single type of clinical document or information exchange, such as a discharge summary. It is assembled using DCMs that have been constrained to eliminate data components not relevant to the particular context. For example, *Procedure* in a discharge summary uses only some of the data components required by *Procedure* in a specialist report.

D.2 The Structured Content Specification Metamodel

Our metamodel for structured content specifications (see Figure 1) is used to specify the overall structure of a structured content specification. The structure is a tree, so every item in the tree, other than the root node, has a parent node. For an SCS, the root node is a Structured Document. For a DCM, the root node is a Data Group.

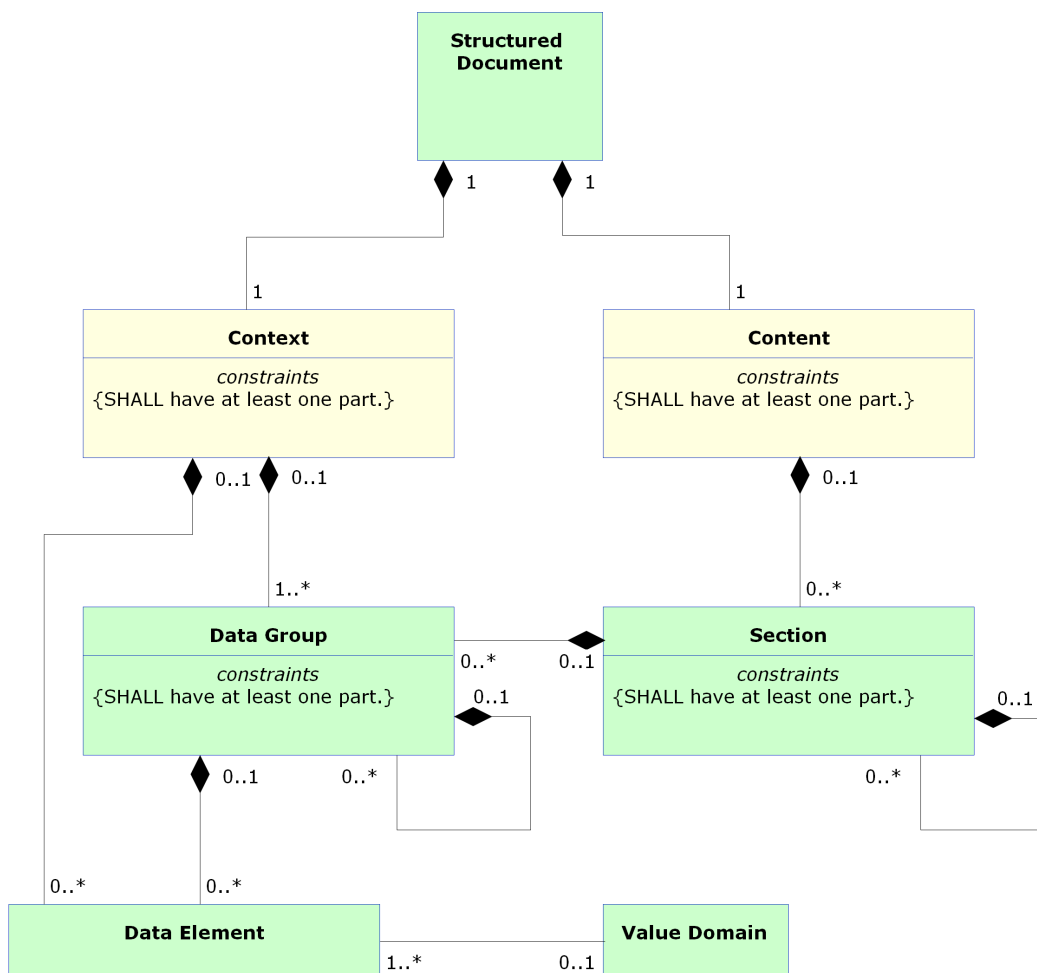


Figure D.1. SCS Metamodel

There are two main items used to organise information within an SCS as follows:

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

Content: This contains information that changes between different SCSs, but is always structured as shown in Figure 1, and consists of the following data components:

- Section
- Data Group
- Data Element
- Value Domain

These data components are described in more detail below.

Structured Document

A structured document is a collection of health information about a subject of care that is relevant to the ongoing care of that person. They are composed of one or more data groups and data elements that are organised into sections. Ex-

amples of structured documents are *Discharge Summary*, *Shared Health Summary*, and *Advance Care Directive Custodian Record*.

Context

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

Content

Content contains a collection of personal information and health information pertinent to a subject of care that is derived from the healthcare event described in the document. The detail is organised into one or more data groups, which are optionally grouped into sections.

Section

A section is composed of data groups, other sections, or both. It is an organising container that cues the reader about expected content. A section organises information in a manner suitable for the primary purpose for which it is collected and provides a way to navigate through the data components within the document, thereby enabling more efficient querying. It is recommended that the section support safe reuse for secondary purposes, e.g. clinical coding or inclusion in a summarised form in an electronic health record. A section is context-specific to the document in which it resides.

Data Group

Each data group is used to represent one concept. A data group consists of other data groups, data elements, or both. Some data groups are reused across DCMs.

Every instance of a data group **SHALL** have at least one child data component instantiated.

Participation

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

A Participant has been defined to align with the concepts of the Agency's [Interoperability Framework \[NEHT2007b\]](#). It equates to an *Entity* that is related to the action described in an SCS as an *Actor*. A Participant can be a human, an organisation, or an IT system.

Choice

Choice represents a selection, to be made at run-time, of a single member from a set of data groups, where the set is defined at design-time, i.e. one and only one member of the set is chosen for each instance of the choice.

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

Data Element

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

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

Value Domain

A value domain constrains the permissible values for a data element. The values are often a subset of values based on a generic data type.

Value domains are reusable items, therefore the same value domain can be referred to by different data elements in different contexts. Value domains are often specified with reference to a *reference set*. A reference set is a constrained list of SNOMED CT-AU concepts that are appropriate to a particular context or use. Since many of these reference sets have been developed specifically for the context in which they appear, it is recommended that an assessment of fitness for purpose be undertaken before using any of the reference sets in another context.

