nehta

e-Referrals

Core Information Components

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Document Information

Change history

Version	Date	Contributor	Comments
0.01	2009-06-05	Rob Eastwood	The essential components from the 2007 Data Content Specifications were extracted to create a first draft of the core. This draft was subsequently reviewed, amended and endorsed by NEHTA Clinical Leaders in preparation for broader external review.
0.21	2009-07-03	Rob Eastwood	Draft document distributed to Internal Gating reviewers
0.24	2009-08-07	Rob Eastwood	Draft document distributed to external organisations for comment.
0.25	2009-11-06	Rob Eastwood	Final draft subsequent to national survey feedback.
0.26	2010-02-15	Rob Eastwood	Release for public comment.
1.0	2010-12-17	Rob Eastwood	2010 release
1.1	2011-02-11	Rob Eastwood	Release
1.1.1	2011-05-04	Rob Eastwood	Added reference to DCM in section 2.1
1.1.2	2011-08-29	Rob Eastwood	Revised definition of data item "Reason for Referral" (pg 11)
1.1.3	2011-12-12	Rob Eastwood	Preface: removed sentence with reference to "*the Business Requirements Specification and Solution Design*".

Document authorisation

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Preface

Document Purpose

This document presents the core information components of the e-Referrals Release 1.1 package, which are recommended for use when sending referrals from general practitioners to specialists in Australia.

The e-Referrals Core Information Components are a logical set of data items for exchange and are therefore independent of any particular platform, technology, exchange format or presentation format.

The e-Referrals package describes the specifications and guidelines to be adopted by implementers when developing interoperable referral solutions within the Australian healthcare community. Detailed supporting documentation will become available that will provide specific implementation guidance.

This document is designed to maintain a high level of the information requirements.

Updates to this document will be published as additional package components are developed with feedback from the sector.

Intended Audience

This document is intended for all interested stakeholders including:

- Early adopter hospitals and health departments in the process of planning, implementing or upgrading e-Referral systems
- Software vendors developing e-Referral system products
- Early adopter general practitioner and specialist desktop software vendors
- Senior managers and policy makers, clinical experts, Health Information Managers, IT operations and support teams, system integrators
- Stakeholders associated with the development and use of upcoming e-health initiatives relating to 'continuity of care'
- Both technical and non-technical readers.

Document Map

The following diagram represents the relationship between this document and others within the e-Referrals package.

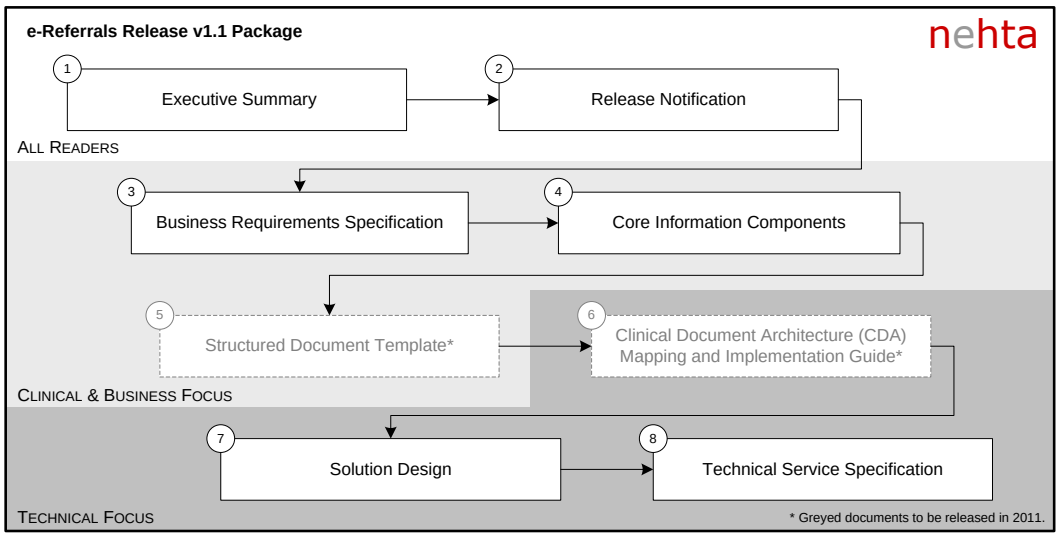

Figure 1 e-Referrals Package Document Map

The Solution Design defines current, interim and future solution states supported by the Business Requirements Specification. The Core Information Components document defines the minimum set of data groups and elements that are recommended for implementation in any system that creates and transfers referral information within Australia.

Document Status

Final.

