Service Referral

CDA Implementation Guide

9 July 2018   v1.1

Approved for external use

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Document Information

Key Information

Owner	Executive General Manager, Innovation and Development
Contact for enquiries	Australian Digital Health Agency Help Centre
	t: 1300 901 001
	e: help@digitalhealth.gov.au

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Product ver-sion	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. This specification has been updated to correct defects extant on v1.0.

Related Documents

Name	Version/Release Date
Service Referral Structured Content Specification	Version 1.1, Issued 9 July 2018
Representing Coding in CDA Documents Implementation Guidance	Version 1.0, Issued 10 October 2011
Participation Data Specification	Version 3.3, Issued 30 January 2017
CDA Rendering Specification	Version 1.0, Issued 07 March 2012
Clinical Documents Common Conformance Profile	Version 1.7, Issued 21 December 2017
eReferral Information Requirements	Version 2.0, Not published

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List of Examples

1 Introduction

1.1 Document Purpose and Scope

This document provides a guide to implementing the logical model detailed by the Australian Digital Health Agency's Service Referral (SR) Structured Content Specification (SCS) as an HL7 Clinical Document Architecture (CDA) Release 2 XML document. This implementation guide is based on Version 1.1 of the SR SCS [DH2018a]. The primary aim of the implementation guide is to take implementers step by step through mapping each data component of the SR SCS to a corresponding CDA attribute or element.

This implementation guide contains descriptions of both constraints on the CDA and, where necessary, custom extensions to the CDA, for the purposes of fulfilling the requirements for Australian implementations of SR. The resulting CDA document can be used for the electronic exchange of SR information between healthcare providers.

In addition, this implementation guide presents conformance requirements against which implementers can attest the conformance of their systems.

This release is intended to inform, and seek feedback from, prospective software system designers and their clinical consultants.

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

1.2 Service Referral Definition

A Service Referral is defined in the SR SCS [DH2018a] as:

> Referral of a subject of care from one healthcare or human services provider to another.

1.3 HL7 Clinical Document Architecture

CDA is a document markup standard that specifies the structure and semantics of clinical documents for the purpose of supporting interoperable exchange and use at human and system levels.

We have chosen CDA as the format for electronic clinical documents because it is consistent with our commitment to a service and document–oriented approach to electronic information exchange, which will contribute to future electronic health records.

Some of the advantages of CDA are:

- It is machine computable and human-readable.

- It provides a standardised display of clinical information without loss of clinical meaning.

- It provides assurance of clinical quality and safety more effectively than message-based interfaces, by storing and displaying the clinical data as entered by the clinician.

- It provides better support than HL7 V2 messages for:

  ○ more complex information structures, such as pathology synoptic reporting; and

  ○ terminologies such as SNOMED CT.

- It supports legal attestation by the clinician (requiring that a document has been signed manually or electronically by the responsible individual).

- It is able to be processed by unsophisticated applications (displayed in web browsers, for instance).

- It provides a number of levels of compliance to assist with technical implementation and migration.

- It aligns Australia with e-health initiatives in other countries (such as Canada, UK, USA, Brazil, Germany and Finland).

1.4 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.

This document and related artefacts are technical in nature and the audience is expected to be familiar with the language of health data specifications and to have some familiarity with health information standards and specifications, such as CDA and Standards Australia IT-014 documents. Definitions and examples are provided to clarify relevant terminology usage and intent.

1.5 Document Map

This implementation guide is not intended to be used in isolation. Companion documents are listed below:
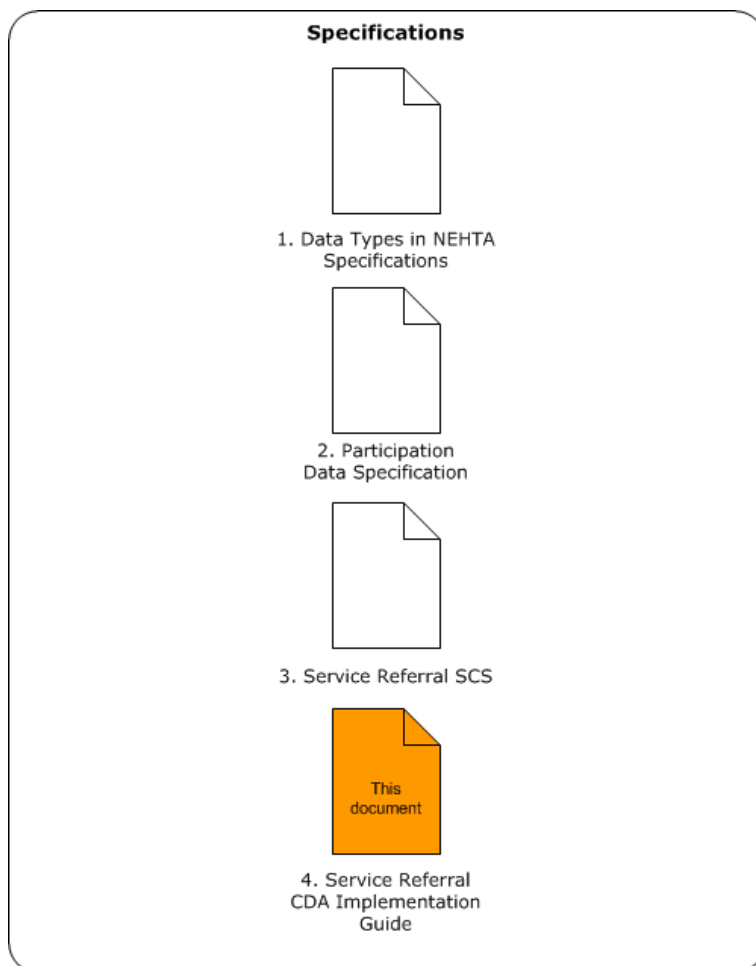
1. *Data Types in NEHTA Specifications: A Profile of the ISO 21090 Specification [NEHT2010c]* is a detailed description of the data types used within the structured content specification.

2. *Participation Data Specification [DH2017a]* contains the full specification that forms the basis of all participations contained in our structured content specifications.

3. *Service Referral Structured Content Specification [DH2018a]* is a clinical content specification describing the logical data structures, data components, and value domains that constitute a Service Referral.

1.6 Acronyms

CDA	Clinical Document Architecture
DCM	Detailed Clinical Model
HL7	Health Level Seven
HPI-I	Healthcare Provider Identifier - Individual
HPI-O	Healthcare Provider Identifier - Organisation
IHI	Individual Healthcare Identifier
NCTIS	National Clinical Terminology and Information Service
OID	Object Identifier
RIM	Reference Information Model
SCS	Structured Content Specification
SR	Service Referral
UUID	Universally Unique Identifier
XHTML	Extensible Hypertext Markup Language
XML	Extensible Markup Language
XSD	XML Schema Definition
XSL	Extensible Stylesheet Language

1.7 Keywords

Where used in this document, 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]*.

Keywords used in this document

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

1.8 Conformance

This document describes how the SR SCS is implemented as a CDA document. Conformance claims are not made against this implementation guide directly; rather, they are made against additional conformance profiles documented elsewhere. Any document that claims conformance to any derived conformance profile **SHALL** meet these base requirements:

- It **SHALL** be a valid HL7 CDA instance. In particular:

  o It **SHALL** be valid against the HL7 CDA Schema (once extensions have been removed, see W3C XML Schema).

  o It **SHALL** conform to the HL7 V3 R1 data type specification.

  o It **SHALL** conform to the semantics of the RIM and Structural Vocabulary.

- It **SHALL** be valid against the Australian Digital Health Agency CDA Schema that accompanies this implementation guide after any additional extensions not in the Australian Digital Health Agency extension namespace have been removed, along with any other CDA content not described by this implementation guide.

- It **SHALL** use the mappings as they are stated in this document.

- It **SHALL** use all fixed values specified in the mappings (e.g. @attribute="`FIXED_VALUE`").

- If the vocabulary has been explicitly stated as 'NS' it **SHALL** be interpreted as:

  NS = 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.

- It **SHALL** be valid against the additional conformance requirements that are established in this document (i.e. any normative use of the word 'shall' identified by the term presented in uppercase and bold typeface).

- The narrative **SHALL** conform to the requirements described in this implementation guide.

- The document **SHALL** conform to the requirements specified in the CDA Rendering Specification [NEHT2012s].

- The data as contained in the data types **SHALL** conform to the additional data type specification [NEHT2010c].

- Any additional content included in the CDA document that is not described by this implementation guide **SHALL NOT** qualify or negate content described by this implementation guide and it **SHALL** be clinically safe for receivers of the document to ignore the non-narrative additions when interpreting the existing content.

A system that *consumes* SR CDA documents may claim conformance if it correctly processes conformant instance documents, including correctly understanding all the information in the header. It may, but is not required to, reject non-conformant documents. Conformant systems that consume SR CDA documents are not required to process any or all of the structured data entries in the CDA document, but they **SHALL** be able to correctly render the document for end-users when appropriate (see Clinical Document Architecture Release 2).

Conformance profiles of this document **MAY** make additional rules that override this document in regard to:

- Allowing the use of alternative value sets in place of the value sets specified in this document.

- Allowing the use of alternative identifiers in place of the Healthcare Identifiers Service identifiers.

- Making required data elements and section divisions optional.

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[1] http://www.hl7.org/oid/index.cfm?ref=footer

1.9 Known Issues

This section 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
Throughout document: XML Examples	The examples present in this specification are taken from multiple sample or test referrals, each XML fragment is a standalone fragment that may not fit with other fragments present in the specification. While every effort has been taken to ensure that the examples are consistent with the normative mappings in this message specification, care needs to be taken when copying XML examples for implementation and validation. Where there are conflicts with the written message specification or schema and the XML examples, the specification or schema takes precedence.
Throughout document: R-MIMs	While every effort has been taken to ensure that the R-MIM diagrams are consistent with the normative mappings in this message specification, there may be a few discrepancies between R-MIM diagrams and CDA mapping tables. The CDA mapping takes precedence if there are discrepancies.
Throughout document: Participation types	The participation types in the OID register are not exhaustive, hence the absence of a participation type is not an error.
Throughout document	Australian vs American spelling - in cases where definitions have been taken from HL7 documentation, the American spelling has been preserved, e.g. organization rather than organisation.
6.1.1 SUBJECT OF CARE :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
6.1.2 DOCUMENT AUTHOR :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
6.1.3.1 PATIENT NOMINATED CONTACT as a PERSON - Healthcare or Human Services Provider :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
6.1.3.1 PATIENT NOMINATED CONTACT as a PERSON - Healthcare or Human Services Provider :: ENTITLEMENT	Prohibition of ENTITLEMENT is not currently mapped.
6.1.3.2 PATIENT NOMINATED CONTACT as a PERSON - Not a Healthcare or Human Services Provider :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
6.1.3.2 PATIENT NOMINATED CONTACT as a PERSON - Not a Healthcare or Human Services Provider :: ENTITLEMENT	Prohibition of ENTITLEMENT is not currently mapped.
6.1.3.3 PATIENT NOMINATED CONTACT as an ORGANISATION :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
6.1.3.3 PATIENT NOMINATED CONTACT as an ORGANISATION :: ENTITLEMENT	Prohibition of ENTITLEMENT is not currently mapped.
6.1.4.1 PRIMARY CARE PROVIDER as a PERSON :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
6.1.4.2 PRIMARY CARE PROVIDER as an ORGANISATION :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
6.1.4.2 PRIMARY CARE PROVIDER as an ORGANISATION :: ENTITLEMENT	Prohibition of ENTITLEMENT is not currently mapped.

Reference	Description
6.1.6.1 INTERESTED PARTY as a PERSON :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
6.1.6.2 INTERESTED PARTY as an ORGANISATION :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
6.1.6.2 INTERESTED PARTY as an ORGANISATION :: ENTITLEMENT	Prohibition of ENTITLEMENT is not currently mapped.
7.1.1.1.1.1 SERVICE PROVIDER as a PERSON :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
7.1.1.1.1.2 SERVICE PROVIDER as an ORGANISATION :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
7.1.1.1.1.2 SERVICE PROVIDER as an ORGANISATION :: ENTITLEMENT	Prohibition of ENTITLEMENT is not currently mapped.
7.1.1.2 RELATED DOCUMENT	The mapping for the RELATED DOCUMENT data group does not follow the data hierarchy as specified in the SCS because CDA does not allow (without extensions) related documents in the header.
7.1.2.1.1 SERVICE PROVIDER :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
7.1.2.1.1 SERVICE PROVIDER :: ENTITLEMENT	Prohibition of ENTITLEMENT is not currently mapped.
7.1.3.1 EXCLUSION STATEMENT - ADVERSE REACTIONS	Only the *Global Statement* logical data element is mapped. The other logical model data elements are deliberately not mapped; representing these elements in CDA would affect a normative change to the current implementation which is beyond the scope of the release of this document. The exclusion statement logical models are the subject of ongoing development and review and are expected to be revised.
7.1.3.2 ADVERSE REACTION :: Substance/Agent	The value of typeCode is fixed to "CAGNT" when not all relationships or associations between the agent and the reaction can be deemed to be "causative" in nature. An additional appropriate typeCode might be "EXPAGNT" (exposure agent).
7.1.3.2 ADVERSE REACTION :: Reaction Type and REACTION EVENT	The current mapping of *REACTION EVENT* is not aligned with the logical model, which, as a consequence, impacts the mapping choices for *Reaction Type*. *REACTION EVENT* should be mapped to an Act or an Organizer with *Reaction Type* as the code.
7.1.4.1 EXCLUSION STATEMENT - MEDICATIONS	Only the *Global Statement* logical data element is mapped. The other logical model data elements are deliberately not mapped; representing these elements in CDA would affect a normative change to current implementation which is beyond the scope of the release of this document. The exclusion statement logical models are the subject of ongoing development and review and are expected to be revised.

Reference	Description
7.1.5.1 PROBLEM/DIAGNOSIS :: Date of Resolution/Remission	The mappings for *Date of Resolution/Remission* do not link back to the *Date of Onset*, however the *Date of Resolution/Remission* is not necessarily the end of the problem (or diagnosis) described. The mappings depend on how an instance of the *Problem/Diagnosis* DCM is defined. If it is defined as an episode of a problem then using effectiveTime.high for *Date of Resolution/Remission* (thereby linking it to *Date of Onset*) would be fine because then a recurrence of the same problem would be a separate instance of *Problem/Diagnosis*. If, however, it is defined as covering the full duration of a problem in a person's life, then several remissions and relapses may occur and effectiveTime.high cannot be used as the *Date of Resolution/Remission*. It is intended that the *Problem/Diagnosis* DCM will be modified to represent a single episode of a problem or diagnosis and, when it is, the CDA mappings for *Date of Resolution/Remission* will change.
7.1.6.1 PATHOLOGY TEST RESULT	The *PATHOLOGY TEST RESULT* data group is mapped as a Section, however it would be more appropriate to map it as the Observation that has *Pathology Test Result Name* mapped to its code element.
7.1.6.1 PATHOLOGY TEST RESULT :: Pathology Test Result Name	The mapping of the *Pathology Test Result Name* logical data element (and by implication *PATHOLOGY TEST RESULT*) is to an Observation, however no logical data elements are mapped to the value element of that Observation. An Observation without a value is meaningless calling into question the mapping of *Pathology Test Result Name* (and by implication *PATHOLOGY TEST RESULT*) to an Observation.
7.1.6.1 PATHOLOGY TEST RESULT :: Overall Pathology Test Result Status	The current mapping of the *Overall Pathology Test Result Status* logical data element to the value element of a subordinate Observation of the *Pathology Test Result* Observation is semantically weak. This mapping was forced by the choice of logical value domain; consideration should be given to instead using the statusCode element of the *Pathology Test Result* Observation.
7.1.6.1 PATHOLOGY TEST RESULT :: Test Requested Name	The *Test Requested Name* logical element is mapped as the value element of a subordinate Observation to the *TEST REQUEST DETAILS* Act. However, it would be more appropriate to map it as the code element of the *TEST REQUEST DETAILS* Act.
7.1.6.1 PATHOLOGY TEST RESULT :: Observation DateTime	The *Observation DateTime* logical element is mapped as the effectiveTime element of a subordinate Observation to the *Pathology Test Result* Observation. However, it would be more appropriate to map it as the effectiveTime element of the *Pathology Test Result* Observation.
7.1.6.1.1 Test Specimen Detail (SPECIMEN) 7.1.6.1.2.2 Result Group Specimen Detail (SPECIMEN)	The mapping of the *SPECIMEN* logical data group is to an Observation, however no logical data elements are mapped to the value element of that Observation. An Observation without a value is meaningless calling into question the mapping of *SPECIMEN* to Observation.

Reference	Description
7.1.6.1.1 Test Specimen Detail (SPECIMEN) :: Anatomical Location Image 7.1.6.1.1 Test Specimen Detail (SPECIMEN) :: Image	Both *Anatomical Location Image* and *Image* are mapped as subordinate ObservationMedia of the *SPECIMEN* Observation; there is no provided means to differentiate which ObservationMedia represents the logical data element *Anatomical Location Image* and which represents the logical data element *Image*.
7.1.6.1.2 Result Group (PATHOLOGY TEST RESULT GROUP) :: Individual Pathology Test Result Status	The current mapping of the *Individual Pathology Test Result Status* logical data element to the value element of a subordinate Observation of the *PATHOLOGY TEST RESULT GROUP* Observation is semantically weak. This mapping was forced by the choice of logical value domain; consideration should be given to instead using the statusCode element of the *PATHOLOGY TEST RESULT GROUP* Observation.
7.1.6.1.2.1 Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS)	The logical model reference range data components have changed as a result of ongoing development, however no changes to the mappings for reference range data components have been included in this specification. Representing these changes in CDA would effect a normative change to current implementation which is beyond the scope of the release of this document.
7.1.6.1.2.2 Result Group Specimen Detail (SPECIMEN) :: Anatomical Location Image 7.1.6.1.2.2 Result Group Specimen Detail (SPECIMEN) :: Image	Both *Anatomical Location Image* and *Image* are mapped as subordinate ObservationMedia of the *SPECIMEN* Observation; there is no provided means to differentiate which ObservationMedia represents the logical data element *Anatomical Location Image* and which represents the logical data element *Image*.
7.1.6.2 IMAGING EXAMINATION RESULT	The *IMAGING EXAMINATION RESULT* data group is mapped as a Section, however it would be more appropriate to map it as the Observation that has *Imaging Examination Result Name* mapped to its code element.
7.1.6.2 IMAGING EXAMINATION RESULT :: Imaging Examination Result Name	The mapping of the *Imaging Examination Result Name* logical data element (and by implication *IMAGING EXAMINATION RESULT*) is to an Observation, however no logical data elements are mapped to the value element of that Observation. An Observation without a value is meaningless calling into question the mapping of *Imaging Examination Result Name* (and by implication *IMAGING EXAMINATION RESULT*) to an Observation.
7.1.6.2 IMAGING EXAMINATION RESULT :: Observation Date-Time	The *Observation DateTime* logical element is mapped as the effectiveTime element of a subordinate Observation to the *Imaging Examination Result* Observation. However, it would be more appropriate to map it as the effectiveTime element of the *Imaging Examination Result* Observation.
7.1.6.2.1.1 Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS)	The logical model reference range data components have changed as a result of ongoing development, however no changes to the mappings for reference range data components have been included in this specification. Representing these changes in CDA would affect a normative change to current implementation which is beyond the scope of the release of this document.
7.1.6.3.1.1 SERVICE PROVIDER as a PERSON :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
7.1.6.3.1.2 SERVICE PROVIDER as an ORGANISATION :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
7.1.6.3.1.2 SERVICE PROVIDER as an ORGANISATION :: ENTITLEMENT	Prohibition of ENTITLEMENT is not currently mapped.