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

Table 1: Value Domain Examples

Data Element	Data Type	Example of Value Domain										
Sex	CodedText	Standards Australia AS 4846 (2006) – Health Care Provider Identification [SA2006a] and Standards Australia AS 5017 (2006) – Health Care Client Identification [SA2006b] derive their values from METeOR 287316, which includes values such as: <table border="1" data-bbox="652 1240 1431 1469"> <thead> <tr> <th>Value</th> <th>Meaning</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Male</td> </tr> <tr> <td>2</td> <td>Female</td> </tr> <tr> <td>3</td> <td>Intersex or Indeterminate</td> </tr> <tr> <td>9</td> <td>Not Stated/Inadequately Described</td> </tr> </tbody> </table>	Value	Meaning	1	Male	2	Female	3	Intersex or Indeterminate	9	Not Stated/Inadequately Described
Value	Meaning											
1	Male											
2	Female											
3	Intersex or Indeterminate											
9	Not Stated/Inadequately Described											
Diagnosis	CodeableText	A SNOMED CT-AU reference set that references concepts such as “Bronchitis” (Concept ID: 32398004).										
Therapeutic Good Identification	CodeableText	An AMT reference set that references concepts such as “Ibuprofen Blue (Herron) (ibuprofen 200 mg) tablet: film-coated, 1 tablet” (Concept ID: 54363011000036107).										
Individual Pathology Test Result Name	CodeableText	A LOINC subset that references concepts such as “Cholesterol [Moles/volume] in Serum or Plasma” (ID: 14647-2).										






D.3 Icon Legend

These legends describe all icons that are used in the Agency's DCMs and SCSs.

Metadata Types Legend

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




Table 2: Metadata Types Legend

Icon	Metadata Types
	Structured Document
	Section
	Data Group
	Participation
	Choice

Data Types Legend

The following table explains each of the icons used to represent the data types bound to each data element in the SCSs. These data types are a profile of the **ISO 21090-2011** data types as specified in [Data Types in NEHTA Specifications: A Profile of the ISO 21090 Specification \[NEHT2010c\]](#).

Table 3: Data Types Legend

Icon	Data type	Explanation
	Any (ISO 21090: ANY)	Use of this icon indicates that instances of the data element can be of any concrete data type. There are no limitations on the data type of the data element. The values that can be required will vary considerably depending on the context. This is an abstract data type that is the basis for all data types and SHOULD NOT be used in an actual implementation.
	Boolean (ISO 21090: BL)	A data type, sometimes called the logical data type, having one of the two values: <i>true</i> and <i>false</i> . Many systems represent true as <i>non-zero</i> (often 1, or -1) and false as <i>zero</i> . Usage/Examples • An actual value entered by a user might be “yes” or could be chosen by a mouse click on an icon such as  .



CodeableText
(ISO 21090: CD)

Coded text *with* exceptions; supports various ways of holding text, both free text and coded text.

Often used to support compliance for early adopters of the structured content specifications.

While it is recommended that the values in this data type come from the bound value domain, it allows other value domains to also be used (with or without translations to the bound value domain) or free text alternatives. This is useful when it is not possible to define an entire value domain for a complex concept (e.g. *Diagnosis*) and when there are competing code sets in existence. Note that within exchange specifications or message profiles this data type **MAY** be constrained to mandate compliance with the bound value domain.

Usage/Examples

- The Australian Institute of Health and Welfare (AIHW) defines a data element concept *Episode of admitted patient care-separation mode* (the status at separation of a subject of care and the place to which they are released). An early adopter could have a similar concept (coded or otherwise) that maps to this data element but does not strictly comply with the AIHW values.
- A SNOMED CT-AU coded/complex expression that embodies single or multiple concepts. The SNOMED CT-AU concepts behind these CodeableText data elements are specified in the structured content specification value domains.



CodedText
(ISO 21090: CD)

Coded text *without* exceptions; text with code mappings. Values in this data type **SHALL** come from the bound value domain, with no exceptions.

Often used for reference sets with only a small number of applicable values, e.g. Gender and Document Status.

Usage/Examples

[Standards Australia AS 5017 \(2006\) – Health Care Client Identification \[SA2006b\]](#) specifies the following value domain representing a type of address:

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



DateTime
(ISO 21090: TS)

A single date, optionally with a time of day.

Has the ability to indicate a level of precision, but not whether the date or time is estimated. Cannot represent a time alone.

String representations of known dates **SHALL** conform to the format within the **ISO 21090-2011** standard without the use of extensions, i.e. YYYY[MM[DD[HH[MM[SS[.U[U[U[U]]]]]]]]][+|-ZZzz].

Usage/Examples

- Partial dates: 2008, 20081001.
- To indicate 1:20 pm on May the 31st, 1999 for a time zone that is 10 hours ahead of Coordinated Universal Time (UTC): 19990531132000+1000.



Duration

The period of time during which something continues.

(ISO 21090:
PQ.TIME)

Consists of a value and a unit that represents the time value, e.g. hours, months.

Compound durations are not allowed, e.g. 10 days 3 weeks 5 hours.

Usage/Examples

- 3 hours
- 6 months
- 1 year



EncapsulatedData

Data that is primarily intended for human interpretation or for further machine processing outside the scope of this specification. This includes unformatted or formatted written language, multimedia data, or structured information as defined by a different standard (e.g. XML signatures).

(ISO 21090: ED)

Usage/Examples

- JPEG images
- HTML documents
- [\[RFC1521\]](#) MIME types



Integer

The mathematical data type comprising the exact integral values.

(ISO 21090: INT)

Usage/Examples

- 1
- -50
- 125



Link

A general link, reference or pointer to an object, data or application that exists logically or is stored electronically in a computer system.