Definitions, Acronyms and Abbreviations

For a list of abbreviations, acronyms and abbreviations, see the Definitions section at the end of the document, on page 19.

References and Related Documents

For a list of all referenced documents, see the References section at the end of the document, on page 20.

1 Introduction

1.1 Overview

This document presents the Core Information Components of a general practitioner-to-specialist referral, which are recommended for use when sending referrals in Australia. Their implementation is therefore recommended in any GP system that creates or transfers referrals.

The Core Information Components are defined as the minimum set of data items that are considered necessary to support the delivery of quality collaborative care. The inclusion of data in this minimum set is determined by two criteria:

1. The clinical relevancy of the data
2. The need for the data to ensure clinical safety in a collaborative care environment.

These inclusion criteria have been applied to each information component and data item included in this document (see Section 3 Justification Summary).

As these specifications define the Core Information Components for exchange, it is anticipated that some referral templates will contain additional types of data to satisfy specific local or specialty healthcare requirements. It is expected that national extensions to the Core Information Components will be defined to support particular specialty areas.

For referral definitions and business-related discussion, please see the Business Requirements Specification document, also part of the e-Referrals Release 1.1 package [ER-BRS2011].

1.2 Scope

1.2.1 Scope Inclusions

The scope of the e-Referrals Release 1.1 package includes electronic referral processes, between general practitioners and specialists. That is, the creation, delivery, receipt, assimilation and confirmation of patient referral documents in electronic form.

1.2.2 Scope Exclusions

The scope of this package excludes the following:

- The 'decision to refer' process
- The 'booking/scheduling' process at either the general practice or the specialist clinic.

1.3 Purpose

This Core Information Components document defines the information requirements for a nationally-agreed exchange of referrals between healthcare providers in Australia, independent of exchange or presentation formats.

It is anticipated that these Core Information Components will:

- Promote a common understanding of the core information components required for constructing and consumption of referrals by GPs, specialist recipients, implementers and jurisdictions

- Provide a common framework for development and use of semantically interoperable referral information components to be exchanged between applications, providers, jurisdictions
- Provide a common framework for defining queries over core referral information components at logical levels, which may be adopted for implementations in local, jurisdictional or national Electronic Health Record environments
- Provide a common framework upon which to define nationally-agreed, specialty-specific referral components (e.g. for Allied Health)
- Provide a common framework for nationally-defined mappings to specific exchange formats
- Provide a framework which inputs (along with other documents and structures) into the development of national terminology sets that associate specific data items with valid values. These values will be derived from nationally endorsed terminologies maintained and distributed on behalf of Australia by NEHTA's National Clinical Terminology and Information Service (NCTIS). The current terminology sources that will provide this content are LOINC for defined areas of Pathology content, SNOMED CT-AU for all other clinical content and AMT for medicinal products. Administrative content will be derived either from SNOMED CT-AU or specifically defined external codesets.

1.4 Methodology

The Referral Core Information Components were developed through a process of consultation with stakeholders. This consultation process has lead to the endorsement of these Core Information Components by a number of national and local clinical and standards bodies.

The starting point for the Referral Core Information Components was the Data Content Specification that was developed by NEHTA for exchange from a General Practitioner (GP) to a specialist (private or public) and from a General Practitioner to Allied Health care provider [RDCS2007]. From this specification, many of the optional data elements were removed, and the remaining data elements summarised into the table shown in Section 2.3.

Additionally, the following stakeholders were invited to comment on this document: ACT Division of General Practice, Australian Capital Territory Department of Health, Australian College of Rural and Remote Medicine, Australian Commission on Safety and Quality in Health Care, Australian General Practice Network, Australian Healthcare & Hospitals Association, Department of Defence (Australian Government), Department of Health and Families (Northern Territory Government), Department of Health and Human Services (Tasmania), Department of Health (Government of Western Australia), Department of Human Services (State Government of Victoria), Department of Veterans' Affairs, General Practice Network NT, General Practice NSW, General Practice Queensland, General Practice SA, General Practice Tasmania, General Practice Victoria, GP Workforce Tasmania, Health Workforce Queensland, Mater Health Services, NSW Department of Health (New South Wales Government), NSW Rural Doctors Network, Queensland Health , Royal Australasian College of Surgeons, Rural Doctors Workforce Agency, Rural Health West, Rural Workforce Agency (Victoria), SA Health, The Australian Indigenous Doctors' Association Ltd, The Royal Australasian College of Physicians, The Royal Australian College of General Practitioners and the Western Australian General Practice Network.