Reference	Description
8.5 Person Name :: Preferred Name Indicator code	A code for representing "preferred name" has been requested from HL7 International but is not currently available. The proposed code "PRF" for representing preferred name is replaced with "D" *Customary Name*. In October 2015, the HL7 Patient Administration Workgroup approved a change to the description of *Customary Name* with code "D" to incorporate the preferred name. This change applies to HL7 Table 0200 Name Type. The definition of *Customary Name* was changed from "Known as/conventional/the one you use" to "Known as/conventional/the one you use. May also be known as a preferred name". An updated Australian Digital Health Agency schema allowing use of a code for preferred name will be made available after HL7 V2.9 (which contains the above updates) is published.
10 Vocabularies and Code Sets: AS 4846-2006 and AS 5017-2006 superseded	AS 4846-2014 *Person and provider identification in healthcare* has been published and supersedes both AS 4846-2006 *Healthcare provider identification* and AS 5017-2006 *Healthcare client identification*.
10.2 AS 5017-2006 Health Care Client Identifier Sex	The codeSystemName value in 10.2 AS 5017-2006 Health Care Client Identifier Sex is not the name associated with the OID in the HL7 OID Registry[2].
REFERRER	The referrer is not explicitly modelled, though the information is available as the Document Author is also the referrer. There is value in modelling the referrer as a separate data component to the author. This can be done using Service Requester in Requested Service, this approach is used in HL7 FHIR and may be used in a future version of this specification

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[2] http://www.hl7.org/oid/index.cfm?ref=footer

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2 Guide for Use

This document describes how to properly implement the SR SCS [DH2018a] as a conformant HL7 CDA XML document. The SR specification is contained in two publications:

1) A logical specification, which, in conjunction with its related documents (see Document Map), describes the Service Referral in a form that is consistent with other Agency specifications. It has the potential to be implemented in multiple different exchange formats as is most suitable for a particular context. It describes the data content of a Service Referral as a hierarchy of data components and provides documentation concerning their use and meaning.

2) An implementation guide (this document), which specifies how the data described in the SCS is properly represented in a CDA document.

In order to properly implement this specification, the reader should be familiar with the SR SCS and the HL7 CDA documentation, and understand how to read this document.

For further information regarding our structured content specifications, see the links in Document Map.

2.1 Clinical Document Architecture Release 2

A CDA document is an XML document built following the rules described in the CDA specification, which conforms to the HL7 CDA Schema provided by HL7. The CDA document is based on the semantics provided by the *HL7 V3 RIM, Data types and Vocabulary [HL7V3DT]*.

A CDA document has two main parts: the header and the body.

The CDA document header is consistent across all CDA documents, regardless of document type. The header identifies and classifies the document and provides information on authentication, the encounter, the patient, and the involved providers.

The body contains the clinical report. The body can be marked-up text (narrative, renderable text) or a combination of both marked-up text and structured data. The marked-up text can be transformed to XHTML and displayed to a human. The structured data allows machine processing of the information shown in the narrative section.

It is a requirement that all of the clinical information **SHALL** be marked up in CDA narratives. These narratives are CDA-defined hypertext, able to be rendered in web browsers with only a standard accompanying transformation. This transformation is produced and distributed by HL7.

It is a conformance requirement that the rendered narrative **SHALL** be able to stand alone as a source of authenticated information for consuming parties. Content from the CDA body **SHALL NOT** be omitted from the narrative.

Further information and guidance on the CDA narrative is available in Appendix A, *CDA Narratives*.

The following references are recommended to gain a better understanding of CDA:

- *HL7 Clinical Document Architecture [HL7CDAR2]*

- *HL7 V3 RIM, Data types and Vocabulary [HL7V3DT]*

- *CDA Examples [RING2009]*

- *CDA Validation Tools: infoway_release_2_2X_18.zip [INFO2009]*

2.2 Mapping Interpretation

The core of this implementation guide is a mapping from the SR SCS to the CDA document representation.

The mappings may not be deterministic; in some cases the differences in approach between the logical model specified in the SCS and the CDA implementation guide makes it inappropriate to have a 1:1 mapping, or any simple mapping that can be represented in a transform. This is especially true for names and addresses, where the SCS requirements, based on Australian Standards such as AS 5017 2006, differ from the HL7 data types and vocabularies which are not based on these standards.

Many of the mappings use one of several common patterns for mapping between the SCS and the CDA document. These common mapping patterns are described in 8 *Common Patterns*.

An example of a mapping section of this implementation guide is illustrated below.

x.x ITEM NAME

Identification (normative)

Name	ITEM NAME
Metadata type	Metadata type e.g. Section, Data Group or Data Element

Relationships (normative)

Children

Data Type	Name	Occurrence
Icon illustrating the Metadata or Data type.	ITEM NAME (This is a link to another section containing the mapping for this item. Item names in upper case indicate that the item is a section or data group. Item names in title case indicate that the item is a data element).	The number of instances of this child item that may occur.

Parent

Data Type	Name	Occurrences (child within parent)
Icon illustrating the Metadata or Data type.	ITEM NAME (This is a link to another section containing the mapping for this item. Item names in upper case indicate that the item is a section or data group. Item names in title case indicate that the item is a data element).	The number of instances of the child item within the parent that may occur.

CDA R-MIM Representation (non-normative)

The text contains an explanation of the mapping.

The model is a constrained representation of the R-MIM. The colours used in the CDA model align with the usage in the R-MIM. In many cases the cardinalities shown in the model will be less constrained than those shown in the mapping table.
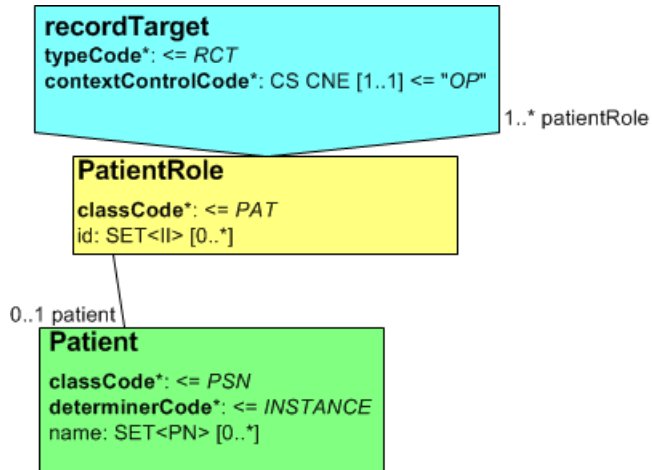
Figure 2.1. Example - Header Part
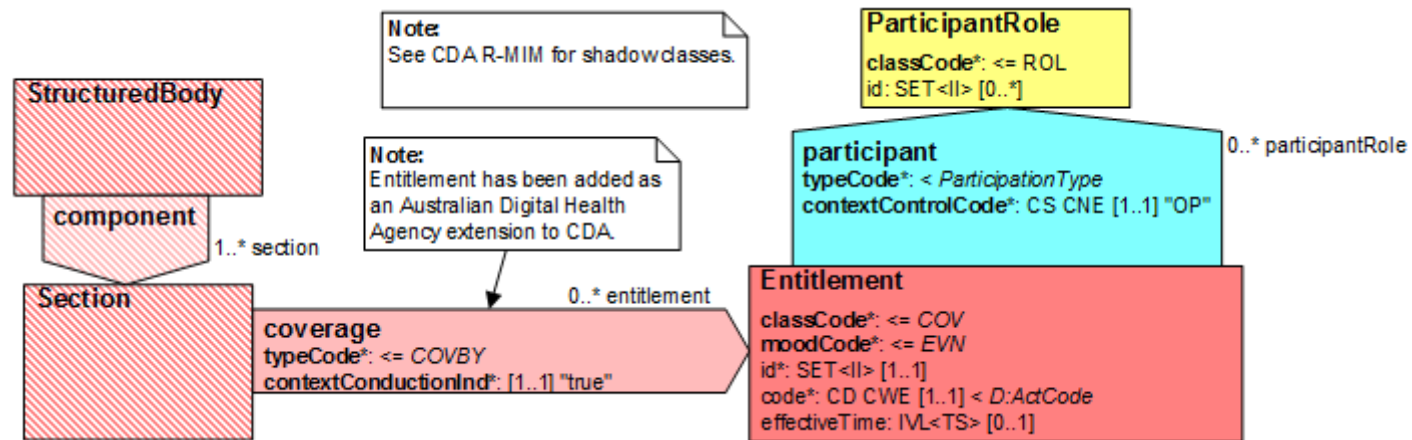
Figure 2.2. Example - Body Part

CDA Mapping (normative)

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Element Type (Header, Body Level 2 etc.)			**Context: Parent of elements below**		
The path in the SCS. Each section in this document corresponds to an SCS section or data group, and is scoped by that section or data group. The hierarchical path uses ">" as a separator for paths within the SCS data hierarchy. If there is a name in round brackets after the path, this is the name of the reused data group for the SCS component. The data component in **bold** text (the last in the path) is the data component for this row. i.e. Parent Data Component > **Child Data Component**	The definition of the item from the SCS.	The cardinality of the data element in the SCS. The cardinality of the data element in the SCS maps to the cardinality of the element in the CDA document. Where the cardinality of the SCS data element is more constrained than the cardinality of the CDA element then the SCS cardinality takes precedence. That is, if an element is mandatory in the SCS and optional in CDA then it will also become mandatory in the CDA document. If an item with a maximum cardinality > 1 maps to an XML attribute, the attribute will contain multiple values separated by spaces. No such item will have valid values that themselves contain spaces.	The schema element(s) in the CDA document that correspond(s) to the SCS data component. The syntax for this is similar to XPath: {/name[index]}}n{/<pattern>} Where: • {} indicates optional • {}n means a section that may repeat • <pattern> contains a link to a common pattern • [index] differentiates two similar mappings Examples: 1. component/act/participation[inf_prov]/role/**<Address>** 2. **participant** participant/**@typeCode="ORG"** participant/**associatedEntity** participant/associatedEntity/**@classCode="SDLOC"** participant/associatedEntity/**code** A sequence of names refers to the XML path in the CDA document. The path always starts from a defined context which is defined in the grey header row above each group of mapping rows. The last name is shown in bold to make the path easier to read. The last name may be a reference to an attribute or an element, as defined in the Australian Digital Health Agency CDA Schema. The cardinalities of the items map through from the SCS. It is possible to specify an index after the name, such as 'participation[inf_prov]' in Example 1. The presence of the index means there are two or more mappings to the same participation class that differ only in the inner detail. The indexes show which of the multiple mappings is the parent of the inner detail. Note that each of the indexed participations may exist more than once (as specified by the SCS group cardinality). To determine the mapping for these kinds of elements, a document reader must look at the content inside the element. It is possible for one SCS data component to map to more than one CDA schema element as in Example 2. Any fixed attribute values are represented as a separate line of the mapping, such as those shown in Example 2. The path may end with a pattern designator, such as <Address>. This indicates that the mapping involves a number of sub-elements of the named element following the pattern, as shown in the name (which is a link to the appropriate pattern in this document).	The name of the vocabulary.	Helpful additional information about the mapping.

How to interpret the following example mapping:

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /ClinicalDocument/		
Subject of Care	Person who receives care services.	1..1	recordTarget/**patientRole**		
n/a	n/a	1..1	recordTarget/patientRole/**id**		Required CDA element. If there are any entitlements for Subject of Care, this value **SHALL** be the same as: ClinicalDocument/ component/ structuredBody/ component[admin_obs]/ section/ entry/ act/ participant/ participantRole/ **id** where participantRole/ @classCode = "PAT".
Subject of Care > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **PERSON**	An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient).	1..1	n/a		Not mapped directly, encompassed implicitly in recordTarget/ patientRole/ patient.
Subject of Care > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **PERSON NAME**	The appellation by which an individual may be identified separately from any other within a social context.	1..*	recordTarget/patientRole/patient/**<Person Name>**		See common pattern: Person Name.
CDA Header Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/		
Subject of Care > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..*	**ext:coverage2/@typeCode="COVBY"**		See Australian Digital Health Agency CDA extension: Entitlement. All data elements within this section **SHALL** be deemed as CDA Header data elements for conformance assessment.
			ext:coverage2/**ext:entitlement**		
			ext:coverage2/ext:entitlement/**@classCode="COV"**		
			ext:coverage2/ext:entitlement/**@moodCode="EVN"**		
			ext:coverage2/ext:entitlement/**ext:participant/@typeCode="BEN"**		
			ext:coverage2/ext:entitlement/ext:participant/**ext:participantRole/@classCode="PAT"**		
			ext:coverage2/ext:entitlement/ext:participant/ext:participantRole/**ext:id**		**SHALL** hold the same value as ClinicalDocument/ recordTarget /patientRole/ **id**.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Subject of Care > PARTICIPANT > ENTITLEMENT > **Entitlement Number**	A number or code issued for the purpose of identifying the entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	1..1	ext:coverage2/ext:entitlement/**ext:id**		
Subject of Care > PARTICIPANT > ENTITLEMENT > **Entitlement Type**	The description of the scope of an entitlement.	1..1	ext:coverage2/ext:entitlement/**ext:code**	NCTIS: Admin Codes - Entitlement Type	See <code> for available attributes.
Subject of Care > PARTICIPANT > ENTITLEMENT > **Entitlement Validity Duration**	The time interval for which an entitlement is valid.	0..1	ext:coverage2/ext:entitlement/**ext:effectiveTime**		
Subject of Care > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **EMPLOYMENT DETAIL**	A person's occupation and employer.	0..0	recordTarget/patientRole/patient/**ext:asEmployment**		

The Subject of Care (Patient) section is part of the context section of the SCS (as opposed to being part of the content section of the SCS). Although it is located in the context section of the SCS, it contains data components that map to the CDA body, as well as data components that map to the CDA header. The information specifying the location of the elements is in the shaded context header row located above each group of mapping rows. The context remains the same until a new context header row starts.

The first row of the mapping (after the context header row), 'Subject of Care', is a CDA Header element and has a context of '/ClinicalDocument' (the root element of a CDA document). Adding together the context and the mapping using '/' gives a full path of:

1) /ClinicalDocument/recordTarget/patientRole

Due to the fact that 'Subject of Care' is part of the context section of the SCS (as opposed to a content element), information about it and its child elements can be located in the SCS document by finding the data component 'Subject of Care' in the table of contents under the context section, and navigating to the relevant page.

If the data component is part of the content section of the SCS, information about it could be located by finding the data component (or its parent) in the table of contents under the content section of the SCS.

2) The next row in the mapping (n/a) is a row that is not defined in the SCS but which is required by CDA. The CDA schema data element is recordTarget/patientRole/id. This is a technical identifier that is used for system purposes, such as matching ENTITLEMENT details back to the Subject of Care (patient). This identifier **SHALL** be a UUID.

3) The next row in the mapping table (Subject of Care > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE >PERSON) is defined in the SCS but is not mapped directly to the CDA because it is already encompassed implicitly by CDA in recordTarget/patientRole/patient.

Moving to the next row in the table (Subject of Care > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **PERSON NAME**) and concatenating the context and the mapping, we get:

4) /ClinicalDocument/recordTarget/patientRole/patient/**<Person Name>**

<PersonName> holds a link to the common pattern section where a new table lays out the mapping for the PERSON NAME common pattern.

Moving down the table to the context row '**CDA Header Data Elements**', any data components after this row (until the occurrence of a new context row) map to the CDA body. Because there is no equivalent concept in CDA, an Australian Digital Health Agency CDA extension has been added in order to represent ENTITLEMENT. This extension is indicated by the presence of the 'ext:' prefix. ENTITLEMENT CDA elements **SHALL** be deemed CDA Header data elements for conformance assessment. For the data component 'ENTITLEMENT', adding together the context and the mapping using '/' gives the following paths for the CDA body level 3 data elements ([index] is dependent on context):

5) /ClinicalDocument/component/structuredBody/component[index]/section/**ext:coverage2/@typeCode="COVBY"**

6) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/**ext:entitlement**

7) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**@classCode="COV"**

8) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**@moodCode="EVN"**

9) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**ext:participant/@typeCode="BEN"**

10) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/ext:participant/**ext:participantRole/@classCode="PAT"**

11) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/ext:participant/ext:participantRole/**ext:id**

This id is also a technical identifier and **SHALL** hold the same value as the /ClinicalDocument/recordTarget/patientRole/id mentioned in comment 1.

The order of the SCS data components is not always the same as the order of the CDA elements. In addition, the CDA elements need to be in the order specified in the Australian Digital Health Agency CDA Schema.

The id element is not specified in the SCS and **SHOULD** be filled with a UUID. This element may be used to reference an act from other places in the CDA document.

The next row in the table (Subject of Care > PARTICIPANT > ENTITLEMENT > Entitlement Number) maps to the id element:

12) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**ext:id**

The next row in the table (Subject of Care > PARTICIPANT > ENTITLEMENT > Entitlement Type) maps to the code element:

13) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**ext:code**

The next row in the table (Subject of Care > PARTICIPANT > ENTITLEMENT > Entitlement Validity Duration) maps to the effectiveTime element:

14) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**ext:effectiveTime**

The next row in the table (Subject of Care > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **EMPLOYMENT DETAIL**) maps to the ext:asEmployment element:

Where the SCS explicitly prohibits a data component, it is shown in the CDA mapping table with a cardinality of [0..0].

This is interpreted as an absolute prohibition against inclusion.

15) /ClinicalDocument/recordTarget/patientRole/patient/**ext:asEmployment**

See comments in the example below.