(ISO 21090: TEL)

Usage/Examples

- URL (Uniform Resource Locator) – the World Wide Web address of a site on the internet, such as the URL for the Google internet search engine – *http://www.google.com*.
- An absolute or relative path within a file or directory structure – e.g. in the Windows operating system, the “link” or absolute path to a particular letter could be *C:\Documents and Settings\GuestUser\MyDocuments\letter.doc*



Quantity

A magnitude value with a unit of measurement.

(ISO 21090: PQ)

This is used for recording many real world measurements and observations. As the default unit of measure is 1, even counts of items can be recorded with *Quantity*.

Usage/Examples

- 100 centimetres
- 25.5 grams
- 3 per month

	<p>QuantityRange (ISO 21090: IVL)</p>	<p>A range of <i>Quantity</i> values.</p> <p>It may be identified using a combination of an optional minimum <i>Quantity</i> and an optional maximum <i>Quantity</i> (i.e. lower and upper bounds).</p> <p>This is typically used for defining the valid range of values for a particular measurement or observation. Unbounded quantity ranges can be identified by not including a minimum or a maximum <i>Quantity</i> value.</p> <p>Usage/Examples</p> <ul style="list-style-type: none"> • -20 to 100 Celsius • 30-50 mg • >10 kg • 2-3 hours
	<p>QuantityRatio (ISO 21090: RTO)</p>	<p>A relative magnitude of two <i>Quantity</i> values.</p> <p>Usually recorded as numerator and denominator.</p> <p>Usage/Examples</p> <ul style="list-style-type: none"> • 25 mg / 500 ml • 200 mmol per litre
	<p>Real (ISO 21090: REAL)</p>	<p>A computational approximation to the standard mathematical concept of real numbers. These are often called floating-point numbers.</p> <p>Usage/Examples</p> <ul style="list-style-type: none"> • 1.075 • -325.1 • 3.14157
	<p>Text (ISO 21090: ST)</p>	<p>A character string (with optional language) containing any combination of alpha, numeric, or symbols from the Unicode character set. Also referred to as <i>free text</i>.</p> <p>Usage/Examples</p> <p>“The patient is a 37 year old man who was referred for cardiac evaluation after complaining of occasional palpitations, racing heart beats and occasional dizziness.”</p>
	<p>TimeInterval (ISO 21090:IVL)</p>	<p>An interval in time.</p> <p>It is identified using a combination of an optional start <i>DateTime</i>, an optional end <i>DateTime</i>, and an optional <i>Duration</i>.</p> <p>Usage/Examples</p> <ul style="list-style-type: none"> • 20080101+1000 - 20081231+1000 • 200801010130+1000 - 200801011800+1000 • 200801010130+1000, duration=16.5 hours



UniquelIdentifier
(ISO 21090: II)

A unique value used to identify a physical or virtual object or concept.

In using this data type, the attributes of the UniquelIdentifier data type **SHOULD** be populated from the identifiers as defined in [AS 4846 \(2006\) – Health Care Provider Identification \[SA2006a\]](#) and [AS 5017 \(2006\) – Health Care Client Identification \[SA2006b\]](#) as follows:

- *root*: a globally unique object identifier that identifies the combination of geographic area, issuer and type. If no such globally unique object identifier exists, it **SHALL** be created.
- *extension*: a unique identifier within the scope of the root that is directly equivalent to the identifier designation element.
- *identifierName*: a human readable name for the namespace represented by the root that is populated with the issuer or identifier type values, or a concatenation of both, as appropriate. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used for that purpose.
- *identifierScope*: the geographic span or coverage that applies to or constrains the identifier. It is directly equivalent to the geographic area element. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used as such.

Also, the following constraints apply on the UniquelIdentifier data type:

- 1) The *root* attribute **SHALL** be used.
- 2) For an Entity Identifier, the *root* attribute **SHALL** be an OID that consists of a node in a hierarchically assigned namespace, formally defined using the ITU-T's ASN.1 standard.
- 3) For an Entity Identifier, the *root* attribute **SHALL NOT** be a UUID.

Usage/Examples

Australian health identifiers (e.g. IHI, HPI-I and HPI-O) and patient hospital medical record numbers are examples of identifiers that may be carried by data elements of this data type.

Keywords Legend

Where used in this document and in DCMs and SCSs, the keywords **SHALL**, **SHOULD**, **MAY**, **SHALL NOT** and **SHOULD NOT** are to be interpreted as described in [Key Words for Use in RFCs to Indicate Requirement Levels \[RFC2119\]](#). Our specifications use the terms **SHALL** in place of “MUST” and **SHALL NOT** in place of “MUST NOT”. The key word definitions in RFC 2119, adjusted to remove the key words not used in the Agency specifications, are presented in the following table.

Table 4: Keywords Legend

Keyword	Definition
SHALL	This word means that the statement is an absolute requirement of the specification.
SHOULD	This word means that there may exist valid reasons in particular circumstances to ignore a particular data component, but the full implications must be understood and carefully weighed before choosing a different course.

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

Obligation Legend

In DCMs and SCSs obligations on a data component specify whether or not it **SHALL** be populated in the logical record architecture of a message. We intend that all data components that are not **PROHIBITED** will be implemented.

Obligations in statements about values specify whether or not certain values are permitted.

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

The following table defines the obligations.