As the Referral Core Information Components continue to evolve through consultation and feedback, it is intended that a full set of Referral Components will be maintained as a superset of both the core information components and any specialty Referral Components that are developed.

1.5 Exchange and Presentation Formats

The information presented here is defined at the logical level, and is therefore independent of specific exchange or presentation formats (e.g. HL7 v2 or HL7 CDA).

Consequently, the Core Information Components may be mapped to multiple exchange formats. It is anticipated that such mappings will be defined and published following the endorsement of the Core Information Components.

Similarly, the requirement that a particular piece of data be exchanged in a referral does not imply a requirement on the user interface. Some data elements (e.g. 'Document Originating System Identifier') are intended purely for purposes of internal processes within the receiving system. Similarly, other data elements (e.g. 'Date of Birth') have a number of different presentation options available (e.g. 'Birth Day' + 'Year of Birth' etc), which are not considered here. In addition to this, the names given to data components and data items are in many cases not appropriate to be used as field labels on a user interface.

Implementations which modify the data item names in the 'Item' column of Section 2.3 'Definition' to accommodate local practices (e.g. 'Person name' represented as 'Patient Name') may still conform to this specification, but only if the meaning of the variables listed in the other columns (e.g. 'Purpose', 'Type') are not modified.

Please also note that the order in which the data items are listed in this document is not indicative of the order in which this data should be exchanged or presented to the user.

1.6 Adding Data

It is expected that the referrer will use their clinical judgement to manually enter some of the data into the Referral Core Information Components. However, it is envisaged that Clinical Information Systems operating at the source healthcare facility should be capable, wherever possible, of transferring relevant data into many of the core information components. This will minimise data entry and may reduce the issues of recording data redundantly in multiple data stores. It is expected that where feeder systems are used, the referrer's discretion is exercised in only allowing information relevant to the ongoing care of the patient to be included in the referral, and that the referrer's due diligence is applied to ensure that the information included from feeder system is current and accurate.

Note that some of the data elements included in this specification are required for ALL referrals whereas others need only be completed where appropriate. That is, a conformant e-referral implementation must be capable of collecting and transferring/receiving all Core Information Components (CIC) elements. However:

- Not all data elements require a value in each and every referral (e.g. items that are categorised with '0..1' or '0..Many'). For example, "Patient Contact (0..Many)" - for patient who has provided a contact, this should be recorded and sent, otherwise, it does not need to be populated.
- Not all data elements are required to be displayed to users, and their labels may be different from those used in the 'Item' column of the Definition table in section 2.3..

2 Core Components

2.1 Overview

The information components of the Referrals Core Information Components (as defined in Section 2.3) define the minimum set of data that is recommended for best practice implementation in a system that creates and exchanges referrals within Australia.

The current Referral Core Information Components are:

Component	**Corresponding DCM / source** *Link*: http://www.nehta.gov.au/vendors
Patient	(Participation Data Specification)
Benefits Card Details	(Participation Data Specification)
Patient's Nominated Contact	(Known issue, refer to SCS)
Referrer	(Participation Data Specification)
Usual GP	(Participation Data Specification)
Referee	(Participation Data Specification)
Referral Details	DCM: Miscellaneous DCM
Current and Past Medical History	DCM: Problem/Diagnosis DCM: Procedure
Current Medications	DCM: Medication Action and Instruction
Allergies / Adverse Reactions	DCM: Adverse Substance Reaction
Diagnostic Investigations	DCM: Pathology Test DCM: Imaging Test
Attachments	(CDA Mapping and Implementation Guide)
Document Control	(CDA Mapping and Implementation Guide)

2.2 Definition Description

The Core Information Components are defined below, using the following columns:

- *Component:* A high level section or group of data elements
- *Item:* An individual data element or data group. A data item may be a single unit of data (e.g. "Date of Birth"), or a set of data that has a standard structure (e.g. "Address")
- *Purpose:* The main purposes for exchanging this data, including:
  - C: Clinician to Clinician Communication
  - S: System to System Communication
  - D: Decision Support
  - E: Epidemiology and Statistics
  - Q: Safety and Quality

- *Type:* The type of data associated with the component or data item. Note that this may be a simple data type (e.g. text, date) requiring a single field, or a predefined structure requiring a group of fields. For a full list of types used please refer to Section 3
- *Number of Values Allowed:* The number of times that the given component/item may be included in a Referral. For items, this is the number of times that the given item may be included, each time the component to which it belongs is included. The number of values may be either:
  - 0..1 (Zero or One): At most one data value
  - 1 (One)[1] Exactly one data value
  - 0..Many (Zero to Many) Any number of data values
  - 1..Many (One to Many) At least one data value
- *Notes:* Additional comments that clarify, explain or constrain the given data.