Example 2.1. Mapping Interpretation (non-normative)

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
```

```xml
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >

    …

    <!-- Begin Subject of Care - Header Part -->
    <recordTarget>
        <!-- 1 Corresponds to:
               '//recordTarget/patientRole'
           in the mapping. -->
        <patientRole>
            <!-- 2 Corresponds to:
                   '//recordTarget/patientRole/id'
               in the mapping -->
            <id root="989da303-3bbd-44b9-bc0f-ab98dd0b6dde"/>

            …

            <telecom value="tel:0499999999" use="H"/>
            <!-- 3 -->
            <patient>
                <!-- 4 Corresponds to:
                       '//recordTarget/patientRole/patient/<Person Name>'
                   in the mapping -->
                <name use="L">
                    <prefix>Ms</prefix>
                    <given>Sally</given>
                    <family>Grant</family>
                </name>

                …

            </patient>
        </patientRole>
    </recordTarget>
    <!-- End Subject of Care - Header Part -->

 …

    <!-- Begin CDA Body -->
    <component>
        <structuredBody>

            <!-- Begin section -->
            <component>
                <section>

                    …

                    <!-- Begin SUBJECT OF CARE ENTITLEMENT -->
                    <!-- 5 Corresponds to:
                           '//ext:coverage2'
                       in the mapping. -->
                    <ext:coverage2 typeCode="COVBY">
                        <!-- 6, 7, 8 Corresponds to:
                               '//ext:coverage2/ext:entitlement',
                               '//ext:coverage2/ext:entitlement/@classCode="COV"',
                               '//ext:coverage2/ext:entitlement/@moodCode="EVN"'
```

```xml
                    in the mapping -->
                <ext:Entitlement classCode="COV" moodCode="EVN">
                    <!-- 12 Corresponds to:
                            '//ext:coverage2/ext:entitlement/ext:id'
                        in the mapping -->
                    <ext:id root="1.2.36.174030967.0.5" extension="1234567892"
                        assigningAuthorityName="Medicare Identifier"/>
                    <!-- 13 Corresponds to:
                        '//ext:coverage2/ext:entitlement/ext:code'
                    in the mapping -->
                    <ext:code code="1" codeSystem="1.2.36.1.2001.1001.101.104.16047" codeSystemName="NCTIS Entitlement Type Values" displayName="Medicare Benefits" />
                    <!-- 14 Corresponds to:
                            '//ext:coverage2/ext:entitlement/ext:effectiveTime'
                        in the mapping -->
                    <ext:effectiveTime>
                        <low value="200701010101+1000"/>
                        <high value="202701010101+1000"/>
                    </ext:effectiveTime>
                    <!-- 9 Corresponds to:
                            '//ext:coverage2/ext:entitlement/ext:participant/@typeCode="BEN"'
                        in the mapping -->
                    <ext:participant typeCode="BEN">
                        <!-- 10 Corresponds to:
                                '//ext:coverage2/ext:entitlement/ext:participant/ext:participantRole/@classCode="PAT"'
                            in the mapping -->
                        <ext:participantRole classCode="PAT">
                            <!-- 11 Corresponds to:
                                    '//ext:coverage2/ext:entitlement/ext:participant/ext:participantRole/ext:id'
                                in the mapping -->
                            <!-- Same as recordTarget/patientRole/id -->
                            <ext:id root="989da303-3bbd-44b9-bc0f-ab98dd0b6dde"/>
                        </ext:participantRole>
                    </ext:participant>
                </ext:Entitlement>
            </ext:coverage2>
            <!-- End SUBJECT OF CARE ENTITLEMENT -->

                …

        </section>
    </component>
    <!-- End section -->

    </structuredBody>
  </component>
  <!-- End CDA Body -->
</ClinicalDocument>
```

2.3 CDA Extensions

The SCS is based on Australian requirements, either as expressed in existing Australian Standards, or based on extensive consultation with major stakeholders. Not all of these requirements are supported by HL7 Clinical Document Architecture Release 2 (CDA).

CDA provides a mechanism for handling this. Implementation guides are allowed to define extensions, provided some key rules are followed:

- Extensions have a namespace other than the standard HL7v3 namespace.

- The extension cannot alter the intent of the standard CDA document. For example, an extension cannot be used to indicate that an observation does not apply where the CDA document requires it.

- HL7 encourages users to get their requirements formalised in a subsequent version of the standard so as to maximise the use of shared semantics.

Accordingly, a number of extensions to CDA have been defined in this implementation guide. To maintain consistency, the same development paradigm has been used as CDA, and all the extensions have been submitted to HL7 for inclusion into a future release of CDA (Release 3 currently under development).

The extensions in Version 3.0 are incorporated in the namespace `http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0` as shown in the CDA example output throughout this document. Future versions of CDA extensions will be versioned as per the following example:

```
http://ns.electronichealth.net.au/Ci/Cda/Extensions/4.0
```

2.4 W3C XML Schema

This document refers to an accompanying CDA W3C XML Schema (referred to in this document as the Australian Digital Health Agency CDA Schema). This schema differs from the base HL7 CDA W3C XML Schema (referred to in this document as the HL7 CDA Schema) as mentioned below:

- Australian Digital Health Agency CDA extensions have been added to the Australian Digital Health Agency CDA Schema.

CDA documents which include extensions will fail to validate against the HL7 CDA Schema – this is a known limitation.

A Service Referral document that conforms to this specification **SHALL** validate against the Australian Digital Health Agency CDA Schema that accompanies this specification, and **SHALL** validate against the HL7 CDA Schema once the extensions have been removed. Note that merely passing schema validation does not ensure conformance. For more information, refer to Conformance.

2.5 Schematron

Many of the rules this document makes about CDA documents cannot be captured in the W3C XML Schema language (XSD) as XSD does not provide a mechanism to state that the value or presence of one attribute is dependent on the values or presence of other attributes (co-occurrence constraints).

Schematron is a rule-based validation language for making assertions about the presence or absence of patterns in XML trees. The rules defined by this document may be captured as Schematron rules. As of this release, the matching Schematron assertions have not yet been developed. We are considering the distribution of these rules in association with future releases of this implementation guide.

2.6 Implementation Strategies

There are many platform-specific implementation options for readers implementing a CDA document according to this guide. Examples of these implementation options include:

- Read or write CDA documents directly using a Document Object Model (DOM) or 3rd Generation Language (3GL) code (or both).

- Transform an existing XML format to and from a CDA document.

- Use a toolkit to generate a set of classes from HL7 CDA Schema or the Australian Digital Health Agency CDA Schema provided with this implementation guide, to read or write documents.

- Use existing libraries, possibly open source, that can read and write CDA documents.

The best approach for any given implementation is strongly dictated by existing architecture, technology and legacy constraints of the implementation project or existing system.

3 Service Referral Data Hierarchy

The data hierarchy below provides a logical representation of the data structure of the SR SCS data components.

The data hierarchy is a logical representation of the data components of a Service Referral, and is not intended to represent how the data contents are represented in a CDA document.

Note

Items below whose icon is 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.

	SERVICE REFERRAL			
CONTEXT				
	SUBJECT OF CARE			1..1
	DOCUMENT AUTHOR			1..1
	Document Instance Identifier			1..1
	RELATED DOCUMENT			0..*
		Link Nature		1..1
		Document Target		1..1
		DOCUMENT DETAILS		1..1
			Document Type	0..1
			Document Title	1..1
			Document Identifier	0..1
	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
				Request Urgency	0..1
				Request Urgency Notes	0..1
				Service Commencement Window	0..1
				Service Booking Status	1..1
				SERVICE PROVIDER	0..1
				Request Validity Period	0..1
				Requested Service DateTime	1..1
				Requested Service Instance Identifier	0..1
				Detailed Clinical Model Identifier	1..1
				Interpreter Required Alert (COMMUNICATION ALERT)	0..1
				Alert Description	1..1
				Preferred Language	1..*
				Communication Alert Instance Identifier	0..1
				Detailed Clinical Model Identifier	1..1
				Other Alerts (ALERT)	0..*
				Alert Type	1..1
				Alert Description	1..1
				Alert Instance Identifier	0..1

				Detailed Clinical Model Identifier	1..1
				Service Referral Detail Instance Identifier	0..1
				Section Type	1..1
				CURRENT SERVICES	0..1
				Current Service (REQUESTED SERVICE)	1..*
				Service Category	0..1
				Service Description	0..1
				Service Booking Status	1..1
				Service Comment	0..1
				SERVICE PROVIDER	1..1
				Requested Service DateTime	1..1
				Requested Service Instance Identifier	0..1
				Detailed Clinical Model Identifier	1..1
				Current Services Instance Identifier	0..1
				Section Type	1..1
				ADVERSE REACTIONS	0..1
				EXCLUSION STATEMENT - ADVERSE REACTIONS	0..1
				Global Statement	1..1
				Detailed Clinical Model Identifier	1..1
				ADVERSE REACTION	0..*
				Substance/Agent	1..1
				REACTION EVENT	0..1
				Manifestation	0..*
				Reaction Type	0..1
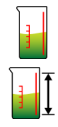
				Adverse Reaction Instance Identifier	0..1
				Detailed Clinical Model Identifier	1..1
				Adverse Reactions Instance Identifier	0..1
				Section Type	1..1
				Medications (MEDICATION ORDERS)	0..1
				EXCLUSION STATEMENT - MEDICATIONS	0..1
				Global Statement	1..1
				Detailed Clinical Model Identifier	1..1
				Known Medication (MEDICATION INSTRUCTION)	0..*
				Therapeutic Good Identification	1..1
				Directions	1..1
				Clinical Indication	0..1
				Medication Instruction Comment	0..1
				Medication Instruction Instance Identifier	0..1
				Detailed Clinical Model Identifier	1..1
				Medication Orders Instance Identifier	0..1
				Section Type	1..1
				Past and Current Medical History (MEDICAL HISTORY)	0..1
				PROBLEM/DIAGNOSIS	0..*
				Problem/Diagnosis Identification	1..1
				Date of Onset	0..1
				Date of Resolution/Remission	0..1
				Problem/Diagnosis Comment	0..1
				Problem/Diagnosis Instance Identifier	0..1
				Detailed Clinical Model Identifier	1..1

		🔗	**PROCEDURE**				0..*
			🅣	Procedure Name			1..1
			🅣	Procedure Comment			0..1
			⏳	Procedure DateTime			1..1
			🆔	Procedure Instance Identifier			0..1
			🆔	Detailed Clinical Model Identifier			1..1
		🔗	**UNCATEGORISED MEDICAL HISTORY ITEM**				0..*
			🅣	Medical History Item Description			1..1
			⏳	Medical History Item TimeInterval			0..1
			🅣	Medical History Item Comment			0..1
			🆔	Uncategorised Medical History Item Instance Identifier			0..1
			🆔	Detailed Clinical Model Identifier			1..1
		🆔	Medical History Instance Identifier				0..1
		🆔	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

						Anatomical Location Description	0..1
						Anatomical Location Image	0..*
						Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)	0..*
						Weight	0..1
						DIMENSIONS	0..1
						Volume	0..1
						Description (Object Description)	0..1
						Image	0..1
						COLLECTION AND HANDLING	0..1
						Sampling Preconditions	0..1
						HANDLING AND PROCESSING	1..1
						Collection DateTime	1..1
						Collection Setting	0..1
						Date and Time of Receipt (DateTime Received)	0..1
						IDENTIFIERS	0..1
						Specimen Identifier	0..1
						Parent Specimen Identifier	0..1
						Container Identifier	0..1
						Overall Pathology Test Result Status	1..1
						Clinical Information Provided	0..1
						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
								Anatomical Location Description	0..1
								Anatomical Location Image	0..*
							Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)		0..*
								Weight	0..1
								DIMENSIONS	0..1
								Volume	0..1
								Description (Object Description)	0..1
								Image	0..1
							COLLECTION AND HANDLING		0..1

							Sampling Preconditions	0..1
							HANDLING AND PROCESSING	1..1
							Collection DateTime	1..1
							Collection Setting	0..1
							Date and Time of Receipt (DateTime Received)	0..1
							IDENTIFIERS	0..1
							Specimen Identifier	0..1
							Parent Specimen Identifier	0..1
							Container Identifier	0..1
					Pathological Diagnosis			0..*
					Conclusion (Pathology Test Conclusion)			0..1
					Test Result Representation			0..1
					Test Comment			0..1
					TEST REQUEST DETAILS			0..*
						Test Requested Name		0..*
						Laboratory Test Result Identifier		0..1
					Observation DateTime			1..1
					Pathology Test Result Instance Identifier			0..1
					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
						Anatomical Location Description	0..1
						Anatomical Location Image	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
								Anatomical Location Description	0..1

						Anatomical Location Image	0..*
						Examination Result Representation	0..1
						EXAMINATION REQUEST DETAILS	0..*
						Examination Requested Name	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
						Observation DateTime	1..1
						Imaging Examination Result Instance Identifier	0..1
						Detailed Clinical Model Identifier	1..1
						Pending Diagnostic Investigation (REQUESTED SERVICE)	0..*
						Reason for Service	0..1
						Reason for Service Description	0..1
						Service Description	1..1
						DateTime Service Scheduled	0..1
						Service Commencement Window	0..1
						Service Booking Status	1..1
						Service Comment	0..1
						Subject of Care Instruction Description	0..*

				SERVICE PROVIDER	0..1
				Requested Service DateTime	1..1
				Requested Service Instance Identifier	0..1
				Detailed Clinical Model Identifier	1..1
			Diagnostic Investigations Instance Identifier		0..1
			Section Type		1..1

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4 Administrative Observations

The SR SCS contains a number of data elements that are logically part of the SCS context, but for which there are no equivalent data elements in the CDA header. These data elements are considered to be "Administrative Observations" about the encounter, the patient or some other participant. Administrative Observations is a CDA section that is created to hold these data components in preference to creating extensions for them.

CDA R-MIM Representation

Figure 4.1 Administrative Observations shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The Administrative Observations section is composed of a Section class related to its context ClinicalDocument.structuredBody through a component relationship.

Figure 4.1. Administrative Observations

Approved for external use
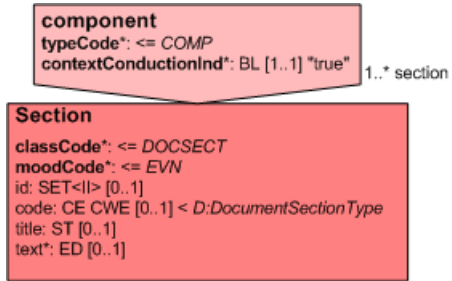
CDA Mapping

At most one instance of Administrative Observation section **SHOULD** be present in a CDA document. The cardinality of this section comes from its linking context data elements (e.g. CDA context data element(s) mapped to Administrative Observation Section). If any of the linking context data elements are mandatory, then this section **SHALL** be marked as a mandatory section.

This section **SHALL NOT** be populated if there are no entries or text to go in it.

This section **SHALL** contain a code if provided.

All data elements (with the exception of narrative text) within this section **SHALL** be deemed as CDA Header data elements for conformance assessment.

The <text> data element is **OPTIONAL** and **SHALL** be treated as a Level 2 CDA data element.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: /ClinicalDocument/component/structuredBody/		
n/a	n/a	Cardinality comes from linking context data elements	**component[admin_obs]/section**		
		0..1	component[admin_obs]/section/**id**		See <id> for available attributes.
		1..1	component[admin_obs]/section/**code**		See <code> for available attributes.
			component[admin_obs]/section/code/**@code="102.16080"**		
			component[admin_obs]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[admin_obs]/section/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			component[admin_obs]/section/code/**@displayName="Administrative Observations"**		
			component[admin_obs]/section/**title="Administrative Observations"**		
		0..1	component[admin_obs]/section/**text**		See Appendix A, *CDA Narratives*.

Example 4.1. Administrative Observations XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
    xmlns="urn:hl7-org:v3"
    xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
    …
    >
    …

    <!-- Begin CDA Body -->
    <component>
        <structuredBody>
            …

            <!-- Begin Administrative Observations -->
            <component typeCode="COMP">
                <section classCode="DOCSECT" moodCode="EVN">
                    <id root="8c173d55-e8d7-43c1-b06b-e427b39342d4"/>
                    <code code="102.16080"
                        codeSystem="1.2.36.1.2001.1001.101"
                        codeSystemName="NCTIS Data Components"
                        displayName="Administrative Observations"/>
                    <title>Administrative Observations</title>

                    <!-- narrative block -->
                    <text/>
                    …

                </section>
            </component>
            <!-- End Administrative Observations -->
            …

        </structuredBody>
    </component>
    <!-- End CDA Body -->
</ClinicalDocument>
```

5 CDA Header

This chapter contains CDA-specific header elements (both **REQUIRED** and **OPTIONAL**) that are not specified in the SR SCS specification. The CDA Schema Data Element describes each element.

All the definitions in this chapter are sourced from "HL7 Clinical Document Architecture, Release 2" [HL7CDAR2].

5.1 ClinicalDocument

Identification

Name	ClinicalDocument
Definition	The ClinicalDocument class is the entry point into the CDA R-MIM, and corresponds to the <ClinicalDocument> XML element that is the root element of a CDA document.

Relationships

Children

Name	Occurrence
LegalAuthenticator	0..1
InformationRecipient	0..1
Custodian	1..1

CDA R-MIM Representation

ClinicalDocument

classCode*: <= *DOCCLIN*
moodCode*: CS CNE [1..1] < *D:EVN*
id*: II [1..1]
code*: CE CWE [1..1] < *D:DocumentType*
title: ST [0..1]
effectiveTime*: TS [1..1]
confidentialityCode*: CE CWE [1..1] < *D:x_BasicConfidentialityKind*
languageCode: CS CNE [0..1] < *V:HumanLanguage*
setId: II [0..1]
versionNumber: INT [0..1]
completionCode: CE CWE [0..1] < *D:DocumentCompletion*

Note:
completionCode is added as an
Australian Digital Health Agency
extension to CDA.

Figure 5.1. ClinicalDocument

CDA Mapping

CDA Schema Data Element	Definition	Card	Vocab	Comments
CDA Header Data Elements	Context: /			
ClinicalDocument	The ClinicalDocument class is the entry point into the CDA R-MIM, and corresponds to the <ClinicalDocument> XML element that is the root element of a CDA document.	1..1		
ClinicalDocument/**typeId**	A technology-neutral explicit reference to the CDA Release 2 specification.	1..1		
ClinicalDocument/typeId/**@extension="POCD_HD000040"**		1..1		The unique identifier for the CDA Release 2 Hierarchical Description.
ClinicalDocument/typeId/**@root="2.16.840.1.113883.1.3"**		1..1		The OID for HL7 Registered models.
ClinicalDocument/**templateId**	A templateId signals the imposition of a set of template-defined constraints.	1..*		One or more template identifiers that indicate constraints on the CDA document that this document conforms to. One of the identifiers must be the templateId that identifies this specification (see immediately below). Additional template identifiers may be required by other specifications, such as the CDA Rendering Specification. Systems are not required to recognise any other template identifiers than the one below in order to understand the document as a [type] but these identifiers may influence how the document must be handled.
ClinicalDocument/templateId/**@root="1.2.36.1.2001.1001.100.1002.231"**		1..1		The healthcare context-specific name of the published Service Referral CDA Implementation Guide.
ClinicalDocument/templateId/**@extension="1.1"**		1..1		The identifier of the version that was used to create the document instance.
ClinicalDocument/**id**	Represents the unique instance identifier of a clinical document.	1..1		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
ClinicalDocument/**code**	The code specifying the particular kind of document (e.g. History and Physical, Discharge Summary, Progress Note).	1..1		code/@nullFlavor **SHALL NOT** be present. Referral of a subject of care from one healthcare or human services provider to another.
ClinicalDocument/code/**@code="57133-1"**				
ClinicalDocument/code/**@codeSystem="2.16.840.1.113883.6.1"**				
ClinicalDocument/code/**@codeSystemName**			The value **SHOULD** be "LOINC". See CodeSystem OIDs.	Optional CDA element.
ClinicalDocument/code/**@displayName="Referral note"**				
ClinicalDocument/**title**	Represents the title of the document.	0..1		

CDA Schema Data Element	Definition	Card	Vocab	Comments
ClinicalDocument/**effectiveTime**	Signifies the document creation time, when the document first came into being. Where the CDA document is a transform from an original document in some other format, the ClinicalDocument.effectiveTime is the time the original document is created.	1..1		See common pattern: time.
ClinicalDocument/**confidentialityCode/@nullFlavor="NA"**	Codes that identify how sensitive a piece of information is and/or that indicate how the information may be made available or disclosed.	1..1		
ClinicalDocument/**languageCode**	Specifies the human language of character data (whether they be in contents or attribute values).	0..1	[RFC3066] – Tags for the Identification of Languages	<Language Code> – <DIALECT> The <Language Code> **SHALL** be "en". The <DIALECT> **SHOULD** be "AU".
ClinicalDocument/**setId**	Represents an identifier that is common across all document revisions.	0..1		
ClinicalDocument/**versionNumber/@value**	An integer value used to version successive replacement documents.	0..1		
ClinicalDocument/**ext:completionCode**	The lifecycle status of a document.	1..1	NCTIS: Admin Codes - Document Status	See Australian Digital Health Agency CDA extension: ClinicalDocument.completionCode.