Table 5: Obligations Legend

Keyword	Interpretation
ESSENTIAL	<p>Indicates that the data component is considered a mandatory item of information and SHALL be populated.</p> <p>Usage/Examples:</p> <p>The Participant data component for a Subject of Care SHALL include an Entity Identifier data component in order to hold the IHI.</p>
OPTIONAL	<p>Indicates that the data component is not considered a mandatory item of information and MAY be populated.</p> <p>Usage/Examples:</p> <p>Such data components will be implemented, only inclusion and population are optional.</p> <p>This is only needed when a DCM incorrectly asserts that a data component is ESSENTIAL. It will be used with a note stating that the DCM needs revision.</p>
PROHIBITED	<p>On a data component this indicates that the data component is considered a forbidden item of information and SHALL NOT be included.</p> <p>In a statement about values this indicates that the use of the specified values is considered forbidden and they SHALL NOT be used.</p> <p>Usage/Examples:</p> <p>Within a Participation data group depicting a Subject of Care, the Participation Healthcare Role SHALL NOT be populated.</p>

CONDITIONAL	<p>Indicates that a data component is considered ESSENTIAL only on satisfaction of a given condition. Individual data components specify the obligation of the data component when the condition is not met.</p> <p>When a condition is met, the data component is considered to be ESSENTIAL and SHALL be populated.</p> <p>When a condition is not met, the data component may be considered PROHIBITED, or the data component may be considered OPTIONAL.</p> <p>Usage/Examples:</p> <p>Within a Pathology Result Report, the <i>Specimen Detail</i> data group is ESSENTIAL if the requested test is to be performed on a specimen; otherwise it SHALL NOT be included.</p>
--------------------	---

Obligations follow the usual scope rules: where **ESSENTIAL** child data components are contained within **OPTIONAL** parent data components, the child data components **SHALL NOT** be included when the parent is not included.

D.4 Exceptional Values

Occasionally a data element will have an exceptional value: an abnormal value (i.e. the value cannot be described using the expected set of values) or an absent value (i.e. no value is provided). Some abnormal values are only relevant to data elements of certain data types (e.g. positive infinity is relevant to numbers but not Booleans).

Unless otherwise specified, all data elements are permitted to have exceptional values. Constraints on the use of exceptional values are contained in the [Exceptional Values row](#) of the Usage section, except for instances of [Participation](#), when they are in the [Conditions of Use row](#). The most common statements constraining exceptional values are:

- Absent values are **PROHIBITED**.
- Abnormal values are **PROHIBITED**.

The commonly used implementation specifications ISO 21090 and HL7 CDA R2 use *nullFlavor* to manage abnormal and absent values.

The following table provides a classification of nullFlavor values as abnormal or absent.

Table 6: Classification of ISO 21090 nullFlavor values as absent or abnormal

Level	Code	Term	Abnormal	Absent
1	NI	No information		Absent
2	INV	Invalid	Abnormal	
3	OTH	Other	Abnormal	
4	PINF	Positive infinity	Abnormal	
4	NINF	Negative infinity	Abnormal	
3	UNC	Unencoded	Abnormal	
3	DER	Derived	Abnormal	
2	UNK	Unknown		Absent
3	ASKU	Asked but unknown		Absent
4	NAV	Temporarily unavailable		Absent
3	NASK	Not asked		Absent
3	QS	Sufficient quantity	Abnormal	
3	TRC	Trace	Abnormal	
2	MSK	Masked		Absent

Level	Code	Term	Abnormal	Absent
2	NA	Not applicable		Absent

D.5 Information Model Specification Parts Legends

This section illustrates the format and parts used to define each section, data group and data element within the Agency’s DCMs and SCSs, and identifies when each part is applicable.

Chapter Name

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

Identification Section Legend

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

Table 7: Identification Section Legend

Label	A suggested display name for the data component.
Metadata Type	The type of the data component, e.g. section, data group or data element.
Identifier	An Agency-assigned internal identifier of the data component. Note that if one data component is used twice (e.g. <i>Therapeutic Good Identification</i> is used in both <i>Medication Instruction</i> and <i>Medication Action</i>), both uses of the data component will have the same identifier. A data component identifier identifies a data component, not a use of a data component.
OID	An object identifier equivalent to the data component identifier.
External Identifier	An identifier of the concept represented by the data component that is assigned by an organisation other than the Agency.

Definition Section Legend

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

Table 8: Definition Section Legend

Definition	The meaning, description or explanation of the data component. For data groups used in a particular context, the definition MAY be a refinement of the generic data group definition.
Definition Source	The authoritative source for the Definition statement.
Synonymous Names	A list of any names the data component may also be known as. Implementers may prefer to use synonymous names to refer to the data component in specific contexts.
Scope	Situations in which the data component may be used, including the Scope circumstances where specified data are required or recommended.

	For example, Medication Instruction (data group) has a scope that includes all prescribable therapeutic goods, both medicines and non-medicines.
	This item is not relevant to data elements or value domains.
Scope Source	The authoritative source for the Scope statement.
Context	The environment in which the data component is meaningful, i.e. the circumstance, purpose and perspective under which this data component is defined or used.
	For example, Street Name has a context of Address.
	This item is applicable only to data elements.
Assumptions	Suppositions and notions used in defining the data component.
Assumptions Source	The authoritative source for the Assumptions statement.
Notes	Informative text that further describes the data component, or assists in the understanding of how the data component can be used.
Data Type	The data type (or data types) of the data element, e.g. DateTime or Text.
	The valid data types are specified in the Data Types Legend .
	This item is applicable only to data elements.
Value Domain	The name of the Value Domain used to define the range of values of the data element, or a statement describing what values to use in the absence of a defined value domain for the related data element.
	The statement is: <ul style="list-style-type: none"> In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure with an appropriate object identifier (OID), and SHALL be publicly available. When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.
	This item is applicable only to data elements with data type CodedText or CodeableText.

Data Hierarchy

The top-level data components (a Structured Document in an SCS or Data Groups in a DCM) contain a data hierarchy. Each row contains information about a single data component. The entries are nested to represent inclusion of one data component in another. Each entry contains at least three occupied cells. The left-most cell contains an icon to indicate the entry's data type. The next cell to the right contains the label of the data component (if the label is different from the name, the name is displayed in brackets after the label). The next cell to the right contains the multiplicity range for the data component.

If a row is not shaded, this indicates that the data component **SHOULD** be used. Where the minimum multiplicity is zero, this does not mean that it is optional to support the data component in the clinical information system, rather it means that the clinical information system has the capability to record that data component but that it may not populate it in a particular clinical document instance.

If a row is shaded grey, this indicates that the data component **SHOULD NOT** be used. This will be because analysis of requirements either did not find reasons to use it or found reasons to not use it.