[1] This is generally expressed in technical documentation as "1..1". It has been simplified in the following table to "1"

2.3 Definition

The following table uses three shades to differentiate data structures: yellow indicates component sections, white indicates data items within the preceding component section, while light grey indicates predominately system-to-system requirements.

If a value of one or one-to-many (i.e. [1] and [1..Many]) appears in the 'No. of Values Allowed' column, an actual value (e.g. character string, integer) is required for all referrals.

Component	Item	Purpose	Type	No. of Values Allowed	Notes
Patient		C, S, D, E, Q	Participation Person	1	Identifies the person about whom the clinical interaction has been captured and interchanged, that led to the creation of the referral, i.e. the subject of the referral.
	Person Identifier	S, D, E, Q	Unique Identifier	1..Many	The unique identifier of the patient. This must include the patient's Individual Healthcare Identifier (IHI) and optionally the patient's local identifier.
	Person Name	C, S, Q	Person Name	1	The patient's name, structured using a predefined type, consistent with Australian standards of naming (e.g. family name and first name etc).
	Date of Birth	C, S, D, E, Q	Date Time	1	The patient's date of birth. Where the exact date of birth is not known, this may be an approximation, which includes only the year, or the month and year.
	Sex	C, S, D, E, Q	Coded Text	1	The sex of the patient. Sex is the biological distinction between male and female. Where there is an inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.
	Address	C, S, E, Q	Address	1..Many	The address of the patient, recorded in a structured format consistent with Australian standards of address recording. Allows for multiple addresses such as 'temporary' or 'postal'. May include "No fixed address" if appropriate.
	Communication Details	C, S	Electronic Communication Details	1..Many	The patient's preferred means of contact should be included to facilitate clinical follow-up. Each Communication Details data item includes the medium (e.g. telephone), usage (e.g. home) and

Component	Item	Purpose	Type	No. of Values Allowed	Notes
					details.
	Indigenous Status	C, S, Q, E	Coded Text	1	A description of whether a person identifies as being of Aboriginal or Torres Strait Islander origin.
Benefits Card Details		C, S, E, Q	Section	0..1	Details pertaining to the identification of patient held benefits cards, where applicable. For example, Medicare Number, Government Benefits or DVA membership. This is not intended to include health insurance.
	Benefits Card Detail	C, S, E, Q	Group	1.. Many	The data group containing the Benefits Card Details. Multiple Benefits Card Details are allowed and the following data items apply for each one added.
	Benefit Type	C, S, E, Q	Coded Text	1	Identifies the type of benefit with which the patient is eligible to receive benefits. Note - a Medicare Number must be recorded if the patient has one. Similarly, when a patient is receiving a Government Benefit, that must be provided along with the number. When a patient is a DVA Card holder, the corresponding details of card colour and number should be provided.
	Benefit Number	C, S, E, Q	Unique Identifier	1	An identification number identifying a patient's eligibility to receive the stated benefits.
Patient's Nominated Contacts		C, Q, S, E	Participation	0..1	Details pertaining to the organisation or individual(s) nominated to act as the contact to receive information about the patient. The patient themselves may not be the primary point of contact (e.g. dementia or paediatrics).
	Patient's Nominated Contact	C, Q, S, E	Group	1..Many	The data group containing the Patient's Nominated Contacts. Multiple Patient's Nominated Contacts are allowed and the following data items apply for each one added.
	Name	C, Q	Person Name or Organisation Name	1	The contact person's or organisation name, structured using a predefined type, consistent with Australian standards of naming (e.g. family name

Component	Item		Purpose	Type	No. of Values Allowed	Notes
						and first name etc).
		Address	C, S, E, Q	Address	0..Many	The address of the contact person, recorded in a structured format, consistent with Australian standards of address recording. For the purpose of facilitating contact, either an address or an Electronic Communication Detail must be provided.
		Communication Details	C, S	Electronic Communication Details	0..Many	The contact person's preferred means of contact. Each Communication Details data item includes the medium (e.g. telephone), usage (e.g. home) and details. For the purpose of facilitating contact, either an address or an Electronic Communication Detail must be provided.
		Relationship to Patient	C, Q	Codeable Text	1	The relationship of the contact person to the patient.
Referrer			C, S, E, Q	Participation	1	The General Practitioner who is doing the referring.
	Person Identifier		S, E, Q	Unique Identifier	1..Many	The unique individual identifier of the Referrer. Must contain the referrer's Provider Number and the Healthcare Provider Identifier – Individual (HPI-I).
	Person Name		C, Q	Person Name	1	The name of the referrer, structured using a predefined type, consistent with Australian standards of naming (e.g. family name and first name etc).
	Healthcare Role		C, Q, S	Codeable Text	1	The role the referrer is playing in the course of initiating the referral. For example, 'Usual GP' or 'Locum GP'.
	Organisation Identifier		S, E, Q	Unique Identifier	0..Many	The unique organisation identifier of the referring organisation. This must include the Healthcare Provider Identifier of the organisation (HPI-O). When an Organisation Name is provided, the Organisation Identifier should be included.