Example 5.1. ClinicalDocument XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
    xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
    xmlns:xs="http://www.w3.org/2001/XMLSchema"
    xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">

    <!-- Begin CDA Header -->
    <typeId extension="POCD_HD000040" root="2.16.840.1.113883.1.3"/>
    <templateId root="1.2.36.1.2001.1001.100.1002.231" extension="1.1"/>
    <id root="460158a6-984b-472f-8e9f-1e434ad0c342"/>
    <code code="57133-1" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
        displayName="Referral note"/>
    <title>Referral</title>
    <effectiveTime value="201211061639+1100"/>
    <confidentialityCode nullFlavor="NA"/>
    <languageCode code="en-AU"/>
    <setId root="fc7fecc0-8255-11e3-baa7-0800200c9a66"/>
    <versionNumber value="1"/>
    <ext:completionCode code="F" codeSystem="1.2.36.1.2001.1001.101.104.20104"
        codeSystemName="NCTIS Document Status Values" displayName="Final"/>
    <!-- End CDA Header -->

</ClinicalDocument>
```

5.1.1 LegalAuthenticator

Identification

Name	LegalAuthenticator
Definition	Represents a participant who has legally authenticated the document.

Relationships

Parent

Name	Occurrences (child within parent)
ClinicalDocument	0..1

CDA R-MIM Representation

Figure 5.2 LegalAuthenticator shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The LegalAuthenticator maps to the CDA Header element legalAuthenticator. The legalAuthenticator participation class represents who has legally authenticated the document. The role is AssignedEntity and is represented by the Person, and optionally Organization, entities.
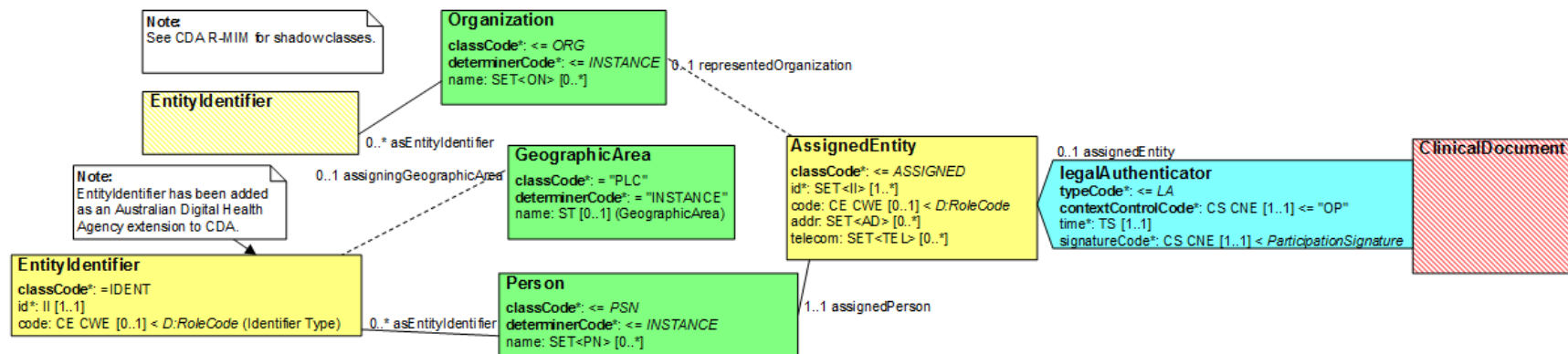
Figure 5.2. LegalAuthenticator

CDA Mapping

Note

NS = 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.

CDA Schema Data Element	Definition	Card	Vocab	Comments
Context: /ClinicalDocument/				
legalAuthenticator	Represents a participant who has legally authenticated the document.	0..1		
legalAuthenticator/**time/@value**	Indicates the time of authentication.	1..1		Required CDA element. The time/@value **SHALL** include both a time and a date.
legalAuthenticator/**signatureCode/@code="S"**	Indicates that the signature has been affixed and is on file.	1..1		
legalAuthenticator/**assignedEntity**	A legalAuthenticator is a person in the role of an assigned entity (AssignedEntity class). An assigned entity is a person assigned to the role by the scoping organization. The entity playing the role is a person (Person class). The entity scoping the role is an organization (Organization class).	1..1		
legalAuthenticator/assignedEntity/**code**	The specific kind of role.	0..1	NS	See <code> for available attributes.
legalAuthenticator/assignedEntity/**id**	A unique identifier for the player entity in this role.	1..1		See <id> for available attributes.
legalAuthenticator/assignedEntity/**assignedPerson**	The entity playing the role (assignedEntity) is a person.	1..1		
legalAuthenticator/assignedEntity/assignedPerson/**<Entity Identifier>**	The entity identifier of the person.	0..*		See common pattern: Entity Identifier.
legalAuthenticator/assignedEntity/**<Address>**	A postal address for the entity (assignedPerson) while in the role (assignedEntity).	0..*		See common pattern: Address.
legalAuthenticator/assignedEntity/**<Electronic Communication Detail>**	A telecommunication address for the entity (assignedPerson) while in the role (assignedEntity).	0..*		See common pattern: Electronic Communication Detail.
legalAuthenticator/assignedEntity/assignedPerson/**<Person Name>**	A non-unique textual identifier or moniker for the entity (assignedPerson).	0..*		See common pattern: Person Name.
legalAuthenticator/assignedEntity/**representedOrganization**	The entity scoping the role (assignedEntity).	0..1		
legalAuthenticator/assignedEntity/representedOrganization/**<Entity Identifier>**	A unique identifier for the scoping entity (represented organization) in this role (assignedEntity).	0..*		See common pattern: Entity Identifier.
legalAuthenticator/assignedEntity/representedOrganization/**name**	A non-unique textual identifier or moniker for the entity (representedOrganization).	0..*		

---

[1] http://www.hl7.org/oid/index.cfm?ref=footer

Example 5.2. LegalAuthenticator XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
<!-- Begin CDA Header -->
 …

<!-- Begin legalAuthenticator -->
<legalAuthenticator>
 <time value="200910201235+1000"/>
 <signatureCode code="S"/>
 <assignedEntity>
  <id root="b830b9a6-4ea7-4a1a-92eb-ddf18b82a291"/>
  <code code="253111" codeSystem="2.16.840.1.113883.13.62"
   codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
   displayName="General Medical Practitioner"/>

  <!-- Address -->
  <addr use="WP">
   <streetAddressLine>1 Clinician Street</streetAddressLine>
   <city>Healthville</city>
   <state>QLD</state>
   <postalCode>5555</postalCode>
   <additionalLocator>32568931</additionalLocator>
  </addr>

  <!-- Electronic Communication Detail -->
  <telecom use="WP" value="tel:0712341234"/>

  <assignedPerson>
   <!-- Person Name -->
   <name>
    <prefix>Dr.</prefix>
    <given>Good</given>
    <family>Doctor</family>
   </name>

   <!-- Entity Identifier -->
   <ext:asEntityIdentifier classCode="IDENT">
    <ext:id assigningAuthorityName="HPI-I"
     root="1.2.36.1.2001.1003.0.8003611566682112"/>
    <ext:assigningGeographicArea classCode="PLC">
     <ext:name>National Identifier</ext:name>
    </ext:assigningGeographicArea>
   </ext:asEntityIdentifier>
  </assignedPerson>

  <representedOrganization>
   <name>Good Health Clinic</name>

   <!-- Entity Identifier -->
   <ext:asEntityIdentifier classCode="IDENT">
```

```xml
        <ext:id assigningAuthorityName="HPI-O"
         root="1.2.36.1.2001.1003.0.8003621566684455"/>
        <ext:assigningGeographicArea classCode="PLC">
         <ext:name>National Identifier</ext:name>
        </ext:assigningGeographicArea>
      </ext:asEntityIdentifier>
    </representedOrganization>

  </assignedEntity>
 </legalAuthenticator>
 <!-- End legalAuthenticator -->

 …

 <!-- End CDA Header -->

</ClinicalDocument>
```

5.1.2 InformationRecipient

Identification

Name	Information Recipient
Definition	Represents a recipient who should receive a copy of the document.

Relationships

Parent

Name	Occurrences (child within parent)
ClinicalDocument	0..1

CDA R-MIM Representation

Figure 5.3 InformationRecipient shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The INFORMATION RECIPIENT maps to the CDA Header element informationRecipient. The informationRecipient participation class represents who should receive a copy of the document. The role is IntendedRecipient and is represented by the Person and/or Organization entities.
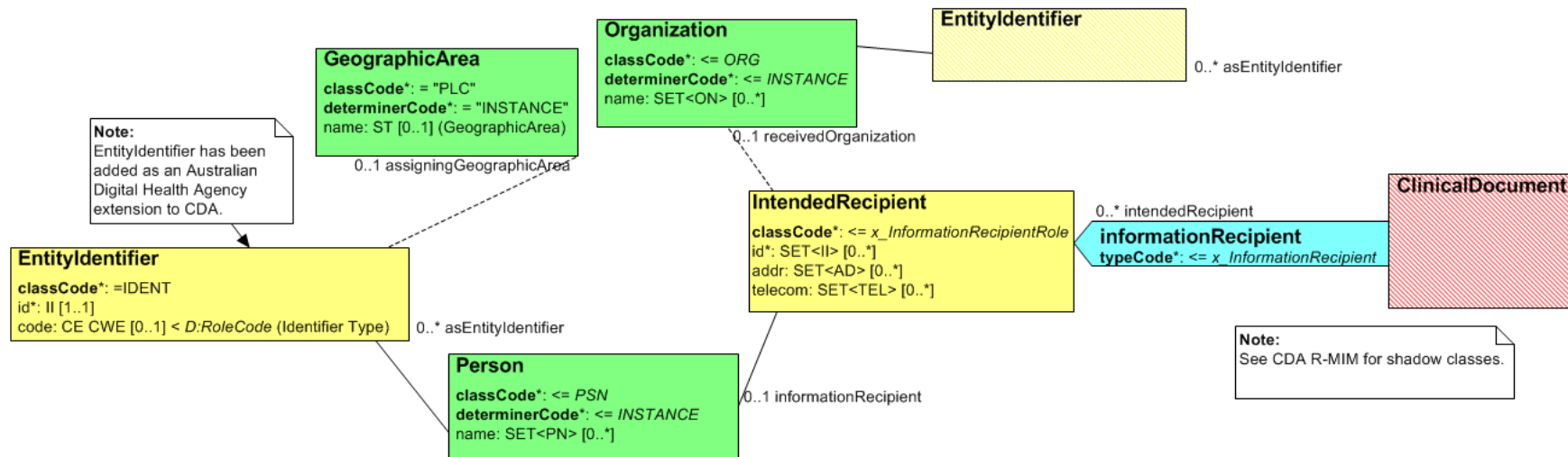
Figure 5.3. InformationRecipient

CDA Mapping

CDA Schema Data Element	Definition	Card	Vocab	Comments
Context: /ClinicalDocument/				
informationRecipient	Represents a recipient who should receive a copy of the document.	0..1		This **SHALL** be filled with the referee to whom the subject of care is being referred.
informationRecipient/**@typeCode="PRCP"**	Type of recipient	1..1		
informationRecipient/**intendedRecipient**	An informationRecipient is a person in the role of an assigned entity (AssignedEntity class). An assigned entity is a person assigned to the role by the scoping organization. The entity playing the role is a person (Person class). The entity scoping the role is an organization (Organization class).	1..1		
informationRecipient/**intendedRecipient/@classCode="ASSIGNED"**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1		
informationRecipient/intendedRecipient/**informationRecipient**	The entity playing the role (intendedRecipient) is a person.	0..1		
informationRecipient/**intendedRecipient/id**	A unique identifier for the player entity in this role.	1..1	This **SHALL** hold the same value as /ClinicalDocument/component/structuredBody/component[ref_det]/section/entry[service]/act/performer/assignedEntity/id.	See <id> for available attributes.
informationRecipient/intendedRecipient/informationRecipient/**<Entity Identifier>**	The entity identifier of the person.	0..*	If present, the value of one Entity Identifier **SHALL** be the same as SERVICE PROVIDER > PARTICIPANT > Entity Identifier (performer[srd_rs_service_provider_person]/assignedEntity/assignedPerson/ext:asEntityIdentifier).	See common pattern: Entity Identifier.
informationRecipient/intendedRecipient/**<Address>**	A postal address for the entity (informationRecipient) while in the role (intendedRecipient).	0..*		See common pattern: Address.
informationRecipient/intendedRecipient/**<Electronic Communication Detail>**	A telecommunication address for the entity (informationRecipient) while in the role (intendedRecipient).	0..*		See common pattern: Electronic Communication Detail.
informationRecipient/intendedRecipient/informationRecipient/**<Person Name>**	A non-unique textual identifier or moniker for the entity (informationRecipient).	0..*		See common pattern: Person Name.
informationRecipient/intendedRecipient/**receivedOrganization**	The entity scoping the role (intendedRecipient).	0..1		

CDA Schema Data Element	Definition	Card	Vocab	Comments
informationRecipient/intendedRecipient/receivedOrganization/**<Entity Identifier>**	A unique identifier for the scoping entity (represented organization) in this role (intendedRecipient).	0..*	If present, the value of one Entity Identifier **SHALL** be the same as SERVICE PROVIDER > PARTICIPANT > Entity Identifier (performer[srd_rs_service_provider_organisation]/assignedEntity/representedOrganization/asOrganizationPartOf/wholeOrganization/ext:asEntityIdentifier).	See common pattern: Entity Identifier.
informationRecipient/intendedRecipient/receivedOrganization/**name**	A non-unique textual identifier or moniker for the entity (representedOrganization).	0..*		

Example 5.3. InformationRecipient XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 <!-- Begin CDA Header -->
 …

 <!-- Begin informationRecipient :: example as an organisation -->
 <informationRecipient typeCode="PRCP">
  <intendedRecipient classCode="ASSIGNED">
   <!-- id is used for system purposes such as matching -->
   <id root="142e4bc3-2b31-4dc8-90ac-32c3fbeb6ae0"/>

   <!-- Address -->
   <addr use="WP">
    <streetAddressLine>55 Provider Road</streetAddressLine>
    <city>Healthville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568931</additionalLocator>
    <country>Australia</country>
   </addr>

   <!-- Electronic Communication Detail -->
   <telecom use="WP" value="tel:0722222222"/>

   <receivedOrganization>
    <name>Acme Hospital Group</name>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
     <ext:id assigningAuthorityName="ACN"
      root="1.2.36.87493897"/>
     <ext:code code="XX"
      codeSystem="2.16.840.1.113883.12.203"/>
    </ext:asEntityIdentifier>
   </receivedOrganization>

  </intendedRecipient>
 </informationRecipient>
 <!-- End informationRecipient -->
 …

 <!-- End CDA Header -->

</ClinicalDocument>
```

5.1.3 Custodian

Identification

Name	Custodian
Definition	The organization that is in charge of maintaining the document. The custodian is the steward that is entrusted with the care of the document. Every CDA document has exactly one custodian.

Relationships

Parent

Name	Occurrences (child within parent)
ClinicalDocument	1..1

CDA R-MIM Representation

Figure 5.4 Custodian shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The Custodian maps to the CDA Header element custodian. The custodian participation class represents the organisation that is in charge of maintaining the document. The role is Assigned-Custodian and is represented by the CustodianOrganization entity.
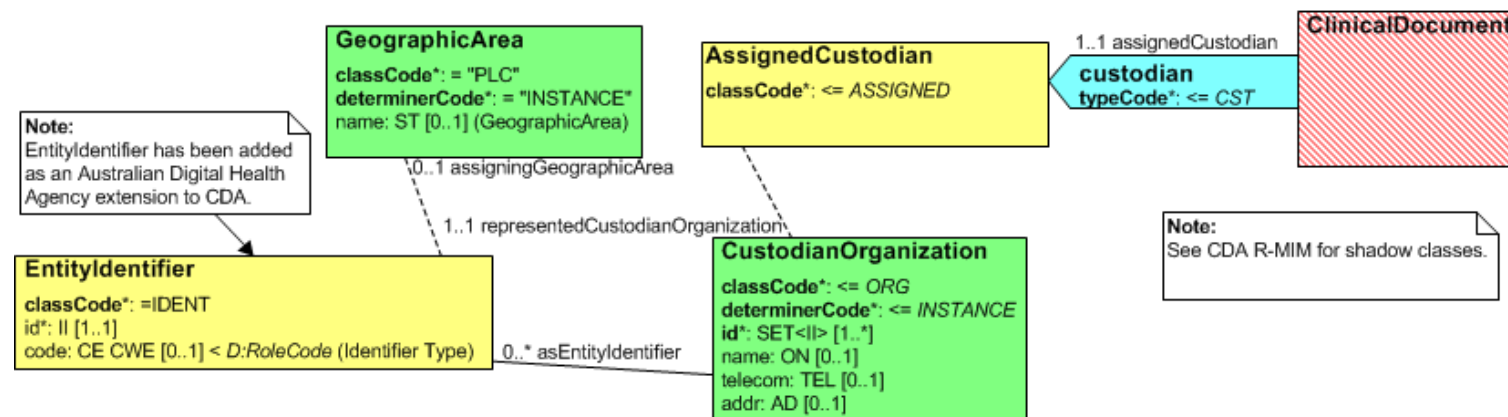
Figure 5.4. Custodian

CDA Mapping

CDA Schema Data Element	Definition	Card	Vocab	Comments
Context: /ClinicalDocument/				
custodian	Represents the organization that is in charge of maintaining the document. The custodian is the steward that is entrusted with the care of the document. Every CDA document has exactly one custodian.	1..1		
custodian/**assignedCustodian**	A custodian is a scoping organization in the role of an assigned custodian.	1..1		
custodian/assignedCustodian/**representedCustodianOrganization**	The steward organization (CustodianOrganization class) is an entity scoping the role of AssignedCustodian.	1..1		
custodian/assignedCustodian/representedCustodianOrganization/**id**	A unique identifier for the scoping entity (representedCustodianOrganization) in this role.	1..*		See <id> for available attributes.
custodian/assignedCustodian/representedCustodianOrganization/**<Entity Identifier>**	The entity identifier of the custodian organization.	0..*		See common pattern: Entity Identifier.
custodian/assignedCustodian/representedCustodianOrganization/**name**	The name of the steward organization.	0..1		
custodian/assignedCustodian/representedCustodianOrganization/**<Electronic Communication Detail>**	The telecom of the steward organization.	0..1		See common pattern: Electronic Communication Detail.
custodian/assignedCustodian/representedCustodianOrganization/**<Address>**	The address of the steward organization.	0..1		See common pattern: Address.

Example 5.4. Custodian XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
<!-- Begin CDA Header -->
 …

<!-- Begin Custodian -->
<custodian>
  <assignedCustodian>
   <representedCustodianOrganization>
    <!-- id is used for system purposes such as matching -->
    <id root="c9c04faf-d7a8-4802-8c69-980b0ce4d798"/>
    <name>Acme Hospital Group</name>

    <!-- Electronic Communication Detail -->
    <telecom use="WP" value="tel:0712341234"/>

    <!-- Address -->
    <addr use="WP">
     <streetAddressLine>1 Clinician Street</streetAddressLine>
     <city>Healthville</city>
     <state>QLD</state>
     <postalCode>5555</postalCode>
     <additionalLocator>32568931</additionalLocator>
    </addr>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
     <ext:id assigningAuthorityName="HPI-O"
      root="1.2.36.1.2001.1003.0.8003621566684455"/>
     <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
     </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>
   </representedCustodianOrganization>

  </assignedCustodian>
 </custodian>
<!-- End Custodian -->
 …

<!-- End CDA Header -->

</ClinicalDocument>
```

6 Context Data Specification - CDA Mapping

6.1 SERVICE REFERRAL

Identification

Name	SERVICE REFERRAL
Metadata Type	Structured Document
Identifier	SD-17034

Relationships

Children

Data Type	Name	Occurrence
	SUBJECT OF CARE	1..1
	DOCUMENT AUTHOR	1..1
	PATIENT NOMINATED CONTACT	0..*
	PRIMARY CARE PROVIDER	0..1
	INTERESTED PARTY	0..*