If the text in a row is in a ~~strike through~~ font and the multiplicity is 0..0, this indicates that the data component **SHALL NOT** be used. This will be because analysis of requirements found reasons to prohibit the use of it.

Sample SCS Data Hierarchy

















Note

Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. Typically, such identifiers will be generated internally by systems and not displayed to users since they rarely have clinical significance.

Items below with a grey background are data components that are included in the relevant detailed clinical model specification, but whose use is discouraged in this particular scenario.

Items below with a clear background are data components whose use is encouraged in this particular scenario.

 SPECIALIST LETTER			
CONTEXT			
		SUBJECT OF CARE	1..1
		DOCUMENT AUTHOR	1..1
		ENCOUNTER	1..1
		DateTime Subject of Care Seen (DateTime Health Event Started)	1..1
		DateTime Health Event Ended	0..0
		HEALTHCARE FACILITY	0..0
		Document Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Document Type	1..1
CONTENT			
		RESPONSE DETAILS	1..1
		Diagnosis (PROBLEM/DIAGNOSIS)	0..*
		Diagnosis Name (Problem/Diagnosis Identification)	1..1
		Clinical Description	0..0
	and more		

Value Domain Section Legend

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

Table 9: Value Domain Section Legend

Source	The name of the terminology or vocabulary from which the value domain's permissible values are sourced, e.g. SNOMED CT-AU, LOINC.
Version Number	Version number of the value domain source.
Permissible Values	<p>A specification of the permissible values in the value domain.</p> <p>This may be a list of codes. (Each code is typically presented as a triple with code values, text equivalent, and description) for example:</p> <p>1, Registered No result yet available.</p> <p>This may be a conformance statement (e.g. "The permissible values are the members of the following seven AMT reference sets: ...").</p>

Usage Section Legend

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

Table 10: Usage Section Legend

Examples	<p>Sample values for the data element, with or without notes about sample values.</p> <p>Where a data element has an associated value domain, examples representative of that domain are used where possible. Where the value domain is yet to be determined, indicative examples are provided.</p> <p>Implementation guides may contain specific examples of how data elements may be populated and how they relate to each other.</p> <p>This item is applicable only to data elements.</p>
Conditions of Use	Prerequisites, provisos or restrictions for use of the data component.
Conditions of Use Source	The authoritative source for the Conditions of Use statement.
Misuse	Incorrect, inappropriate or wrong uses of the data component.
Default Value	A common denomination, or at least a usable denomination, from the Value Domain where available or applicable, typically assigned at the creation of an instance of the data component.
Exceptional Values	<p>A statement of limitations on the use of exceptional values, see Exceptional Values.</p> <p>Unless otherwise specified, all data elements are permitted to have exceptional values. The most common statements constraining exceptional values are:</p> <ul style="list-style-type: none"> Abnormal values are PROHIBITED. Absent values are PROHIBITED. <p>This item is applicable only to data elements.</p>

Relationships Section Legend

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

The following table illustrates the layout of the Parent relationships table. Note that the occurrences in the relationships described by this table are from the parent to the child data component, i.e. from the data component listed in the table to the data component described by the section.

Table 11: Parent Legend

Data Type	Name	Occurrences (child within parent)
The icon illustrating the metadata type or data type.	Parent Data Component Name	The minimum and maximum number of instances of the data component described on this page that SHALL occur.

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

Table 12: Children Legend

Data Type	Name	Occurrences
The icon illustrating the metadata type or data type.	Child Data Component Name	The minimum and maximum number of instances of the data component described on this page that SHALL occur.

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Index

A

ADVERSE REACTION, 139
 Adverse Reaction Instance Identifier, 150
 Adverse Reaction Type Values, 149
 ADVERSE REACTIONS, 56
 Adverse Reactions Instance Identifier, 58
 ALERT, 108
 Alert Description, 102, 112
 Alert Instance Identifier, 114
 Alert Type, 110
 ANATOMICAL LOCATION, 211, 261, 303, 330
 Anatomical Location Description, 218, 268, 310, 337
 Anatomical Location Image, 219, 269, 311, 338
 Anatomical Location Name, 214, 264, 306, 333
 Anatomical Site, 211, 261, 303, 330

B

Body Structure Foundation Reference Set, 215, 265, 307, 334

C

Clinical Indication, 167
 Clinical Information Provided, 239, 315
 Clinical Manifestation Values, 146
 COLLECTION AND HANDLING, 226, 276
 Collection DateTime, 229, 279
 Collection Procedure, 210, 260
 Collection Setting, 230, 280
 COMMUNICATION ALERT, 100
 Communication Alert Instance Identifier, 104
 Conclusion, 287
 Container Identifier, 235, 285
 Current Service, 118
 CURRENT SERVICES, 53
 Current Services Instance Identifier, 54

D

Data Element
 Adverse Reaction Instance Identifier, 150
 Adverse Reactions Instance Identifier, 58
 Alert Description, 102, 112
 Alert Instance Identifier, 114
 Alert Type, 110
 Anatomical Location Description, 218, 268, 310, 337
 Anatomical Location Image, 219, 269, 311, 338
 Anatomical Location Name, 214, 264, 306, 333
 Clinical Indication, 167
 Clinical Information Provided, 239, 315
 Collection DateTime, 229, 279
 Collection Procedure, 210, 260
 Collection Setting, 230, 280
 Communication Alert Instance Identifier, 104
 Container Identifier, 235, 285
 Current Services Instance Identifier, 54
 Date of Onset, 176
 Date of Resolution/Remission, 177