Component	Item	Purpose	Type	No. of Values Allowed	Notes
	Organisation Name	C, Q	Organisation Name	0..1	The name of the referring organisation. When an Organisation Identifier is provided, the Organisation Name should be included.
	Address	C	Address	1..Many	The address of the referrer, recorded in a structured format, consistent with Australian standards of address recording.
	Communication Details	C	Electronic Communication Details	1..Many	The contact details for the referrer. The Referrer's preferred means of contact must include at least one method of communication. Each Communication Details data item includes the medium (e.g. telephone), usage and details.
Usual GP		C, S, E	Participation	0..1	The medical practitioner nominated by the patient as his/her "usual GP". The Usual GP is represented as a separate component to cater for the requirement where the referring GP is not the usual GP. In the circumstances where they are equivalent, then the information would not need to be replicated and the Usual GP is clearly stated in the referrer section. Note that where the 'Referrer' is not the Usual GP, this component should be completed, unless there are compelling reasons not to.
	Person Identifier	S, E, Q	Unique Identifier	0..Many	The unique individual identifier of the Usual GP. This must include the Healthcare Provider Identifier for the individual (HPI-I). Person Identifier must have a value when the Person Name has a value.
	Person Name	C, Q	Person Name	0..1	The name of the usual GP, structured using a predefined type, consistent with Australian standards of naming (e.g. family name and first name etc). Person Name must have a value when the Person Identifier has a value.

Component	Item	Purpose	Type	No. of Values Allowed	Notes
	Healthcare Role	S	Codeable Text	1	Defaulted to 'Usual GP'.
	Organisation Identifier	S, E	Unique Identifier	0..Many	The unique organisation identifier of the Usual GP's organisation. This must include the Healthcare Provider Identifier for the organisation (HPI-O). Organisation Identifier must have a value when the Organisation Name has a value.
	Organisation Name	C, Q	Organisation Name	0..1	The name of the GP Practice. Organisation Name has a value exactly when Organisation Identifier has a value.
	Communication Details	C, S	Electronic Communication Details	0..Many	The GP's preferred means of contact. Each Communication Details data item includes the medium (e.g. telephone), usage (e.g. work) and details.
Referee		C, S, E, Q	Participation	1	The specialist to whom the patient is being referred.
	Organisation Identifier	S	Unique Identifier	0..Many	The unique organisation identifier of the organisation to which the patient is being referred. When an Organisation Name is provided, the Organisation Identifier must be included.
	Organisation Name	C, Q, S	Organisation Name	0..1	The name of the organisation to which the patient is being referred. When an Organisation Identifier is provided, the Organisation Name should be included
	Person Identifier	S	Unique Identifier	0..Many	The Healthcare Provider Identifier – Individual (HPI-I) for the individual to which the patient is being referred. This must contain a Person Identifier when there is a Person Name.
	Person Name	C, Q, S	Person Name	0..1	The name of the individual to which the patient is being referred (if available), structured using a predefined type, consistent with Australian standards of naming (e.g. family name and first name etc). This must contain a Person Name when there is a

Component	Item	Purpose	Type	No. of Values Allowed	Notes
					Person Identifier. An individual's name must be provided for Medicare reimbursable referrals.
	Specialty	C, Q, S, E	Codeable Text	1	The clinical specialty of the clinician being referred to. For example, 'Orthopaedic Surgery''.
	Address	C	Address	1..Many	The address of the party to which the patient is being referred, recorded in a structured format, consistent with Australian standards of address recording.
	Communication Details	C	Electronic Communication Details	1..Many	The contact details for the party to which the patient is being referred. The preferred means of contact must include at least one method of communication. Each Communication Details data item includes the medium (e.g. telephone), usage (e.g. home) and details.
Referral Details		C, S, E, Q	Section	1	This section captures detailed information about the clinical referral.
	Date of Referral	C, S, Q, E	Date Time	1	The date/time when the Referral document was sent.
	Reason For Referral	C	Text	1	In the creation of a referral, relevant information about the patient's Current and Past Medical History, Current Medications, Allergies / Adverse reactions and optionally Diagnostic Investigations will be included as structured data, according to the information components that follow. To complement this structured data, the data item "Reason for Referral" is a free text narrative for the referrer to include content regarding the patient's clinical story. This may include any details at the discretion of the referrer, such as a synopsis of the case, presenting problems, the service that is requested, pertinent history or key physical findings etc. The content in this data item may vary from a single line in simple cases to many paragraphs for more complex circumstances.
	Referral Validity Duration	C, S, Q	Time Interval	1	The length of time the referral is valid from the date of the first patient/specialist encounter.