CDA R-MIM Representation

Figure 6.1 SERVICE REFERRAL Context shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.
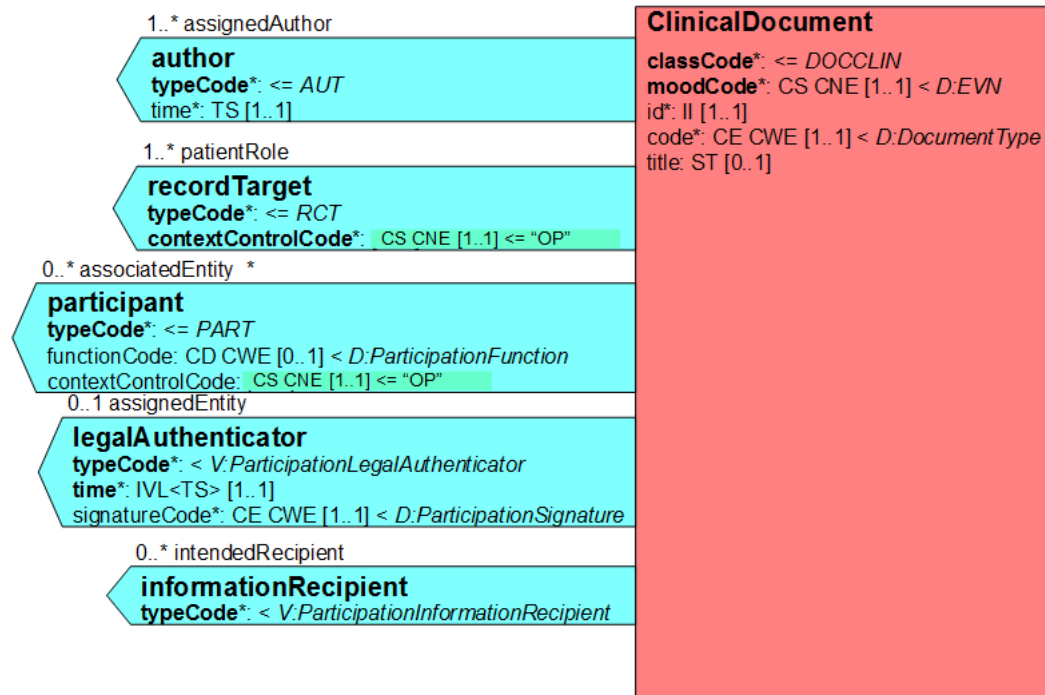
Figure 6.1. SERVICE REFERRAL Context

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /		
SERVICE REFERRAL	Referral of a subject of care from one healthcare or human services provider to another.	1..1	**ClinicalDocument**		
SERVICE REFERRAL > **SUBJECT OF CARE**	Person who receives care services.	1..1	See: SUBJECT OF CARE		
SERVICE REFERRAL > **DOCUMENT AUTHOR**	Composer of the document.	1..1	See: DOCUMENT AUTHOR		
SERVICE REFERRAL > **Document Instance Identifier**	Globally unique identifier for each instance of a Service Referral document.	1..1	ClinicalDocument/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
SERVICE REFERRAL > **RELATED DOCUMENT**	Information about a document of interest.	0..*	See: RELATED DOCUMENT		This logical data component could not be mapped to CDA Header elements and is instead mapped as a child of SERVICE REFERRAL DETAIL.
SERVICE REFERRAL > **Document Type**	Type of document.	1..1	ClinicalDocument/**code**		See <code> for available attributes. code/@nullFlavor **SHALL NOT** be present.
			ClinicalDocument/code/**@code="57133-1"**		
			ClinicalDocument/code/**@codeSystem="2.16.840.1.113883.6.1"**		
			ClinicalDocument/code/**@codeSystemName**	The value **SHOULD** be "LOINC". See CodeSystem OIDs.	Optional CDA element.
			ClinicalDocument/code/**@displayName="Referral note"**		
SERVICE REFERRAL > **Document Title**	Title of the document.	0..1	ClinicalDocument/**title**		
SERVICE REFERRAL > **PATIENT NOMINATED CONTACT**	Contact nominated to receive information about the subject of care.	0..*	See: PATIENT NOMINATED CONTACT		
SERVICE REFERRAL > **PRIMARY CARE PROVIDER**	Healthcare provider (person or organisation) nominated by the subject of care as being primarily responsible for their ongoing healthcare.	0..1	See: PRIMARY CARE PROVIDER		
SERVICE REFERRAL > **INTERESTED PARTY**	Party who should receive correspondence from the referral receiver regarding the referral.	0..*	See: INTERESTED PARTY		
SERVICE REFERRAL > **DateTime Attested**	Date and time that the document author, authoriser or approver confirms that a document is complete and genuine.	0..1	ClinicalDocument/**legalAuthenticator/time/@value**	The time/@value **SHALL** include both a time and a date.	See <time> for available attributes.

For CDA Header mappings and model which are not explicitly included in the SCS, see ClinicalDocument.

Example 6.1. Service Referral Context XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
 xmlns="urn:hl7-org:v3"
 xmlns:xs="http://www.w3.org/2001/XMLSchema"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0">
 <!-- Begin CDA Header -->
 …

 <!-- Document Instance Identifier -->
 <id root="8f281000-498d-11e2-bcfd-0800200c9a66"/>
 <!-- Document Type -->
 <code code="57133-1"
  codeSystem="2.16.840.1.113883.6.1"
  codeSystemName="LOINC"
  displayName="Referral Note" />
 <!-- Document Title -->
 <title>Referral</title>
 …

 <!-- Begin SUBJECT OF CARE -->
 <recordTarget>
  …
 </recordTarget>
 <!-- End SUBJECT OF CARE -->

 <!-- Begin DOCUMENT AUTHOR -->
 <author>
  …
 </author>
 <!-- End DOCUMENT AUTHOR -->

 <!-- Begin LegalAuthenticator -->
 <legalAuthenticator>

  <!-- DateTime Attested -->
  <time value="200910201235+1100"/>

 </legalAuthenticator>
 <!-- End LegalAuthenticator -->

 <!-- Begin PATIENT NOMINATED CONTACT -->
 <participant>
  …
 </participant>
 <!-- End PATIENT NOMINATED CONTACT -->

 <!-- Begin PRIMARY CARE PROVIDER -->
 <participant>
  …
 </participant>
 <!-- End PRIMARY CARE PROVIDER -->

 <!-- Begin INTERESTED PARTY -->
```

```xml
<informationRecipient>
 …
</informationRecipient>

<!-- End INTERESTED PARTY -->
…

<!-- End CDA Header -->

<!-- Begin CDA Body -->
<component>
 <structuredBody>
  …

   <!-- Begin SERVICE REFERRAL DETAIL -->
   <component>
    <section>
     …

     <!-- Begin RELATED DOCUMENT -->
     <entry>
      <act>
       …
      </act>
     </entry>
     <!-- End RELATED DOCUMENT -->
     …