DateTime Attested, 49
 DateTime Received, 231, 281
 DateTime Service Scheduled, 364
 DE-10141, 167
 DE-10146, 369
 DE-10194, 163
 DE-10335, 36, 40
 DE-11008, 208, 258
 DE-11012, 233, 283
 DE-11013, 229, 279
 DE-11014, 231, 281
 DE-11017, 202
 DE-11018, 292
 DE-11023, 246, 322
 DE-11024, 252, 328
 DE-11028, 248, 325
 DE-11029, 255
 DE-15507, 176
 DE-15510, 177
 DE-15514, 174
 DE-15521, 141
 DE-15554, 147
 DE-15561, 293, 351
 DE-15564, 145
 DE-15579, 184
 DE-15584, 110
 DE-15585, 102, 112
 DE-15595, 186
 DE-16044, 168
 DE-16054, 364
 DE-16056, 89, 123, 366
 DE-16111, 210, 260
 DE-16128, 84
 DE-16132, 94
 DE-16149, 204
 DE-16153, 214, 264, 306, 333
 DE-16155, 236
 DE-16159, 288
 DE-16171, 227, 277
 DE-16187, 234, 284
 DE-16188, 235, 285
 DE-16198, 347
 DE-16199, 219, 225, 269, 275, 311, 338, 350
 DE-16302, 134, 155
 DE-16319, 218, 268, 310, 337
 DE-16327, 221, 271
 DE-16335, 223, 273
 DE-16336, 216, 266, 308, 335
 DE-16397, 239, 315
 DE-16402, 286
 DE-16403, 287
 DE-16404, 291
 DE-16428, 241
 DE-16429, 166
 DE-16466, 253, 329
 DE-16467, 254
 DE-16468, 289
 DE-16475, 187
 DE-16479, 197
 DE-16498, 300

DE-16500, 301
 DE-16502, 312
 DE-16503, 316
 DE-16509, 339
 DE-16512, 341
 DE-16513, 342
 DE-16514, 343
 DE-16516, 345
 DE-16517, 346
 DE-16519, 348
 DE-16520, 349
 DE-16529, 230, 280
 DE-16545, 178
 DE-16561, 188
 DE-16567, 318
 DE-16568, 320
 DE-16571, 243
 DE-16574, 251, 327
 DE-16621, 224, 274
 DE-16628, 194
 DE-16629, 195
 DE-16630, 196
 DE-16635, 95, 128, 373
 DE-16693, 52, 55, 59, 63, 67, 71, 97, 105, 115, 130, 136,
 151, 157, 170, 180, 189, 198, 296, 354, 375
 DE-16697, 150
 DE-16698, 30
 DE-16702, 179
 DE-16713, 169
 DE-16714, 295
 DE-16715, 353
 DE-16716, 96, 129, 374
 DE-16963, 58
 DE-16964, 62
 DE-16965, 66
 DE-16966, 38, 41
 DE-16972, 33
 DE-17011, 70
 DE-17015, 114
 DE-17021, 81, 120
 DE-17022, 87
 DE-17025, 54
 DE-17029, 104
 DE-17030, 79, 360
 DE-17033, 51
 DE-17035, 125, 368
 DE-20101, 28, 39
 DE-20106, 49
 DE-20117, 82, 121, 362
 DE-20172, 77, 358
 DE-20173, 88, 365
 DE-21136, 103
 Detailed Clinical Model Identifier, 97, 105, 115, 130, 136,
 151, 157, 170, 180, 189, 198, 296, 354, 375
 Diagnostic Investigations Instance Identifier, 70
 Diagnostic Service, 204
 DICOM Series Identifier, 346
 DICOM Study Identifier, 342
 Directions, 166
 Document Identifier, 39
 Document Instance Identifier, 28
 Document Target, 33
 Document Title, 38, 41
 Document Type, 36, 40
 Examination Requested Name, 341
 Examination Result Representation, 339
 Findings, 316
 Global Statement, 134, 155
 Image, 225, 275, 350
 Image DateTime, 349
 Image Identifier, 345
 Image View Name, 347
 Imaging Examination Result Group Name, 318
 Imaging Examination Result Instance Identifier, 353
 Imaging Examination Result Name, 300
 Imaging Examination Result Status, 312
 Imaging Examination Result Value, 322
 Imaging Modality, 301
 Individual Imaging Examination Result Name, 320
 Individual Pathology Test Result Comment, 253
 Individual Pathology Test Result Name, 243
 Individual Pathology Test Result Reference Range Guid-
 ance, 254
 Individual Pathology Test Result Status, 255
 Individual Pathology Test Result Value, 246
 Laboratory Test Result Identifier, 292
 Link Nature, 30
 Manifestation, 145
 Medical History Instance Identifier, 66
 Medical History Item Comment, 196
 Medical History Item Description, 194
 Medical History Item TimeInterval, 195
 Medication Instruction Comment, 168
 Medication Instruction Instance Identifier, 169
 Medication Orders Instance Identifier, 62
 Normal Status, 248, 325
 Object Description, 224, 274
 Observation DateTime, 293, 351
 Overall Pathology Test Result Status, 236
 Parent Specimen Identifier, 234, 284
 Pathological Diagnosis, 286
 Pathology Test Conclusion, 287
 Pathology Test Result Group Name, 241
 Pathology Test Result Instance Identifier, 295
 Pathology Test Result Name, 202
 Preferred Language, 103
 Problem/Diagnosis Comment, 178
 Problem/Diagnosis Identification, 174
 Problem/Diagnosis Instance Identifier, 179
 Procedure Comment, 186
 Procedure DateTime, 187
 Procedure Instance Identifier, 188
 Procedure Name, 184
 Reaction Type, 147
 Reason for Service, 77, 358
 Reason for Service Description, 79, 360
 Reference Range, 252, 328
 Reference Range Meaning, 251, 327
 Report Identifier, 343
 Request Urgency, 84