Component	Item	Purpose	Type	No. of Values Allowed	Notes
					Captures the valid duration of the referral which may be constrained by, e.g. Medicare funding policy.
Current and Past Medical History		C, Q	Section	1	Describes all relevant diagnoses and health/medical problems pertaining to the patient, as well as any relevant clinical interventions that have been performed on or for the patient.
	Current and Past Medical History	C, Q	Group	1..Many	The data group containing the Current and Past Medical History. Multiple Current and Past Medical History items are allowed and the following data items apply for each one added.
	Medical History Description	C, S, D, E, Q	Codeable Text	1	A description of the problem, diagnosis or intervention. The datatype of Codeable text allows for free text entry in the short term, with coded options in the longer term.
	Medical History comments	C, Q	Text	0..1	Free text comments providing additional information relevant to the problem, diagnosis or intervention in question.
	Medical History DateTime Range	C, Q	Time Interval	0..1	The date range (start date and/or end date) during which a patient's problem/diagnosis was active, or that the clinical intervention was performed. If necessary, this may be an estimate (such as April 2005, or 1998 - 2007).
Current Medications		C, S, D, E, Q	Section	1	Medications that the patient is currently taking.
	Current Medications Exclusion Statement	C, S, E, Q	Medication Exclusion	0..1	This exclusion statement data group allows for explicit assertions of exclusion of all medications, i.e. that the patient is not currently taking any medications.
					IF no exclusion statement THEN. The Number of Values Allowed below are only applicable if there is no Current Medications Exclusion Statement.

Component	Item		Purpose	Type	No. of Values Allowed	Notes
	Current Medication		C, S, D, E, Q	Group	1..Many	The data group containing the Current Medication. Multiple Current Medications are allowed and the following data items apply for each one added.
		Item Description	C, S, D, E, Q	Codeable Text	1	The details that fully describe a medication, including the name of the medication (active ingredients or brand name), strength and dose form, where appropriate.
		Dose Instruction	C, Q	Text	1	A description of how a particular product is being taken by the patient, at the time of the referral. This must include the route, dose quantity, frequency and any additional instructions required to safely describe the appropriate dosage. This should also include the administration schedule. In Referral systems, which support atomic dosage instructions, this item only needs to be populated when the atomic dosage items are not.
Allergies / Adverse reactions			C, S, D, E, Q	Section	1	Describes the known allergies and adverse reactions for the patient, and any relevant reaction details.
	Allergies / Adverse Reactions Exclusion Statement		C, S, E, Q	Adverse Reaction Exclusion	0..1	The exclusion statement data group allows for explicit assertions of exclusion of all Allergies / adverse reactions, i.e. that the patient has no known Allergies / adverse reactions, or that this information is unknown.
						IF no exclusion statement THEN. The 'Number of Values Allowed' below are only applicable if there is no Allergies/Adverse Reactions Exclusion Statement'.
	Allergies / Adverse reaction		C, S, D, E, Q	Group	1..Many	The data group containing the Allergies / Adverse reactions. Multiple Allergies / Adverse reactions are allowed and the following data items apply for each one added.
		Agent Description	C, S, D, E, Q	Codeable Text	1	The agent / substance causing the allergy / adverse reaction experienced by the patient.