    </section>
   </component>
   <!-- End SERVICE REFERRAL DETAIL -->
   …

 </structuredBody>
</component>
<!-- End CDA Body -->
</ClinicalDocument>
```

6.1.1 SUBJECT OF CARE

Identification

Name	SUBJECT OF CARE
Metadata Type	Data Group
Identifier	DG-10296

Relationships

Parent

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

CDA R-MIM Representation

Figure 6.2 SUBJECT OF CARE - Header Data Elements and Figure 6.3 SUBJECT OF CARE - Body Data Elements show a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to both CDA Header and CDA Body elements.

The SUBJECT OF CARE data group maps mostly to CDA Header elements. The recordTarget participation class represents the medical record to which this document belongs. The recordTarget is associated with the Patient class by the PatientRole class. In order to represent the Date of Death of the Subject of Care, Patient.deceasedTime has been added as an Australian Digital Health Agency CDA extension.
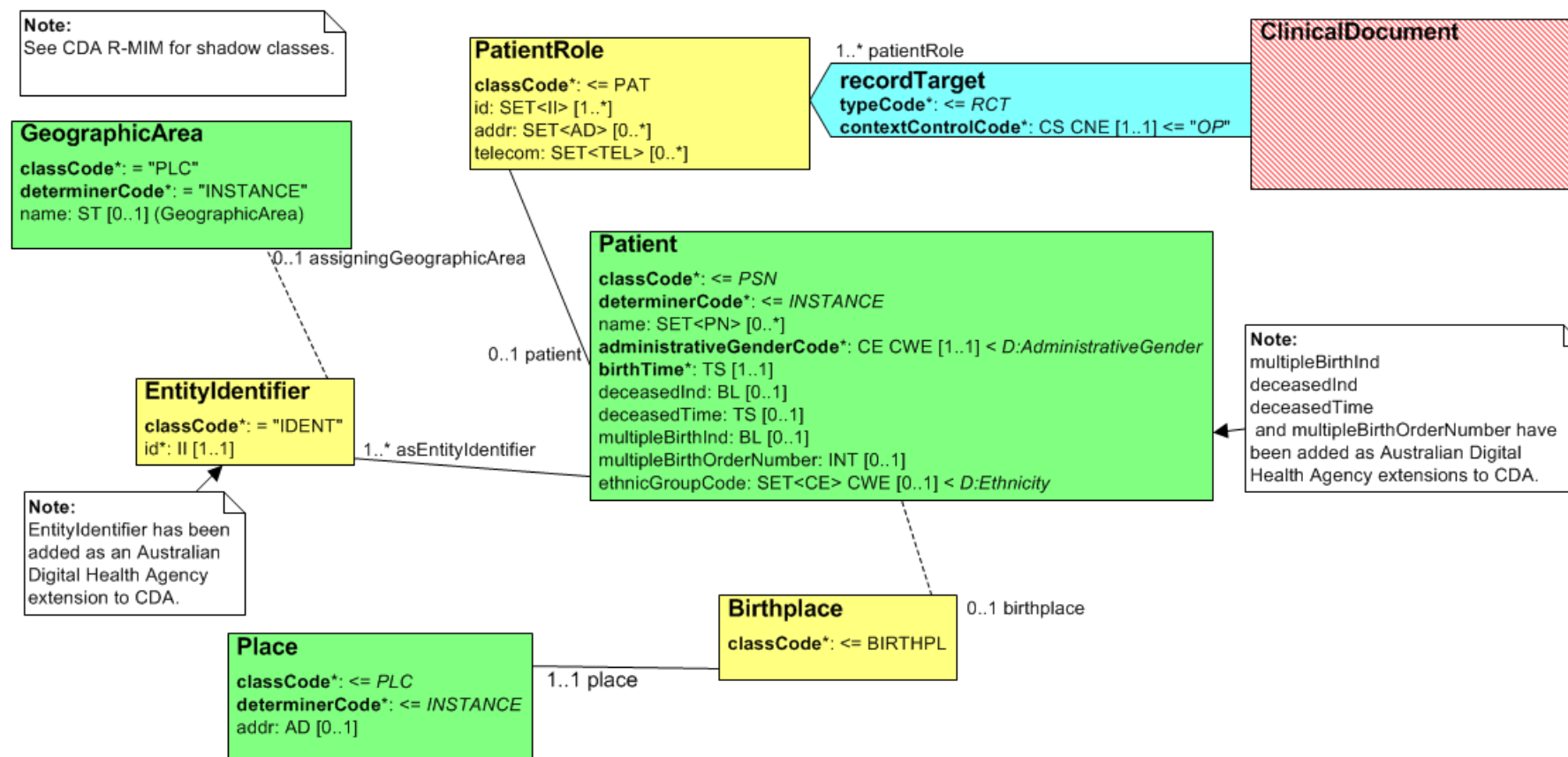
Figure 6.2. SUBJECT OF CARE - Header Data Elements

Note

Several data elements contained in the SUBJECT OF CARE data group could not be mapped to CDA Header elements. These data elements have been mapped to Observations in the Administrative Observations section (see *4 Administrative Observations*).

Figure 6.3. SUBJECT OF CARE - Body Data Elements

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /ClinicalDocument/		
SUBJECT OF CARE	Person who receives care services.	1..1	recordTarget/**patientRole**		
n/a	n/a	1..1	recordTarget/patientRole/**id**		Required CDA element. See <id> for available attributes.
SUBJECT OF CARE > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	0..0	n/a		This logical data component has no mapping to CDA.
SUBJECT OF CARE > **LOCATION OF PARTICIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIPATION is not currently mapped.
SUBJECT OF CARE > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	n/a	Participation Type **SHALL** have an implementation-specific value equivalent to "Subject of Care".	Not mapped directly, encompassed implicitly in recordTarget/ typeCode = "RCT" (optional, fixed value).
SUBJECT OF CARE > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	n/a	Role **SHALL** have an implementation-specific value equivalent to "Patient".	Not mapped directly, encompassed implicitly in recordTarget/ patientRole/ classCode = "PAT".
SUBJECT OF CARE > **PARTICIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	recordTarget/patientRole/**patient**		
SUBJECT OF CARE > PARTICIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..*	recordTarget/patientRole/patient/**<Entity Identifier>**		See common pattern: Entity Identifier. The Subject of Care's Medicare card number is recorded in ENTITLEMENT, not Entity Identifier.
SUBJECT OF CARE > PARTICIPANT > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	1..*	recordTarget/patientRole/**<Address>**		See common pattern: Address.
SUBJECT OF CARE > PARTICIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	recordTarget/patientRole/**<Electronic Communication Detail>**		See common pattern: Electronic Communication Detail.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **PERSON**	An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient).	1..1	n/a		Not mapped directly, encompassed implicitly in recordTarget/ patientRole/ patient.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **PERSON NAME**	The appellation by which an individual may be identified separately from any other within a social context.	1..*	recordTarget/patientRole/patient/**<Person Name>**		See common pattern: Person Name.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **Relationship to Subject of Care**	The relationship of a participant to a subject of care (patient).	0..0	n/a		This logical data component has no mapping to CDA.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **EMPLOYMENT DETAIL**	A person's occupation and employer.	0..0	recordTarget/patientRole/patient/**ext:asEmployment**		
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **DEMOGRAPHIC DATA**	Additional characteristics of a person that may be useful for identification or other clinical purposes.	1..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **Sex**	The biological distinction between male and female. Where there is inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.	1..1	recordTarget/patientRole/patient/**administrativeGenderCode**	AS 5017-2006 Health Care Client Identifier Sex	administrativeGenderCode/@nullFlavor **SHALL NOT** be present.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **DATE OF BIRTH DETAIL**	Details of the accuracy, origin and value of a person's date of birth.	1..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF BIRTH DETAIL > **Date of Birth**	The date of birth of the person.	1..1	recordTarget/patientRole/patient/**birthTime**		See <time> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*)		
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF BIRTH DETAIL > **Date of Birth is Calculated From Age**	Indicates whether or not a person's date of birth has been derived from the value in the Age data element.	0..1	**entry[calc_age]**		
			entry[calc_age]/**observation**		
			entry[calc_age]/observation/**@classCode="OBS"**		
			entry[calc_age]/observation/**@moodCode="EVN"**		
			entry[calc_age]/observation/**code**		See <code> for available attributes.
			entry[calc_age]/observation/code/**@code="103.16233"**		
			entry[calc_age]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[calc_age]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[calc_age]/observation/code/**@displayName="Date of Birth is Calculated From Age"**		
			entry[calc_age]/observation/**id**		See <id> for available attributes.
			entry[calc_age]/observation/**value:BL**		If the date of birth has been calculated from the age this is true, otherwise it is false.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF BIRTH DETAIL > **DATE OF BIRTH ACCURACY INDICATOR**	The level of certainty or estimation of a person's date of birth.	0..1	**entry[dob_acc]**		
			entry[dob_acc]/**observation**		
			entry[dob_acc]/observation/**@classCode="OBS"**		
			entry[dob_acc]/observation/**@moodCode="EVN"**		
			entry[dob_acc]/observation/**code**		
			entry[dob_acc]/observation/code/**@code="102.16234"**		
			entry[dob_acc]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[dob_acc]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[dob_acc]/observation/code/**@displayName="Date of Birth Accuracy Indicator"**		
			entry[dob_acc]/observation/**id**		See <id> for available attributes.
			entry[dob_acc]/observation/**value:CS**	AS 5017-2006 Health Care Client Identifier Date Accuracy Indicator	
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF BIRTH DETAIL > DATE OF BIRTH ACCURACY INDICATOR > **Date of Birth Day Accuracy Indicator**	The accuracy of the day component of a person's date of birth.	1..1	n/a		Encompassed in the mapping for DATE OF BIRTH ACCURACY INDICATOR (above).
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF BIRTH DETAIL > DATE OF BIRTH ACCURACY INDICATOR > **Date of Birth Month Accuracy Indicator**	The accuracy of the month component of a person's date of birth.	1..1	n/a		Encompassed in the mapping for DATE OF BIRTH ACCURACY INDICATOR (above).
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF BIRTH DETAIL > DATE OF BIRTH ACCURACY INDICATOR > **Date of Birth Year Accuracy Indicator**	The accuracy of the year component of a person's date of birth.	1..1	n/a		Encompassed in the mapping for DATE OF BIRTH ACCURACY INDICATOR (above).

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **AGE DETAIL**	Details of the accuracy and value of a person's age.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > AGE DETAIL > **Age**	The age of a person/subject of care at the time.	1..1	**entry[age]**		
			entry[age]/**observation**		
			entry[age]/observation/**@classCode="OBS"**		
			entry[age]/observation/**@moodCode="EVN"**		
			entry[age]/observation/**code**		
			entry[age]/observation/code/**@code="103.20109"**		
			entry[age]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[age]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[age]/observation/code/**@displayName="Age"**		
			entry[age]/observation/**id**		See <id> for available attributes.
			entry[age]/observation/**value:PQ**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > AGE DETAIL > **Age Accuracy Indicator**	The accuracy of a person's age.	0..1	**entry[age_acc]**		
			entry[age_acc]/**observation**		
			entry[age_acc]/observation/**@classCode="OBS"**		
			entry[age_acc]/observation/**@moodCode="EVN"**		
			entry[age_acc]/observation/**code**		
			entry[age_acc]/observation/code/**@code="103.16279"**		
			entry[age_acc]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[age_acc]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[age_acc]/observation/code/**@displayName="Age Accuracy Indicator"**		
			entry[age_acc]/observation/**id**		See <id> for available attributes.
			entry[age_acc]/observation/**value:BL**		If the age is considered to be accurate, this is true, otherwise it is false.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **Birth Plurality**	An indicator of multiple birth, showing the total number of births resulting from a single pregnancy.	0..1	**entry[brth_plr]**		
			entry[brth_plr]/**observation**		
			entry[brth_plr]/observation/**@classCode="OBS"**		
			entry[brth_plr]/observation/**@moodCode="EVN"**		
			entry[brth_plr]/observation/**code**		
			entry[brth_plr]/observation/code/**@code="103.16249"**		
			entry[brth_plr]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[brth_plr]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[brth_plr]/observation/code/**@displayName="Birth Plurality"**		
			entry[brth_plr]/observation/**id**		See <id> for available attributes.
			entry[brth_plr]/observation/**value:INT**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /ClinicalDocument/		
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **Birth Order**	The sequential order of each baby of a multiple birth regardless of live or still birth.	0..1	recordTarget/patientRole/patient/**ext:multipleBirthInd**		See Australian Digital Health Agency CDA extension: Multiple Birth.
			recordTarget/patientRole/patient/**ext:multipleBirthOrderNumber**		
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **DATE OF DEATH DETAIL**	Details of the accuracy and value of a person's date of death.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF DEATH DETAIL > **Date of Death**	The date or date and time at which a person was estimated or certified to have died.	1..1	recordTarget/patientRole/patient/**ext:deceasedInd**		See Australian Digital Health Agency CDA extension: Deceased Time.
			recordTarget/patientRole/patient/**ext:deceasedTime**		See <time> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*)		
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF DEATH DETAIL > **DATE OF DEATH ACCURACY IN-DICATOR**	The level of certainty or estimation of a person's date of death.	0..1	**entry[dod_acc]**		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
			entry[dod_acc]/**observation**		
			entry[dod_acc]/observation/**@classCode="OBS"**		
			entry[dod_acc]/observation/**@moodCode="EVN"**		
			entry[dod_acc]/observation/**code**		
			entry[dod_acc]/observation/code/**@code="102.16252"**		
			entry[dod_acc]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[dod_acc]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[dod_acc]/observation/code/**@displayName="Date of Death Accuracy Indicator"**		
			entry[dod_acc]/observation/**id**		See <id> for available attributes.
			entry[dod_acc]/observation/**value:CS**	AS 5017-2006 Health Care Client Identifier Date Accuracy Indicator	
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF DEATH DETAIL > DATE OF DEATH ACCURACY INDIC-ATOR > **Date of Death Day Accuracy Indic-ator**	The accuracy of the day component of a person's date of death.	1..1	n/a		Encompassed in the mapping for DATE OF DEATH ACCURACY IN-DICATOR (above).
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF DEATH DETAIL > DATE OF DEATH ACCURACY INDIC-ATOR > **Date of Death Month Accuracy Indicator**	The accuracy of the month component of a person's date of death.	1..1	n/a		Encompassed in the mapping for DATE OF DEATH ACCURACY IN-DICATOR (above).

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF DEATH DETAIL > DATE OF DEATH ACCURACY INDICATOR > **Date of Death Year Accuracy Indicator**	The accuracy of the year component of a person's date of death.	1..1	n/a		Encompassed in the mapping for DATE OF DEATH ACCURACY INDICATOR (above).
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **Source of Death Notification**	The person, location, organisation or other originator of information relating to the date of death.	0..1	**entry[src_notif]**		
			entry[src_notif]/**observation**		
			entry[src_notif]/observation/**@classCode="OBS"**		
			entry[src_notif]/observation/**@moodCode="EVN"**		
			entry[src_notif]/observation/**code**		
			entry[src_notif]/observation/code/**@code="103.10243"**		
			entry[src_notif]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[src_notif]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[src_notif]/observation/code/**@displayName="Source of Death Notification"**		
			entry[src_notif]/observation/**id**		See <id> for available attributes.
			entry[src_notif]/observation/**value:CD**	AS 5017-2006: Health Care Client Source of Death Notification	See <code> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **Mother's Original Family Name**	The original family name of the person's mother.	0..1	**entry[mothers_name]**		
			entry[mothers_name]/**observation**		
			entry[mothers_name]/observation/**@classCode="OBS"**		
			entry[mothers_name]/observation/**@moodCode="EVN"**		
			entry[mothers_name]/observation/**code**		
			entry[mothers_name]/observation/code/**@code="103.10245"**		
			entry[mothers_name]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[mothers_name]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[mothers_name]/observation/code/**@displayName="Mother's Original Family Name"**		
			entry[mothers_name]/observation/**id**		See <id> for available attributes.
			entry[mothers_name]/observation/**value:PN**		
CDA Header Data Elements			Context: /ClinicalDocument/		
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **Country of Birth**	The country in which the person was born.	0..1	recordTarget/patientRole/patient/**birthplace/place/addr/country**	*1269.0 - Standard Australian Classification of Countries (SACC), Second Edition [ABS2008]*	Use the name, not the numbered code.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **State/Territory of Birth**	The identifier of the Australian state or territory where a person is born.	0..1	recordTarget/patientRole/patient/**birthplace/place/addr/state**	AS 5017-2006 Australian State/Territory Identifier - Postal	
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **Indigenous Status**	Indigenous Status is a measure of whether a person identifies as being of Aboriginal or Torres Strait Islander origin.	1..1	recordTarget/patientRole/patient/**ethnicGroupCode**	METeOR 291036: Indigenous Status	ethnicGroupCode/@nullFlavor **SHALL NOT** be present.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*)		
SUBJECT OF CARE > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..*	**ext:coverage2[sub_care]/@typeCode="COVBY"**		See Australian Digital Health Agency CDA extension: Entitlement.
			ext:coverage2[sub_care]/**ext:entitlement**		
			ext:coverage2[sub_care]/ext:entitlement/**@classCode="COV"**		
			ext:coverage2[sub_care]/ext:entitlement/**@moodCode="EVN"**		
			ext:coverage2[sub_care]/ext:entitlement/**ext:participant/@typeCode="BEN"**		
			ext:coverage2[sub_care]/ext:entitlement/ext:participant/**ext:participantRole/@classCode="PAT"**		
			ext:coverage2[sub_care]/ext:entitlement/ext:participant/ext:participantRole/**ext:id**		This **SHALL** hold the same value as ClinicalDocument/ recordTarget/ patientRole/ **id**.
SUBJECT OF CARE > PARTICIPANT > ENTITLEMENT > **Entitlement Number**	A number or code issued for the purpose of identifying the entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	1..1	ext:coverage2[sub_care]/ext:entitlement/**ext:id**		See <id> for available attributes.
SUBJECT OF CARE > PARTICIPANT > ENTITLEMENT > **Entitlement Type**	The description of the scope of an entitlement.	1..1	ext:coverage2[sub_care]/ext:entitlement/**ext:code**	NCTIS: Admin Codes - Entitlement Type	See <code> for available attributes.
SUBJECT OF CARE > PARTICIPANT > ENTITLEMENT > **Entitlement Validity Duration**	The time interval for which an entitlement is valid.	0..1	ext:coverage2[sub_care]/ext:entitlement/**ext:effectiveTime**		See <time> for available attributes.
CDA Header Data Elements			Context: /ClinicalDocument/		
SUBJECT OF CARE > PARTICIPANT > **Qualifications**	A list of professional certifications, and certificates recognising having passed a course.	0..0	n/a		This logical data component has no mapping to CDA.

Example 6.2. SUBJECT OF CARE XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 <!-- Begin CDA Header -->
 …

 <!-- Begin SUBJECT OF CARE - Header Part -->
 <recordTarget typeCode="RCT">
  <patientRole classCode="PAT">
   <!-- This system generated id is used for matching patient Entitlement -->
   <id root="52b9470e-db0b-45aa-9a81-86e5243b84df"/>

   <!-- ADDRESS -->
   <addr use="H">
    <streetAddressLine>1 Patient Street</streetAddressLine>
    <city>Healthville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568931</additionalLocator>
    <country>Australia</country>
   </addr>

   <!-- ELECTRONIC COMMUNICATION DETAIL -->
   <telecom use="H" value="tel:0499999999"/>

   <!-- Begin PARTICIPANT -->
   <patient>

    <!-- PERSON NAME -->
    <name use="L">
     <prefix>Ms</prefix>
     <given>Sally</given>
     <family>Grant</family>
    </name>

    <!-- Sex -->
    <administrativeGenderCode code="F"
     codeSystem="2.16.840.1.113883.13.68"
     codeSystemName="AS 5017-2006 Health Care Client Identifier Sex"/>

    <!-- Date of Birth -->
    <birthTime value="19480607"/>

    <!-- Indigenous Status -->
    <ethnicGroupCode code="4" codeSystem="2.16.840.1.113883.3.879.291036" codeSystemName="METeOR Indigenous Status"
     displayName="Neither Aboriginal nor Torres Strait Islander origin" />

    <!-- Multiple Birth Indicator -->
    <ext:multipleBirthInd value="true"/>
    <ext:multipleBirthOrderNumber value="2"/>
```

```xml
        <!-- Date of Death -->
        <ext:deceasedInd value="true"/>
        <ext:deceasedTime value="20101201"/>

        <!-- Country of Birth/State of Birth -->
        <birthplace>
        <place>
         <addr>
          <country>Australia</country>
          <state>QLD</state>
         </addr>
        </place>
        </birthplace>

        <!-- Entity Identifier -->
        <ext:asEntityIdentifier classCode="IDENT">
         <ext:id assigningAuthorityName="IHI" root="1.2.36.1.2001.1003.0.8003608833357361"/>
         <ext:assigningGeographicArea classCode="PLC">
          <ext:name>National Identifier</ext:name>
         </ext:assigningGeographicArea>
        </ext:asEntityIdentifier>

      </patient>
      <!-- End PARTICIPANT -->
     </patientRole>
    </recordTarget>
    <!-- End SUBJECT OF CARE - Header Part -->
    …

<!-- End CDA Header -->

<!-- Begin CDA Body -->
<component>
 <structuredBody>
   …

   <!-- Begin Administrative Observations -->
   <component>
    <section>
     <code code="102.16080"
      codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components"
      displayName="Administrative Observations"/>
     <title>Administrative Observations</title>

      <!-- narrative block -->
      <text>
       <table>
        <tbody>
         <tr>
          <th>Date of Birth is Calculated From Age</th>
          <td>True</td>
         </tr>
         <tr>
          <th>Date of Birth Accuracy Indicator</th>
          <td>AAA</td>
         </tr>
         <tr>
          <th>Age</th>
          <td>54</td>
         </tr>
         <tr>
```

```
    <th>Age Accuracy Indicator</th>
    <td>True</td>
   </tr>
   <tr>
    <th>Birth Plurality</th>
    <td>3</td>
   </tr>
   <tr>
    <th>Australian Medicare Card Number</th>
    <td>2296818481</td>
   </tr>
   …

  </tbody>
 </table>
</text>
…

<!-- Begin SUBJECT OF CARE - Body -->
<!-- Begin Date of Birth is Calculated From Age -->
<entry><!-- [calc_age] -->
 <observation classCode="OBS" moodCode="EVN">
  <id root="fe8bdabd-d5c9-4957-9fd7-bc706b6677e4"/>
  <code code="103.16233"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Date of Birth is Calculated From Age"/>
  <value value="true" xsi:type="BL"/>
 </observation>
</entry><!-- [calc_age] -->
<!-- End Date of Birth is Calculated From Age -->

<!-- Begin DATE OF BIRTH ACCURACY INDICATOR -->
<entry><!-- [dob_acc] -->
 <observation classCode="OBS" moodCode="EVN">
  <id root="27750576-64de-4e5c-9ec8-06c35b55c31d"/>
  <code code="102.16234"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Date of Birth Accuracy Indicator"/>
  <value code="AAA" xsi:type="CS"/>
 </observation>
</entry><!-- [dob_acc] -->
<!-- End DATE OF BIRTH ACCURACY INDICATOR -->

<!-- Begin Age -->
<entry><!-- [age] -->
 <observation classCode="OBS" moodCode="EVN">
  <id root="f3ca6643-d9c0-4112-80ef-0afe478ed11f"/>
  <code code="103.20109"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Age"/>
  <value xsi:type="PQ" value="54" unit="a"/>
 </observation>
</entry><!-- [age] -->
<!-- End Age -->

<!-- Begin Age Accuracy Indicator -->
<entry><!-- [age_acc] -->
 <observation classCode="OBS" moodCode="EVN">
  <id root="55f4cdea-ef2d-4771-a600-800f95fc0abf"/>
  <code code="103.16279"
```

```
            codeSystem="1.2.36.1.2001.1001.101"
            codeSystemName="NCTIS Data Components"
            displayName="Age Accuracy Indicator"/>
          <value value="true" xsi:type="BL"/>
        </observation>
      </entry><!-- [age_acc] -->
      <!-- End Age Accuracy Indicator -->

      <!-- Begin Birth Plurality -->
      <entry><!-- [birth_plr] -->
        <observation classCode="OBS" moodCode="EVN">
          <id root="344b0577-750c-48e6-998d-b38f4ec86d0e"/>
          <code code="103.16249"
            codeSystem="1.2.36.1.2001.1001.101"
            codeSystemName="NCTIS Data Components"
            displayName="Birth Plurality"/>
          <value value="3" xsi:type="INT"/>
        </observation>
      </entry><!-- [birth_plr] -->
      <!-- End Birth Plurality -->

      <!-- Begin DATE OF DEATH ACCURACY INDICATOR -->
      <entry><!-- [dod_acc] -->
        <observation classCode="OBS" moodCode="EVN">
          <id root="455bee4e-ee44-43f1-b722-5ddff67a18c6"/>
          <code code="102.16252"
            codeSystem="1.2.36.1.2001.1001.101"
            codeSystemName="NCTIS Data Components"
            displayName="Date of Death Accuracy Indicator"/>
          <value code="AAA" xsi:type="CS"/>
        </observation>
      </entry><!-- [dod_acc] -->
      <!-- End DATE OF DEATH ACCURACY INDICATOR -->

      <!-- Begin SUBJECT OF CARE ENTITLEMENT -->
      <ext:coverage2 typeCode="COVBY">
        <ext:entitlement classCode="COV" moodCode="EVN">
          <ext:id assigningAuthorityName="Medicare Card Number" root="1.2.36.1.5001.1.0.7.1" extension="2296818481" />
          <ext:code code="1" codeSystem="1.2.36.1.2001.1001.101.104.16047" codeSystemName="NCTIS Entitlement Type Values" displayName="Medicare Benefits"/>
          <ext:effectiveTime>
            <high value="20110101"/>
          </ext:effectiveTime>
          <ext:participant typeCode="BEN">
            <ext:participantRole classCode="PAT">
              <ext:id root="52b9470e-db0b-45aa-9a81-86e5243b84df" />
            </ext:participantRole>
          </ext:participant>
        </ext:entitlement>
      </ext:coverage2>
      <!-- End SUBJECT OF CARE ENTITLEMENT -->
      <!-- End SUBJECT OF CARE - Body -->
      …

    </section>
  </component>
  <!-- End Administrative Observations -->
  …

  </structuredBody>
</component>
<!-- End CDA Body -->
</ClinicalDocument>
```

6.1.2 DOCUMENT AUTHOR

Identification

Name	DOCUMENT AUTHOR
Metadata Type	Data Group
Identifier	DG-10296

Relationships

Parent

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

CDA R-MIM Representation

Figure 6.4 DOCUMENT AUTHOR shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The DOCUMENT AUTHOR data group instantiated as PERSON is related to its context of ClinicalDocument by the author participation class. An author is a person in the role of assignedAuthor (AssignedAuthor class). The entity playing the role is assignedAuthorChoice (Person class). The entity identifier of the participant is mapped to the EntityIdentifier class (Australian Digital Health Agency CDA extension) and is associated to the assignedAuthorChoice.
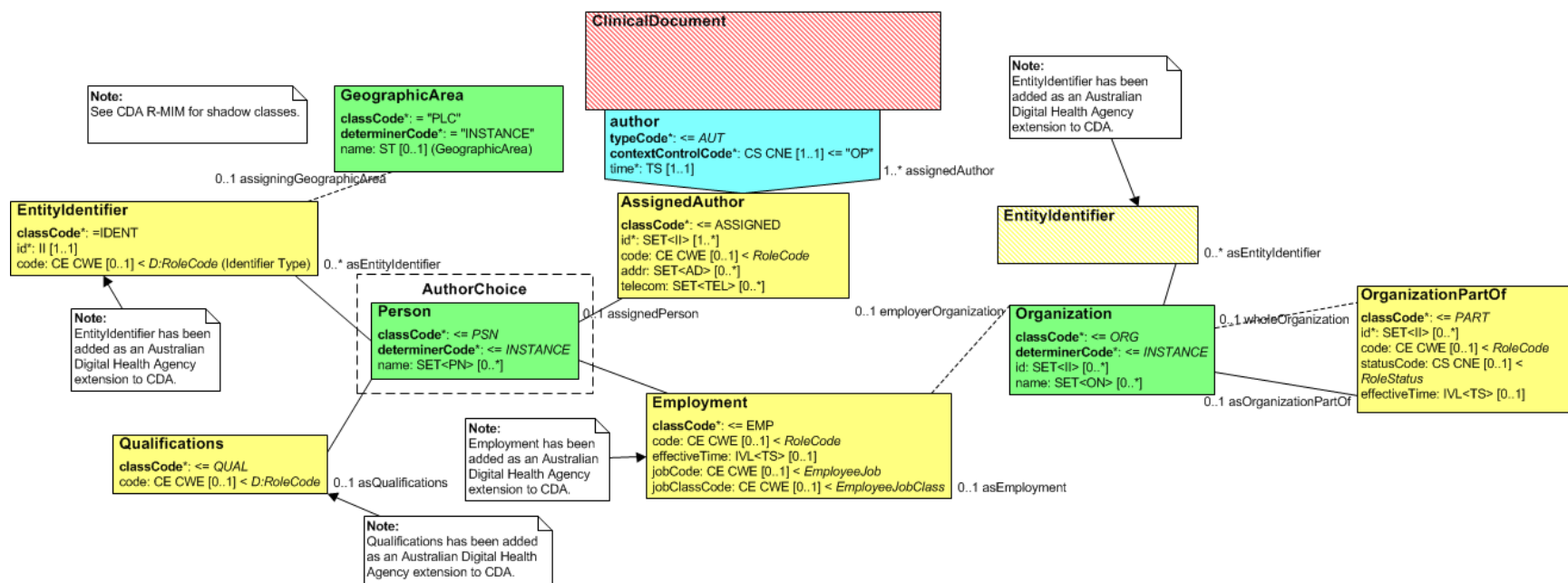
Figure 6.4. DOCUMENT AUTHOR

Figure 6.5 DOCUMENT AUTHOR - ENTITLEMENT shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.
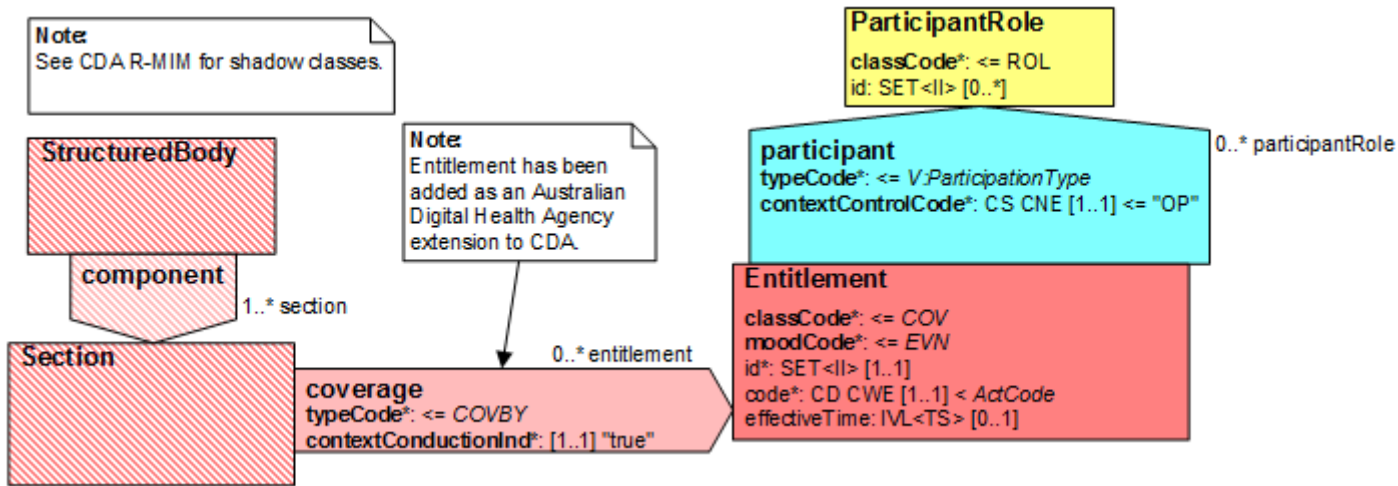
Figure 6.5. DOCUMENT AUTHOR - ENTITLEMENT

CDA Mapping

Note

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /ClinicalDocument/		
DOCUMENT AUTHOR	Composer of the document.	1..1	**author**		Document Author **SHALL** be 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.
n/a	n/a	1..1	author/assignedAuthor/**id**		Required CDA element. See <id> for available attributes.
DOCUMENT AUTHOR > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	1..1	author/**time**	Although the definition of this element states that it is a time interval, the following applies: "The end of the participation period of a Document Author participation is the time associated with the completion of editing the content of a document." Thus only the end time need be recorded.	Required CDA element. The author/time element **SHALL** be implemented as either: • a value attribute (populated with the end time of the authorship or encounter, as appropriate); or • a high element AND a low element, both with value attributes and neither with a nullFlavor attribute.
DOCUMENT AUTHOR > **LOCATION OF PARTICIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIPATION is not currently mapped.
DOCUMENT AUTHOR > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	n/a	Participation Type **SHALL** have an implementation-specific value equivalent to "Document Author".	Not mapped directly; encompassed implicitly in author/typeCode="AUT" (optional, fixed value).