Request Urgency Notes, 87	DG-16515, 344
Request Validity Period, 94	DG-16528, 228, 278
Requested Service DateTime, 95, 128, 373	DG-16627, 192
Requested Service Instance Identifier, 96, 129, 374	DG-16720, 34
Result Comment, 329	DG-16971, 29
Sampling Preconditions, 227, 277	DG-17026, 100
Section Type, 52, 55, 59, 63, 67, 71	DG-20158, 74, 118, 356
Service Booking Status, 89, 123, 366	DIMENSIONS, 222, 272
Service Category, 81, 120	DOCUMENT AUTHOR, 26
Service Commencement Window, 88, 365	DOCUMENT DETAILS, 34
Service Comment, 125, 368	EXAMINATION REQUEST DETAILS, 340
Service Description, 82, 121, 362	EXCLUSION STATEMENT - ADVERSE REACTIONS, 132
Service Referral Detail Instance Identifier, 51	EXCLUSION STATEMENT - MEDICATIONS, 154
Side, 216, 266, 308, 335	HANDLING AND PROCESSING, 228, 278
Specimen Identifier, 233, 283	IDENTIFIERS, 232, 282
Specimen Tissue Type, 208, 258	IMAGE DETAILS, 344
Subject of Care Instruction Description, 369	IMAGING EXAMINATION RESULT, 298
Subject Position, 348	IMAGING EXAMINATION RESULT GROUP, 317
Substance/Agent, 141	IMAGING EXAMINATION RESULT VALUE, 321
Test Comment, 289	INDIVIDUAL IMAGING EXAMINATION RESULT, 319
Test Requested Name, 291	INDIVIDUAL PATHOLOGY TEST RESULT, 242
Test Result Representation, 288	INDIVIDUAL PATHOLOGY TEST RESULT VALUE, 245
Therapeutic Good Identification, 163	INTERESTED PARTY, 47
Uncategorised Medical History Item Instance Identifier, 197	MEDICATION INSTRUCTION, 160
Volume, 223, 273	PATHOLOGY TEST RESULT, 200
Weight, 221, 271	PATHOLOGY TEST RESULT GROUP, 240
Data Group	PATIENT NOMINATED CONTACT, 42
ADVERSE REACTION, 139	PHYSICAL PROPERTIES OF AN OBJECT, 220, 270
ALERT, 108	PRIMARY CARE PROVIDER, 45
ANATOMICAL LOCATION, 211, 261, 303, 330	PROBLEM/DIAGNOSIS, 172
COLLECTION AND HANDLING, 226, 276	PROCEDURE, 182
COMMUNICATION ALERT, 100	REACTION EVENT, 143
DG-10296, 24, 26, 42, 45, 47, 91, 126, 370	REFERENCE RANGE, 250, 326
DG-11023, 245, 321	REFERENCE RANGE DETAILS, 247, 324
DG-11024, 250, 326	RELATED DOCUMENT, 29
DG-15514, 182	REQUESTED SERVICE, 74, 118, 356
DG-15517, 139	SERVICE PROVIDER, 91, 126, 370
DG-15518, 108	SPECIFIC LOCATION, 213, 263, 305, 332
DG-15530, 172	SPECIMEN, 206, 256
DG-16136, 154	SUBJECT OF CARE, 24
DG-16137, 132	TEST REQUEST DETAILS, 290
DG-16144, 200	UNCATEGORISED MEDICAL HISTORY ITEM, 192
DG-16145, 298	Date and Time of Receipt, 231, 281
DG-16150, 211, 261, 303, 330	Date of Onset, 176
DG-16151, 213, 263, 305, 332	Date of Resolution/Remission, 177
DG-16156, 206, 256	DateTime Attested, 49
DG-16160, 290	DateTime Received, 231, 281
DG-16166, 220, 270	DateTime Service Scheduled, 364
DG-16167, 226, 276	Description, 224, 274
DG-16186, 232, 282	Detailed Clinical Model Identifier, 97, 105, 115, 130, 136, 151, 157, 170, 180, 189, 198, 296, 354, 375
DG-16211, 160	DIAGNOSTIC INVESTIGATIONS, 68
DG-16325, 247, 324	Diagnostic Investigations Instance Identifier, 70
DG-16328, 222, 272	Diagnostic Service, 204
DG-16469, 240	Diagnostic Service Values, 205
DG-16474, 143	DICOM Series Identifier, 346
DG-16489, 242	DICOM Study Identifier, 342
DG-16504, 317	DIMENSIONS, 222, 272
DG-16505, 319	Directions, 166
DG-16511, 340	DOCUMENT AUTHOR, 26

DOCUMENT DETAILS, 34

Document Identifier, 39
 Document Instance Identifier, 28
 Document Target, 33
 Document Title, 38, 41
 Document Type, 36, 40

E

EXAMINATION REQUEST DETAILS, 340
 Examination Requested Name, 341
 Examination Result Name, 300
 Examination Result Representation, 339
EXCLUSION STATEMENT - ADVERSE REACTIONS, 132
EXCLUSION STATEMENT - MEDICATIONS, 154

F

Findings, 316

G

Global Statement, 134, 155
 Global Statement Values, 135, 156

H

HANDLING AND PROCESSING, 228, 278

I

IDENTIFIERS, 232, 282
 Image, 225, 275, 350
 Image DateTime, 349
IMAGE DETAILS, 344
 Image Identifier, 345
 Image View Name, 347
IMAGING EXAMINATION RESULT, 298
IMAGING EXAMINATION RESULT GROUP, 317
 Imaging Examination Result Group Name, 318
 Imaging Examination Result Instance Identifier, 353
 Imaging Examination Result Name, 300
 Imaging Examination Result Status, 312
 Imaging Examination Result Status Values, 313
IMAGING EXAMINATION RESULT VALUE, 321
 Imaging Examination Result Value, 322
 Imaging Examination Result Value Reference Ranges, 324
 Imaging Modality, 301
INDIVIDUAL IMAGING EXAMINATION RESULT, 319
 Individual Imaging Examination Result Name, 320
INDIVIDUAL PATHOLOGY TEST RESULT, 242
 Individual Pathology Test Result Comment, 253
 Individual Pathology Test Result Name, 243
 Individual Pathology Test Result Name Values, 244
 Individual Pathology Test Result Reference Range Guidance, 254
 Individual Pathology Test Result Status, 255
INDIVIDUAL PATHOLOGY TEST RESULT VALUE, 245
 Individual Pathology Test Result Value, 246
 Individual Pathology Test Result Value Reference Ranges, 247
INTERESTED PARTY, 47
 Interpreter Required Alert, 100