Component	Item		Purpose	Type	No. of Values Allowed	Notes
		Reaction Description	C, S, D, E, Q	Codeable Text	1..Many	The signs and/or symptoms experienced or exhibited by the patient as a consequence of the allergies / adverse reaction to the specific agent/substance. The severity of the reaction and certainty may be included in this description, where appropriate.
Diagnostic Investigations			C, S, D, E, Q	Section	0..1	Describes any diagnostic investigations performed on the patient, that are considered to be relevant to the patient's ongoing care. This allows the results to be included as an attached report, or as a reference (ie. link) to where the results are located. Pending results can be indicated using a Result Status of 'pending'.
	Diagnostic Investigation		C, S, D, E, Q	Group	1..Many	The data group containing the Diagnostic Investigations. Multiple Diagnostic Investigations are allowed and the following data items apply for each one added.
		Investigation Type	C, S, D, E, Q	Codeable Text	1	The type or category of investigation performed on the patient – e.g. 'Pathology', 'Diagnostic Imaging'.
		Investigation Name	C. S, D, E, Q	Codeable Text	1	The name of the investigation performed on the patient – e.g. 'INR'.
		Investigation Date	C, S, D, E, Q	Date Time	1	The date (or date and time) that the diagnostic investigation was performed (in the case of diagnostic imaging investigations), or the specimen was taken (in the case of pathology investigations).
		Result Status	C, S, Q	Codeable Text	1	The status of the investigation result – e.g. 'pending', 'interim', 'final'.
		Document Control	S	Document Control	0..1	Information about the attached results or pending result (such as the version number, identifiers, document type, status and date attested) that will assist in the processing and document management of the attachment.

Component	Item	Purpose	Type	No. of Values Allowed	Notes
	EITHER / OR				
	Link	C, S, E, Q	Link	0..1	A reference to an external repository where the investigation results are stored.
	Data	C, S, E, Q	Encapsulated Data	0..1	The actual content of the investigation report. The report may use one of a variety of formats (as indicated in the Document Control details), including PDF, structured text, or XML using a NEHTA-defined template.
Attachments		C, S, E, Q	Section	0..1	Documents that have been attached to the Referral (either as a link or as data), because they are relevant to the ongoing care of the patient. For example, pathology reports, diagnostic imaging reports, care plans and assessments.
	Attachment	C, S, E, Q	Group	1..Many	The data group containing the Attachments. Multiple Attachments are allowed and the following data items apply for each one added.
	Document Name	C	Text	1	The name of the attached document, to be used when referencing the attachment (e.g. "Full Blood Count")
	Document Control	S	Document Control	0..1	Information about the attachment (such as the version number, identifiers, document type and date attested) that will assist in the processing and document management of the attachment.
	Section Reference	S	Codeable Text	0..Many	The section in the Referral from which the attachment should be referenced – e.g. Diagnostic Investigations. This information may be used to organise references to the attachments into appropriate groups.
	EITHER / OR				
	Link	C, S, E, Q	Link	0..1	A reference to where the contents of the attachment can be found. This may either be an internal link that references a document within the same message, or a reference to an external repository where the attachment is stored.

Component	Item	Purpose	Type	No. of Values Allowed	Notes
	Data	C, S, E, Q	Encapsulated Data	0..1	The actual content of the attachment. The attachment may use one of a variety of formats (as indicated in the Document Control details), including PDF, structured text or XML structured using a NEHTA-defined template.
Document Control		C, S, E, Q	Document Control	1	Versioning and other document control information associated with the Referral document. These details are required for the technical exchange of the document and do not necessarily need to be displayed to the user. However, there may be value in displaying some items, e.g. date of referral.
	Document Instance Identifier	S	Unique Identifier	1	The unique identifier of this instance of the Referral document.
	Document Set Identifier	S	Unique Identifier	1	The unique identifier of the set of all document revisions, related to a single healthcare event, of which the Referral document is a versioned instance.
	Version Number	C, S, Q	Integer	1	Identifier of a referral document within the same document set used to version successive replacement documents. The version number of the Referral document instance.
	Document Originating System Identifier	S	Unique Identifier	1	A unique identifier of the system used to create the Referral document.
	Business Document Type	S	Coded Text	1	The name of the Structured Document Template used to create the referral document instance – e.g. "NEHTA Core Referral"
	Business Document Type Version Number	S	Integer	1	Identifier of the version of the Structured Document Template used to create the referral document instance.
	DateTime Attested	C, S, Q	Date Time	1	The date/time when the Referral document was attested (or finalised, or signed off) by the document authoriser.
	Document Status	C, S, Q	Coded Text	1	The status of the document (e.g. completed and amended)

Component	Item	Purpose	Type	No. of Values Allowed	Notes
	Language	S	Coded Text	1	The human language primarily used within the document (defaulted to "en-AU")

3 Justification Summary

The table below lists the reason for including each of the core information components in the Core GP Referral, based on the inclusion criteria defined in Section 1.1.