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
DOCUMENT AUTHOR > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	author/**assignedAuthor/code**	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 publicly available **MAY** be used.	See <code> for available attributes.
DOCUMENT AUTHOR > **PARTICIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	author/assignedAuthor/**assignedPerson**		
DOCUMENT AUTHOR > PARTICIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..*	author/assignedAuthor/assignedPerson/**<Entity Identifier>**		See common pattern: Entity Identifier.
DOCUMENT AUTHOR > PARTICIPANT > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	author/assignedAuthor/**<Address>**	AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. Address Purpose (addr/@use) **SHALL** be set to Business (see AS 5017-2006: Health Care Client Identifier Address Purpose).	See common pattern: Address.
DOCUMENT AUTHOR > PARTICIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	author/assignedAuthor/**<Electronic Communication Detail>**	Electronic Communication Usage Code (telecom/@use) **SHALL** be set to Workplace (see HL7: TelecommunicationAddressUse).	See common pattern: Electronic Communication Detail.
DOCUMENT AUTHOR > PARTICIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **PERSON**	An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient).	1..1	n/a		Not mapped directly; encompassed implicitly in author/assignedAuthor/assignedPerson.
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **PERSON NAME**	The appellation by which an individual may be identified separately from any other within a social context.	1..*	author/assignedAuthor/assignedPerson/**<Person Name>**		See common pattern: Person Name.
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **Relationship to Subject of Care**	The relationship of a participant to a subject of care (patient).	0..0	author/assignedAuthor/assignedPerson/**ext:personalRelationship**		
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **EMPLOYMENT DETAIL**	A person's occupation and employer.	1..1	author/assignedAuthor/assignedPerson/**<Employment>**		See common pattern: Employment.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **DEMOGRAPHIC DATA**	Additional characteristics of a person that may be useful for identification or other clinical purposes.	0..0	n/a		This logical data component has no mapping to CDA.\n\nThe cardinality of this component propagates to its children.
			author/assignedAuthor/assignedPerson/**ext:administrativeGenderCode**		
			author/assignedAuthor/assignedPerson/**ext:birthTime**		
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See *4 Administrative Observations*)		
DOCUMENT AUTHOR > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..*	**ext:coverage2[doc_auth]/@typeCode="COVBY"**		
			ext:coverage2[doc_auth]/**ext:entitlement**		
			ext:coverage2[doc_auth]/ext:entitlement/**@classCode="COV"**		
			ext:coverage2[doc_auth]/ext:entitlement/**@moodCode="EVN"**		
			ext:coverage2[doc_auth]/ext:entitlement/**ext:participant/@typeCode="HLD"**		
			ext:coverage2[doc_auth]/ext:entitlement/ext:participant/**ext:participantRole/@classCode="ASSIGNED"**		
			ext:coverage2[doc_auth]/ext:entitlement/ext:participant/ext:participantRole/**ext:id**		This **SHALL** hold the same value as author/assignedAuthor/id.
DOCUMENT AUTHOR > PARTICIPANT > ENTITLEMENT > **Entitlement Number**	A number or code issued for the purpose of identifying the entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	1..1	ext:coverage2[doc_auth]/ext:entitlement/**ext:id**		See <id> for available attributes.
DOCUMENT AUTHOR > PARTICIPANT > ENTITLEMENT > **Entitlement Type**	The description of the scope of an entitlement.	1..1	ext:coverage2[doc_auth]/ext:entitlement/**ext:code**	NCTIS: Admin Codes - Entitlement Type	See <code> for available attributes.
DOCUMENT AUTHOR > PARTICIPANT > ENTITLEMENT > **Entitlement Validity Duration**	The time interval for which an entitlement is valid.	0..1	ext:coverage2[doc_auth]/ext:entitlement/**ext:effectiveTime**		See <time> for available attributes.
CDA Header Data Elements			Context: /ClinicalDocument/		
DOCUMENT AUTHOR > PARTICIPANT > **Qualifications**	A list of professional certifications, and certificates recognising having passed a course.	0..1	author/assignedAuthor/assignedPerson/**ext:asQualifications**		See Australian Digital Health Agency CDA extension: Qualifications.
			author/assignedAuthor/assignedPerson/ext:asQualifications/**@classCode="QUAL"**		
			author/assignedAuthor/assignedPerson/ext:asQualifications/**ext:code/originalText**	Qualifications is a text field, so the text list is entered in the originalText field of the code element.	

Example 6.3. DOCUMENT AUTHOR XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 <!-- Begin CDA Header -->
 …

 <!-- Begin DOCUMENT AUTHOR -->
 <author>
  <!-- Participation Period -->
  <time value="200910201235+1000"/>
  <assignedAuthor>
   <!-- id is used for system purposes such as matching -->
   <id root="b830b9a6-4ea7-4a1a-92eb-ddf18b82a291"/>

   <!-- Role -->
   <code code="253111" codeSystem="2.16.840.1.113883.13.62"
    codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
    displayName="General Medical Practitioner"/>

   <!-- ADDRESS -->
   <addr use="WP">
    <streetAddressLine>1 Clinician Street</streetAddressLine>
    <city>Healthville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568931</additionalLocator>
    <country>Australia</country>
   </addr>

   <!-- ELECTRONIC COMMUNICATION DETAIL -->
   <telecom use="WP" value="tel:0712341234"/>

   <!-- Begin PARTICIPANT -->
   <assignedPerson>
    <!-- PERSON NAME -->
    <name>
     <prefix>Dr.</prefix>
     <given>Good</given>
     <family>Doctor</family>
    </name>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
     <ext:id assigningAuthorityName="HPI-I"
      root="1.2.36.1.2001.1003.0.8003619900015717"/>
     <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
     </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>
```

```
<!-- Begin EMPLOYMENT DETAIL -->
<ext:asEmployment classCode="EMP">
 <!-- Position In Organisation -->
 <ext:code>
  <originalText>GP</originalText>
 </ext:code>

 <!-- Occupation -->
 <ext:jobCode code="253111" codeSystem="2.16.840.1.113883.13.62"
  codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
  displayName="General Medical Practitioner"/>

 <!-- Employment Type -->
 <ext:jobClassCode code="FT" codeSystem="2.16.840.1.113883.5.1059"
  codeSystemName="HL7:EmployeeJobClass" displayName="full-time"/>

 <!-- Begin EMPLOYER ORGANISATION -->
 <ext:employerOrganization>
  <!-- Department/Unit -->
  <name>Good Health Clinic</name>

  <asOrganizationPartOf>
   <wholeOrganization>
    <!-- Organisation Name -->
    <name use="ORGB">Acme Hospital Group</name>

    <!-- ELECTRONIC COMMUNICATION DETAIL -->
    <telecom use="WP" value="tel:0712341234"/>

    <!-- ADDRESS -->
    <addr use="WP">
     <streetAddressLine>1 Clinician Street</streetAddressLine>
     <city>Healthville</city>
     <state>QLD</state>
     <postalCode>5555</postalCode>
     <additionalLocator>32568931</additionalLocator>
    </addr>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
     <ext:id assigningAuthorityName="HPI-O"
      root="1.2.36.1.2001.1003.0.8003621566684455"/>
     <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
     </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>

   </wholeOrganization>
  </asOrganizationPartOf>
 </ext:employerOrganization>
 <!-- End EMPLOYER ORGANISATION -->

</ext:asEmployment>
<!-- End EMPLOYMENT DETAIL -->

<!-- Qualifications -->
<ext:asQualifications classCode="QUAL">
 <ext:code>
  <originalText>M.B.B.S</originalText>
 </ext:code>
</ext:asQualifications>

</assignedPerson>
```

```xml
  <!-- End PARTICIPANT -->
 </assignedAuthor>
</author>
<!-- End DOCUMENT AUTHOR -->
<!-- End CDA Header -->

<!-- Begin CDA Body -->
<component>
 <structuredBody>
  <!-- Begin Administrative Observations -->
  <component>
   <section>
    <code code="102.16080" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Administrative Observations"/>
    <title>Administrative Observations</title>

    <!-- narrative block -->
    <text>
     <table>
      <tbody>
       <tr>
        <th>Australian Medicare Prescriber Number</th>
        <td>049960CT</td>
       </tr>
      </tbody>
     </table>
      …
    </text>
     …

    <!-- Begin DOCUMENT AUTHOR – Body -->
    <!-- Begin DOCUMENT AUTHOR ENTITLEMENT -->
    <ext:coverage2 typeCode="COVBY">
     <ext:entitlement classCode="COV" moodCode="EVN">
      <ext:id assigningAuthorityName="Medicare Prescriber number" root="1.2.36.174030967.0.3" extension="049960CT" />
      <ext:code code="10" codeSystem="1.2.36.1.2001.1001.101.104.16047" codeSystemName="NCTIS Entitlement Type Values"
       displayName="Medicare Prescriber Number" />
      <ext:effectiveTime>
       <low value="200501010101+1100" />
       <high value="202501010101+1100" />
      </ext:effectiveTime>
      <ext:participant typeCode="HLD">
       <ext:participantRole classCode="ASSIGNED">
        <!-- Same as the author (assignedAuthor) id -->
        <ext:id root="b830b9a6-4ea7-4a1a-92eb-ddf18b82a291" />
       </ext:participantRole>
      </ext:participant>
     </ext:entitlement>
    </ext:coverage2>
    <!-- End DOCUMENT AUTHOR ENTITLEMENT -->
    <!-- End DOCUMENT AUTHOR – Body -->

   </section>
  </component>
  <!-- End Administrative Observations -->
   …

 </structuredBody>
</component>
<!-- End CDA Body -->
</ClinicalDocument>
```

6.1.3 PATIENT NOMINATED CONTACT

Identification

Name	PATIENT NOMINATED CONTACT
Metadata Type	Data Group
Identifier	DG-10296

Relationships

Parent

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

Choices

 Note

Mentioned below are the possible 'PATIENT NOMINATED CONTACT' instantiation choices.

Data Type	Name
	PATIENT NOMINATED CONTACT as a PERSON - Healthcare or Human Services Provider
	PATIENT NOMINATED CONTACT as a PERSON - Not a Healthcare or Human Services Provider
	PATIENT NOMINATED CONTACT as an ORGANISATION

6.1.3.1 PATIENT NOMINATED CONTACT as a PERSON - Healthcare or Human Services Provider

CDA R-MIM Representation

Figure 6.6 PATIENT NOMINATED CONTACT as a PERSON - Healthcare or Human Services Provider shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The PATIENT NOMINATED CONTACT data group instantiated as 'PERSON' is related to its context of ClinicalDocument by the participant participation class. A participant is a person in the role of associatedEntity (AssociatedEntity class). The entity playing the role is associatedPerson (Person class). The employment of the participant is mapped to the Employment class (Australian Digital Health Agency CDA extension) which is related to the Person class.

Figure 6.6. PATIENT NOMINATED CONTACT as a PERSON - Healthcare or Human Services Provider

CDA Mapping

Note

NS = 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.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /ClinicalDocument/		
PATIENT NOMINATED CONTACT	Contact nominated to receive information about the subject of care.	0..*	**participant[provider_contact_person]**		Each instance of this participant **SHALL** contain at least one instance of : • ADDRESS (participant/associatedEntity/addr), or • ELECTRONIC COMMUNICATION DETAIL (participant/associatedEntity/telecom).
n/a	n/a	1..1	participant[provider_contact_person]/associatedEntity/**id**		Required CDA element. See <id> for available attributes.
PATIENT NOMINATED CONTACT > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	0..0	participant[provider_contact_person]/**time**		
PATIENT NOMINATED CONTACT > **LOCATION OF PARTICIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIPATION is not currently mapped.
PATIENT NOMINATED CONTACT > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	participant[provider_contact_person]/**@typeCode="IRCP"**		Participation Type **SHALL** have an implementation-specific value equivalent to "Patient Nominated Contact".

---

[1] http://www.hl7.org/oid/index.cfm?ref=footer

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PATIENT NOMINATED CONTACT > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	participant[provider_contact_person]/**associatedEntity/@classCode="CON"**		
			participant[provider_contact_person]/associatedEntity/**code**	Role **SHOULD** have a value chosen from *1220.0 - ANZ-SCO - 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 publicly available **MAY** be used.	See <code> for available attributes.
PATIENT NOMINATED CONTACT > **PARTI-CIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	participant[provider_contact_person]/associatedEntity/**associatedPerson**		
PATIENT NOMINATED CONTACT > PARTI-CIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	0..0	participant[provider_contact_person]/associatedEntity/associatedPerson/**ext:asEntityIdentifier**		
PATIENT NOMINATED CONTACT > PARTI-CIPANT > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	participant[provider_contact_person]/associatedEntity/**<Address>**	AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.	See common pattern: Address.
PATIENT NOMINATED CONTACT > PARTI-CIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	participant[provider_contact_person]/associatedEntity/**<Electronic Communication Detail>**		See common pattern: Electronic Communication Detail.
PATIENT NOMINATED CONTACT > PARTI-CIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
PATIENT NOMINATED CONTACT > PARTI-CIPANT > PERSON OR ORGANISATION OR DEVICE > **PERSON**	An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient).	1..1	n/a		Not mapped directly, encompassed implicitly in participant[provider_contact_person]/associatedEntity/associatedPerson.
PATIENT NOMINATED CONTACT > PARTI-CIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **PERSON NAME**	The appellation by which an individual may be identified separately from any other within a social context.	1..*	participant[provider_contact_person]/associatedEntity/associatedPerson/**<Person Name>**		See common pattern: Person Name.
PATIENT NOMINATED CONTACT > PARTI-CIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **Relationship to Subject of Care**	The relationship of a participant to a subject of care (patient).	0..0	participant[provider_contact_person]/associatedEntity/associatedPerson/**ext:personalRelationship**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **EMPLOYMENT DETAIL**	A person's occupation and employer.	0..1	participant[provider_contact_person]/associatedEntity/associatedPerson/**ext:asEmployment**		
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > **EMPLOYER ORGANISATION**	The organisation that the individual is working for in respect to the role they are playing in the nominated participation.	1..*	participant[provider_contact_person]/associatedEntity/associatedPerson/ext:asEmployment/**ext:employerOrganization**		There is a known issue in the Participation Data Specification [DH2017a] for this logical data component's cardinality. Furthermore the corresponding CDA elements ext:asEmployment and ext:employerOrganization do not allow the cardinality to be multiple. The cardinality range **SHALL** be interpreted as '1..1'.
			participant[provider_contact_person]/associatedEntity/associatedPerson/ext:asEmployment/**@classCode="EMP"**		
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	0..*	participant[provider_contact_person]/associatedEntity/associatedPerson/ext:asEmployment/ext:employerOrganization/**asOrganizationPartOf/wholeOrganization/<Entity Identifier>**		See common pattern: Entity Identifier.
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	participant[provider_contact_person]/associatedEntity/associatedPerson/ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Address>**		See common pattern: Address.
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	participant[provider_contact_person]/associatedEntity/associatedPerson/ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Electronic Communication Detail>**		See common pattern: Electronic Communication Detail.
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **ORGANISATION**	Any organisation of interest to, or involved in, the business of healthcare service provision.	1..1	n/a		Not mapped directly, encompassed implicitly in associatedPerson/ext:asEmployment/employerOrganization.
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > ORGANISATION > **Organisation Name**	The name by which an organisation is known or called.	1..1	participant[provider_contact_person]/associatedEntity/associatedPerson/ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**name**		

Approved for external use

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PATIENT NOMINATED CONTACT > PARTI-CIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > ORGANISA-TION > **Department/Unit**	The name by which a department or unit within a larger organisation is known or called.	0..1	participant[provider_contact_person]/associatedEntity/associatedPerson/ext:asEmployment/ ext:employerOrganization/**name**		
PATIENT NOMINATED CONTACT > PARTI-CIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > ORGANISA-TION > **Organisation Name Usage**	The classification that enables differentiation between recorded names for an organisation or service location.	0..1	participant[provider_contact_person]/associatedEntity/associatedPerson/ext:asEmployment/ ext:employerOrganization/asOrganizationPartOf/wholeOrganization/name/**@use**	AS 4846-2006: Health Care Provider Organisation Name Usage	
PATIENT NOMINATED CONTACT > PARTI-CIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > **Employment Type**	The basis on which the person is employed by the employer organisation.	0..1	participant[provider_contact_person]/associatedEntity/associatedPerson/ ext:asEmployment/**ext:jobClassCode**	NS	
PATIENT NOMINATED CONTACT > PARTI-CIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > **Occupation**	A descriptor of the class of job based on similarities in the tasks undertaken.	0..*	participant[provider_contact_person]/associatedEntity/associatedPerson/ext:asEmployment/**ext:jobCode**	1220.0 - ANZSCO - Australi-an and New Zealand Stand-ard Classification of Occupa-tions, First Edition, Revision 1 [ABS2009]	The corresponding CDA element ext:jobCode does not allow the cardinality to be '0..*'/multiple. The cardinal-ity **SHALL** be interpreted as '0..1' instead of '0..*'.
PATIENT NOMINATED CONTACT > PARTI-CIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > **Position In Organisation**	A descriptor of the job or the job role based on the management hierarchy of the organisation.	0..1	participant[provider_contact_person]/associatedEntity/associatedPerson/ext:asEmployment/**ext:code**	NS	See <code> for available at-tributes.
PATIENT NOMINATED CONTACT > PARTI-CIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **DEMOGRAPHIC DATA**	Additional characteristics of a person that may be useful for identification or other clinical purposes.	0..0	n/a		This logical data component has no mapping to CDA. The cardinality of this com-ponent propagates to its children.
			participant[provider_contact_person]/associatedEntity/associatedPerson/**ext:administrativeGenderCode**		
			participant[provider_contact_person]/associatedEntity/associatedPerson/**ext:birthTime**		
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 Administrative Observations)		
PATIENT NOMINATED CONTACT > PARTI-CIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..0	See Known Issues.		Prohibition of ENTITLEMENT is not currently mapped.
CDA Header Data Elements			Context: /ClinicalDocument/		
PATIENT NOMINATED CONTACT > PARTI-CIPANT > **Qualifications**	A list of professional certifications, and certificates recog-nising having passed a course.	0..0	participant[provider_contact_person]/associatedEntity/associatedPerson/**ext:asQualifications**		

Example 6.4. PATIENT NOMINATED CONTACT as a PERSON - Healthcare or Human Services Provider XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 <!-- Begin CDA Header -->
 …

 <!-- Begin PATIENT NOMINATED CONTACT as a PERSON - Healthcare or Human Services Provider -->
 <participant typeCode="IRCP">
  <associatedEntity classCode="CON">

  <!-- id is used for system purposes such as matching -->
  <id root="7faa90cd-4540-44a5-8565-f06324662fdf"/>

  <!-- Role -->
  <code code="133932002"
   codeSystem="2.16.840.1.113883.6.96"
   codeSystemName="SNOMED CT"
   codeSystemVersion="20090731"
   displayName="Caregiver (Person)"/>

  <!-- ADDRESS -->
  <addr use="WP">
   <streetAddressLine>66 Caregiver Street</streetAddressLine>
   <city>Healthville</city>
   <state>QLD</state>
   <postalCode>5555</postalCode>
   <additionalLocator>32568931</additionalLocator>
   <country>Australia</country>
  </addr>

  <!-- ELECTRONIC COMMUNICATION DETAIL -->
  <telecom use="WP" value="tel:0733333333"/>

   <associatedPerson>
   <!-- PERSON NAME -->
   <name>
    <prefix>Mr.</prefix>
    <family>Caregiver</family>
   </name>

   <!-- Begin EMPLOYMENT DETAIL -->
   <ext:asEmployment classCode="EMP">

    <!-- Position In Organisation -->
    <ext:code>
     <originalText>General Practitioner</originalText>
    </ext:code>

    <!-- Occupation -->
    <ext:jobCode code="253111" codeSystem="2.16.840.1.113883.13.62"
```

```xml
    codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, 2006"
    displayName="General Medical Practitioner" />

   <!-- Employment Type -->
   <ext:jobClassCode code="FT" codeSystem="2.16.840.1.113883.5.1059" codeSystemName="HL7:EmployeeJobClass"
    displayName="full-time" />

   <!-- Begin EMPLOYER ORGANISATION -->
   <ext:employerOrganization>

    <!-- Department/Unit -->
    <name>Acme Hospital One</name>

    <asOrganizationPartOf>
     <wholeOrganization>

      <!-- Organisation Name -->
      <name use="ORGB">Acme Hospital Group</name>

      <!-- ELECTRONIC COMMUNICATION DETAIL -->
      <telecom value="tel:0499999999" use="WP" />

      <!-- ADDRESS -->
      <addr use="WP">
       <houseNumber>1</houseNumber>
       <streetName>Clinician</streetName>
       <streetNameType>St</streetNameType>
       <city>Healthville</city>
       <state>QLD</state>
       <postalCode>5555</postalCode>
       <additionalLocator>32568931</additionalLocator>
      </addr>

      <!-- Entity Identifier -->
      <ext:asEntityIdentifier classCode="IDENT">
       <ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />
       <ext:assigningGeographicArea classCode="PLC">
        <ext:name>National Identifier</ext:name>
       </ext:assigningGeographicArea>
      </ext:asEntityIdentifier>

     </wholeOrganization>
    </asOrganizationPartOf>
   </ext:employerOrganization>
   <!-- End EMPLOYER ORGANISATION -->

  </ext:asEmployment>
  <!-- End EMPLOYMENT DETAIL -->

  </associatedPerson>
 </associatedEntity>
</participant>
<!-- End PATIENT NOMINATED CONTACT as a PERSON - Healthcare or Human Services Provider -->

…
<!-- End CDA Header -->

</ClinicalDocument>
```