K

Known Medication, 160

L

Laboratory Test Result Identifier, 292
 Laterality Reference Set, 217, 267, 309, 336
 Link Nature, 30
 Link Nature Values, 31

M

Manifestation, 145
MEDICAL HISTORY, 64
 Medical History Instance Identifier, 66
 Medical History Item Comment, 196
 Medical History Item Description, 194
 Medical History Item TimeInterval, 195
MEDICATION INSTRUCTION, 160
 Medication Instruction Comment, 168
 Medication Instruction Instance Identifier, 169
MEDICATION ORDERS, 60
 Medication Orders Instance Identifier, 62
 Medications, 60
 Medicines Terminology, 165

N

Normal Status, 248, 325

O

Object Description, 224, 274
 Observation DateTime, 293, 351
 Other Alerts, 108
 Overall Pathology Test Result Status, 236

P

Parent Specimen Identifier, 234, 284
 Past and Current Medical History, 64
 Pathological Diagnosis, 286
 Pathology Test Conclusion, 287
PATHOLOGY TEST RESULT, 200
PATHOLOGY TEST RESULT GROUP, 240
 Pathology Test Result Group Name, 241
 Pathology Test Result Instance Identifier, 295
 Pathology Test Result Name, 202
 Pathology Test Result Name Values, 203
 Pathology Test Result Status Values, 237
PATIENT NOMINATED CONTACT, 42
 Pending Diagnostic Investigation, 356
 Physical Details, 220, 270
PHYSICAL PROPERTIES OF AN OBJECT, 220, 270
 Preferred Language, 103
PRIMARY CARE PROVIDER, 45
PROBLEM/DIAGNOSIS, 172
 Problem/Diagnosis Comment, 178
 Problem/Diagnosis Identification, 174
 Problem/Diagnosis Instance Identifier, 179
 Problem/Diagnosis Reference Set, 175
PROCEDURE, 182
 Procedure Comment, 186

Procedure DateTime, 187
Procedure Foundation Reference Set, 185
Procedure Instance Identifier, 188
Procedure Name, 184

R

REACTION EVENT, 143
Reaction Type, 147
Reason for Service, 77, 358
Reason for Service Description, 79, 360
REFERENCE RANGE, 250, 326
Reference Range, 252, 328
REFERENCE RANGE DETAILS, 247, 324
Reference Range Meaning, 251, 327
RELATED DOCUMENT, 29
Report Identifier, 343
Request Urgency, 84
Request Urgency Notes, 87
Request Urgency Values, 86
Request Validity Period, 94
REQUESTED SERVICE, 74, 118, 356
Requested Service DateTime, 95, 128, 373
Requested Service Instance Identifier, 96, 129, 374
Result, 242, 319
Result Comment, 329
Result Group, 240, 317
Result Group Specimen Detail, 256
Result Value, 245, 321-322
Result Value Values, 323

S

Sampling Preconditions, 227, 277
Section
 ADVERSE REACTIONS, 56
 CURRENT SERVICES, 53
 DIAGNOSTIC INVESTIGATIONS, 68
 MEDICAL HISTORY, 64
 MEDICATION ORDERS, 60
 S-16117, 64
 S-16146, 60
 S-17032, 50
 S-20113, 56
 S-20117, 68
 S-21021, 53
 SERVICE REFERRAL DETAIL, 50
Section Type, 52, 55, 59, 63, 67, 71
Service Booking Status, 89, 123, 366
Service Booking Status Values, 90, 124, 367
Service Category, 81, 120
Service Commencement Window, 88, 365
Service Comment, 125, 368
Service Description, 82, 121, 362
SERVICE PROVIDER, 91, 126, 370
SERVICE REFERRAL, 4
SERVICE REFERRAL DETAIL, 50
Service Referral Detail Instance Identifier, 51
Side, 216, 266, 308, 335
SPECIFIC LOCATION, 213, 263, 305, 332
SPECIMEN, 206, 256
Specimen Identifier, 233, 283

Specimen Tissue Type, 208, 258
Structured Document
 SD-17034, 4
 SERVICE REFERRAL, 4
SUBJECT OF CARE, 24
Subject of Care Instruction Description, 369
Subject Position, 348
Substance/Agent, 141
Substance/Agent Values, 142

T

Test Comment, 289
TEST REQUEST DETAILS, 290
Test Requested Name, 291
Test Result Representation, 288
Test Specimen Detail, 206
Therapeutic Good Identification, 163

U

UNCATEGORISED MEDICAL HISTORY ITEM, 192
Uncategorised Medical History Item Instance Identifier, 197

V

Value Domain
 Adverse Reaction Type Values, 149
 Body Structure Foundation Reference Set, 215, 265, 307, 334
 Clinical Manifestation Values, 146
 Diagnostic Service Values, 205
 Global Statement Values, 135, 156
 Imaging Examination Result Status Values, 313
 Individual Pathology Test Result Name Values, 244
 Laterality Reference Set, 217, 267, 309, 336
 Link Nature Values, 31
 Medicines Terminology, 165
 Pathology Test Result Name Values, 203
 Pathology Test Result Status Values, 237
 Problem/Diagnosis Reference Set, 175
 Procedure Foundation Reference Set, 185
 Request Urgency Values, 86
 Result Value Values, 323
 Service Booking Status Values, 90, 124, 367
 Substance/Agent Values, 142
 VD-11017, 203
 VD-11023, 323
 VD-15521, 142
 VD-15554, 149
 VD-15564, 146
 VD-16055, 90, 124, 367
 VD-16115, 165
 VD-16127, 86
 VD-16148, 205
 VD-16152, 215, 265, 307, 334
 VD-16299, 135, 156
 VD-16312, 217, 267, 309, 336
 VD-16488, 237
 VD-16501, 313
 VD-16571, 244
 VD-16580, 185

VD-16617, 175
VD-16698, 31
Volume, 223, 273

W

Weight, 221, 271