Data Item	Reason for Inclusion
Benefits Card Details	Provides relevant Medicare/DVA information and other benefits.
Patient's Nominated Contact	Provides contact person(s) nominated by patient, especially in case of emergency.
Referrer	Provides correct identification of the healthcare provider who initiates the referral.
Referee	Provides correct identification of the healthcare provider individual and/or organization receiving the referral.
Referral Details	Conveys information relevant to the referral such as reason(s) for referral. This item has both clinical and administrative relevance.
Current and Past Medical History	Clinical safety requirement and critical for ensuring safe management of the patient.
Current Medications	Clinical safety requirement and critical for ensuring safe management of the patient if current medication history exists.
Allergies/Adverse Reactions	Clinical safety requirement and critical for ensuring safe management of the patient if adverse reactions information exists.
Usual GP	Provides details of the usual GP, particularly significant if the referrer was not the patient's usual GP.
Diagnostic Investigations	Clinical safety requirement and critical for ensuring safe management of the patient if any diagnostic interventions relevant to patient's condition currently exist.
Attachments	Includes relevant investigation results as attachments.
Document Control	Provides version control and document lifecycle management.

Definitions

This section explains the specialised terminology used in this document.

Shortened Terms

This table lists abbreviations and acronyms in alphabetical order.

Term	Description
CC	Core Connectivity
CI	Clinical Information
CT	Clinical Terminology
EHR	Electronic Health Record
ICT	Information and Communication Technology
NASH	National Authentication Service for Health
SIL	Service Instance Locator
SNOMED CT	Systemised Nomenclature of Medicine, Clinical Terminology

Glossary

This table lists specialised terminology in alphabetical order.

Term	Description
Business Architect	A Business Architect is anyone who looks at the way work is being directed and accomplished, and then identifies, designs and oversees the implementation of improvements that are harmonious with the nature and strategy of the organisation. Source: http://www.businessarchitects.org
Development Team	The Developer writes the code for the specifications that the Development leads provide. Source: http://www.developer.com
Endpoint	Where a web service connects to the network. Source: http://www.looselycoupled.com/glossary/endpoint
Interoperability	The ability of software and hardware on multiple machines from multiple vendors to communicate. Source: The Free On-line Dictionary of Computing. Denis Howe. 21 Apr. 2008. From: Dictionary.com - http://dictionary.reference.com/browse/Interoperability
Solutions Architect	The Solutions Architect is typically responsible for matching technologies to the problem being solved. Source: http://www.developer.com
Technical Architect	The technical architect is responsible for transforming the requirements into a set of architecture and design documents that can be used by the rest of the team to actually create the solution. Source: http://www.developer.com

References

At the time of publication, the document versions indicated are valid. However, as all documents listed below are subject to revision, readers are encouraged to use the most recent versions of these documents.

Package Documents

The documents listed below are part of the suite delivered in the e-Referrals Package.

e-Referrals Package Documents			
[REF]	Document Name	Publisher	Link
[ER-ES2011]	e-Referrals Release 1.1 - Executive Summary v1.1	NEHTA 2011	http://www.nehta.gov.au/e-communications-in-practice/ereferral Open menu: e-Referrals Package
[ER-RN2011]	e-Referrals Release 1.1 -Release Notification v1.1		
[ER-BRS2011]	e-Referrals Release 1.1 -Business Requirements Specification v1.1		
[ER-SD2011]	e-Referrals Release 1.1 -Solution Design v1.1		
[ER-CIC2011]	e-Referrals Release 1.1 - Core Information Components v1.1		
[ER-TSS2011]	e-Referrals Release 1.1 - Technical Service Specification v1.1		

References

The documents listed below are non-package documents that have been cited in this document.

Reference Documents			
[REF]	Document Name	Publisher	Link
[RDCS2007]	GP and Specialist/Critical Care Referral Data Content Specifications Version 1.0 - 28/2/2007,	NEHTA 2007	http://www.nehta.gov.au/e-communications-in-practice/ereferrals Open menu at bottom of web page: 'e-Referrals Summary Archive'

Related Reading

The documents listed below may provide further information about the issues discussed in this document.

Related Documents			
[REF]	Document Name	Publisher	Link
[NEHTAWEB]	NEHTA Web Site	NEHTA	http://www.nehta.gov.au/
[PDS2011]	Participation Data Specification, Version 3.2	NEHTA 2011	http://nehta.gov.au/connecting-australia/terminology-and-information/clinical-information-mi Open menu at bottom of web page: 'Clinical Information Data Specification - Specifications,

Related Documents			
			Context and Requirements’
[DSSDT2010]	Data Specifications and Structured Document Templates - Guide for Use, Version 1.1 - 20100607	NEHTA 2010	http://www.nehta.gov.au/connecting-australia/terminology-and-information/clinical-information-mi Open menu at bottom of web page: ‘Clinical Information Support Material’