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

CDA R-MIM Representation

Figure 6.7 PATIENT NOMINATED CONTACT as a PERSON - Not a Healthcare or Human Services Provider shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The PATIENT NOMINATED CONTACT data group instantiated as 'PERSON' is related to its context of ClinicalDocument by the participant participation class. A participant is a person in the role of associatedEntity (AssociatedEntity class). The entity playing the role is associatedPerson (Person class). The entity identifier of the participant is mapped to the EntityIdentifier class (Australian Digital Health Agency CDA extension) which is related to the associatedEntity. The relationship to the subject of care is mapped to the PersonalRelationship class (Australian Digital Health Agency CDA extension) which is related to the associatedEntity.

Figure 6.7. PATIENT NOMINATED CONTACT as a PERSON - Not a Healthcare or Human Services Provider

CDA Mapping

Note

NS = In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the <u>HL7 code set registration procedure</u>[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.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /ClinicalDocument/		
PATIENT NOMINATED CONTACT	Contact nominated to receive information about the subject of care.	0..*	**participant[contact_person_non_provider]**		Each instance of this participant **SHALL** contain at least one instance of : • ADDRESS (participant/associatedEntity/addr), or • ELECTRONIC COMMUNICATION DETAIL (participant/associatedEntity/telecom).
n/a	n/a	1..1	participant[contact_person_non_provider]/associatedEntity/**id**		Required CDA element. See <id> for available attributes.
PATIENT NOMINATED CONTACT > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	0..0	participant[contact_person_non_provider]/**time**		
PATIENT NOMINATED CONTACT > **LOCATION OF PARTICIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIPATION is not currently mapped.
PATIENT NOMINATED CONTACT > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	participant[contact_person_non_provider]/**@typeCode="IRCP"**	Participation Type **SHALL** have an implementation-specific value equivalent to "Patient Nominated Contact".	

---

[2] http://www.hl7.org/oid/index.cfm?ref=footer

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PATIENT NOMINATED CONTACT > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	participant[contact_person_non_provider]/**associatedEntity/@classCode="CON"**		
			participant[contact_person_non_provider]/associatedEntity/**code**	Role **MAY** have an implementation-specific value equivalent to "Subject of Care's Representative" or "Not applicable".	See <code> for available attributes.
PATIENT NOMINATED CONTACT > **PARTI-CIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	participant[contact_person_non_provider]/associatedEntity/**associatedPerson**		
PATIENT NOMINATED CONTACT > PARTI-CIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	0..0	participant[contact_person_non_provider]/associatedEntity/associatedPerson/**ext:asEntityIdentifier**		
PATIENT NOMINATED CONTACT > PARTI-CIPANT > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	participant[contact_person_non_provider]/associatedEntity/<**Address**>	AUSTRALIAN OR INTERNA-TIONAL ADDRESS **SHALL** be instantiated as an AUSTRALI-AN ADDRESS.	See common pattern: Address.
PATIENT NOMINATED CONTACT > PARTI-CIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	participant[contact_person_non_provider]/associatedEntity/<**Electronic Communication Detail**>		See common pattern: Electronic Communication Detail.
PATIENT NOMINATED CONTACT > PARTI-CIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
PATIENT NOMINATED CONTACT > PARTI-CIPANT > PERSON OR ORGANISATION OR DEVICE > **PERSON**	An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient).	1..1	n/a		Not mapped directly, encompassed implicitly in author/assignedAuthor/assignedPerson.
PATIENT NOMINATED CONTACT > PARTI-CIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **PERSON NAME**	The appellation by which an individual may be identified separately from any other within a social context.	1..*	participant[contact_person_non_provider]/associatedEntity/associatedPerson/<**Person Name**>		See common pattern: Person Name.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **Relationship to Subject of Care**	The relationship of a participant to a subject of care (patient).	0..1	participant[contact_person_non_provider]/associatedEntity/associatedPerson/**ext:personalRelationship**		See Australian Digital Health Agency CDA extension: PersonalRelationship.
			participant[contact_person_non_provider]/associatedEntity/associatedPerson/ext:personalRelationship/**@classCode="PRS"**		
			participant[contact_person_non_provider]/associatedEntity/associatedPerson/ext:personalRelationship/**ext:code**	NS	
			participant[contact_person_non_provider]/associatedEntity/associatedPerson/ext:personalRelationship/**ext:asPersonalRelationship**		
			participant[contact_person_non_provider]/associatedEntity/associatedPerson/ext:personalRelationship/ext:asPersonalRelationship/**@classCode="PSN"**		
			participant[contact_person_non_provider]/associatedEntity/associatedPerson/ext:personalRelationship/ext:asPersonalRelationship/**@determinerCode="INSTANCE"**		
			participant[contact_person_non_provider]/associatedEntity/associatedPerson/ext:personalRelationship/ext:asPersonalRelationship/**id**		This **SHALL** hold the same value as ClinicalDocument/recordTarget/patientRole/**id**.
			participant[contact_person_non_provider]/associatedEntity/associatedPerson/ext:personalRelationship/ext:asPersonalRelationship/**administrativeGenderCode/@nullFlavor="NA"**		Included for CDA conformance only.
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **EMPLOYMENT DETAIL**	A person's occupation and employer.	0..1	participant[contact_person_non_provider]/associatedEntity/associatedPerson/**ext:asEmployment**		
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > **EMPLOYER ORGANISATION**	The organisation that the individual is working for in respect to the role they are playing in the nominated participation.	0..*	participant[contact_person_non_provider]/associatedEntity/associatedPerson/ext:asEmployment/**ext:employerOrganization**		There is a known issue in the Participation Data Specification [DH2017a] for this logical data component's cardinality. Furthermore the corresponding CDA elements ext:asEmployment and ext:employerOrganization do not allow the cardinality to be multiple. The cardinality range **SHALL** be interpreted as '1..1'.
			participant[contact_person_non_provider]/associatedEntity/associatedPerson/ext:asEmployment/**@classCode="EMP"**		
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	0..*	participant[contact_person_non_provider]/associatedEntity/associatedPerson/ext:asEmployment/ext:employerOrganization/**asOrganizationPartOf/wholeOrganization/<Entity Identifier>**		See common pattern: Entity Identifier.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	participant[contact_person_non_provider]/associatedEntity/associatedPerson/ext:asEmployment/ ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Address>**		See common pattern: Address.
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	participant[contact_person_non_provider]/associatedEntity/associatedPerson/ext:asEmployment/ ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Electronic Communication Detail>**		See common pattern: Electronic Communication Detail.
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **ORGANISATION**	Any organisation of interest to, or involved in, the business of healthcare service provision.	1..1	n/a		Not mapped directly, encompassed implicitly in assignedAuthor/ext:asEmployment/employerOrganization.
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > ORGANISATION > **Organisation Name**	The name by which an organisation is known or called.	1..1	participant[contact_person_non_provider]/associatedEntity/associatedPerson/ext:asEmployment/ ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**name**		
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > ORGANISATION > **Department/Unit**	The name by which a department or unit within a larger organisation is known or called.	0..1	participant[contact_person_non_provider]/associatedEntity/associatedPerson/ext:asEmployment/ ext:employerOrganization/**name**		
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > ORGANISATION > **Organisation Name Usage**	The classification that enables differentiation between recorded names for an organisation or service location.	0..1	participant[contact_person_non_provider]/associatedEntity/associatedPerson/ext:asEmployment/ ext:employerOrganization/asOrganizationPartOf/wholeOrganization/name/**@use**	AS 4846-2006: Health Care Provider Organisation Name Usage	
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > **Employment Type**	The basis on which the person is employed by the employer organisation.	0..1	participant[contact_person_non_provider]/associatedEntity/associatedPerson/ ext:asEmployment/**ext:jobClassCode**	NS	
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > **Occupation**	A descriptor of the class of job based on similarities in the tasks undertaken.	0..*	participant[contact_person_non_provider]/associatedEntity/associatedPerson/ ext:asEmployment/**ext:jobCode**	1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 [ABS2009]	The corresponding CDA element ext:jobCode does not allow the cardinality to be '0..*'/multiple. The cardinality **SHALL** be interpreted as '0..1' instead of '0..*'.
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > **Position In Organisation**	A descriptor of the job or the job role based on the management hierarchy of the organisation.	0..1	participant[contact_person_non_provider]/associatedEntity/associatedPerson/ ext:asEmployment/**ext:code**	NS	See <code> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **DEMOGRAPHIC DATA**	Additional characteristics of a person that may be useful for identification or other clinical purposes.	0..0	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
			participant[contact_person_non_provider]/associatedEntity/ associatedPerson/**ext:administrativeGenderCode**		
			participant[contact_person_non_provider]/associatedEntity/associatedPerson/**ext:birthTime**		
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*)		
PATIENT NOMINATED CONTACT > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..0	See Known Issues.		Prohibition of ENTITLEMENT is not currently mapped.
CDA Header Data Elements			Context: /ClinicalDocument/		
PATIENT NOMINATED CONTACT > PARTICIPANT > **Qualifications**	A list of professional certifications, and certificates recognising having passed a course.	0..0	participant[contact_person_non_provider]/associatedEntity/associatedPerson/**ext:asQualifications**		

Example 6.5. PATIENT NOMINATED CONTACT as a PERSON - Not a Healthcare or Human Services Provider XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
<!-- Begin CDA Header -->
 …

<!-- Begin PATIENT NOMINATED CONTACT as a PERSON - Not a Healthcare or Human Services Provider -->
<participant typeCode="IRCP">
 <associatedEntity classCode="CON">

  <!-- id is used for system purposes such as matching -->
  <id root="7faa90cd-4540-44a5-8565-f06324662fdf"/>

  <!-- Role -->
  <code code="133932002"
   codeSystem="2.16.840.1.113883.6.96"
   codeSystemName="SNOMED CT"
   codeSystemVersion="20090731"
   displayName="Caregiver (Person)"/>

  <!-- ADDRESS -->
  <addr use="WP">
   <streetAddressLine>66 Caregiver Street</streetAddressLine>
   <city>Healthville</city>
   <state>QLD</state>
   <postalCode>5555</postalCode>
   <additionalLocator>32568931</additionalLocator>
   <country>Australia</country>
  </addr>

  <!-- ELECTRONIC COMMUNICATION DETAIL -->
  <telecom use="WP" value="tel:0733333333"/>

  <!-- PERSON NAME -->
  <associatedPerson>
   <name>
    <prefix>Mr.</prefix>
    <family>Caregiver</family>
   </name>

  <!-- Begin EMPLOYMENT DETAIL -->
  <ext:asEmployment classCode="EMP">
   <!-- Position In Organisation -->
   <ext:code>
    <originalText>Special Regional Sales and Marketing Manager for Cheese</originalText>
   </ext:code>

   <!-- Occupation -->
   <ext:jobCode code="131112" codeSystem="2.16.840.1.113883.13.62"
    codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, 2006"
```
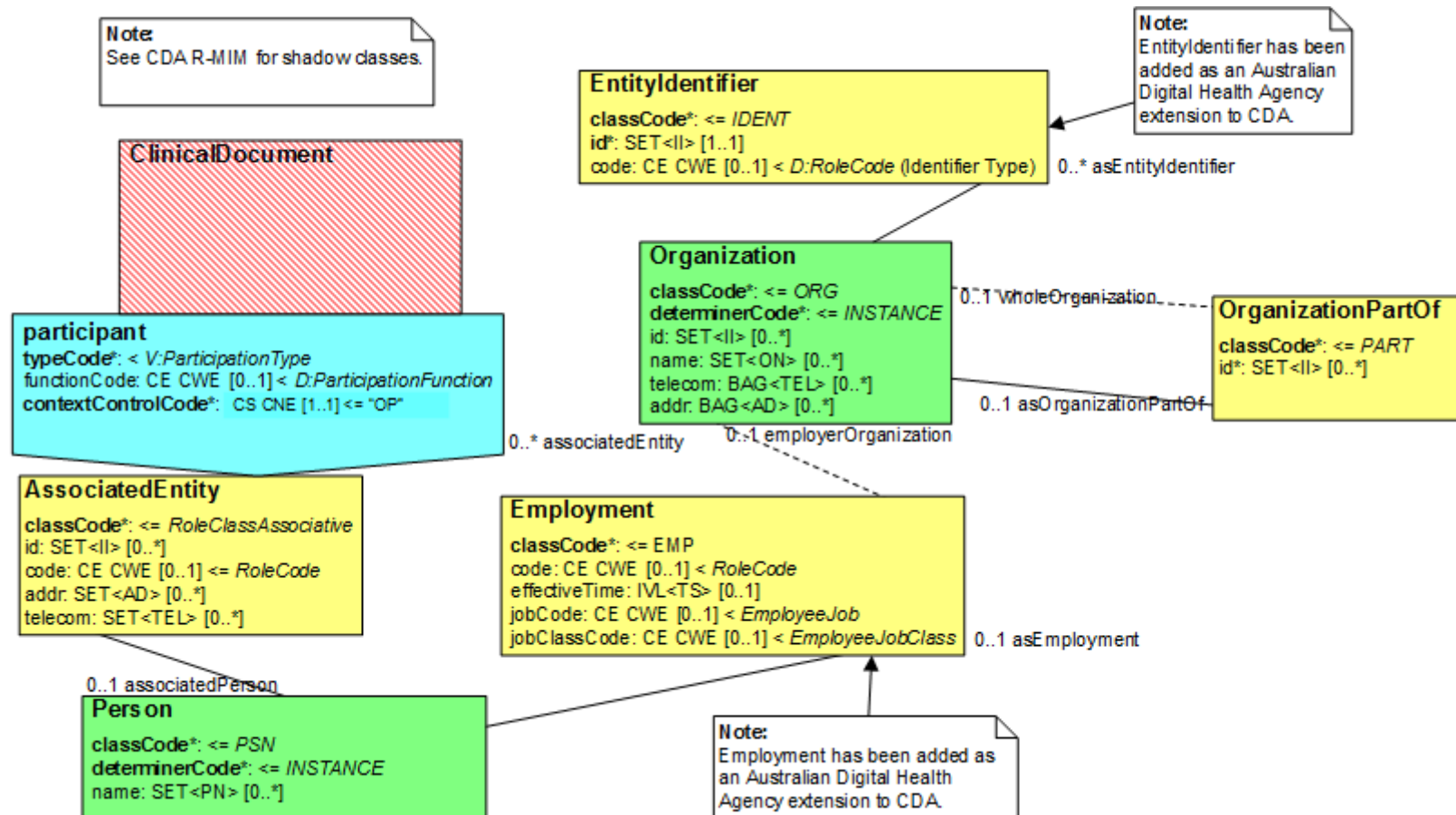
```xml
          displayName="Sales and Marketing Manager" />

      <!-- Employment Type -->
      <ext:jobClassCode code="FT" codeSystem="2.16.840.1.113883.5.1059" codeSystemName="HL7:EmployeeJobClass"
       displayName="full-time" />

      <!-- Begin EMPLOYER ORGANISATION -->
      <ext:employerOrganization>

       <!-- Department/Unit -->
       <name>Acme Cheese One</name>

       <asOrganizationPartOf>
        <wholeOrganization>

         <!-- Organisation Name -->
         <name use="ORGB">Acme Sales Group</name>

         <!-- ELECTRONIC COMMUNICATION DETAIL -->
         <telecom value="tel:0499999944" use="WP" />

         <!-- ADDRESS -->
         <addr use="WP">
          <houseNumber>1</houseNumber>
          <streetName>Sales</streetName>
          <streetNameType>St</streetNameType>
          <city>Healthville</city>
          <state>QLD</state>
          <postalCode>5555</postalCode>
          <additionalLocator>32568932</additionalLocator>
         </addr>

         <!-- Entity Identifier -->
         <ext:asEntityIdentifier classCode="IDENT">
          <ext:id assigningAuthorityName="ACN" root="1.2.36.87493897" />
          <ext:code
           code="XX" codeSystem="2.16.840.1.113883.12.203"
           codeSystemName="Identifier Type (HL7)"
           displayName="Organization identifier"/>
         </ext:asEntityIdentifier>

        </wholeOrganization>
       </asOrganizationPartOf>
      </ext:employerOrganization>
      <!-- End EMPLOYER ORGANISATION -->

     </ext:asEmployment>
     <!-- End EMPLOYMENT DETAIL -->

     <!-- Relationship to Subject of Care -->
     <ext:personalRelationship classCode="PRS">
      <ext:code code="16346" codeSystem="2.16.840.1.113883.1.11" codeSystemName="HL7 PersonalRelationshipRoleType" displayName="Parent" />
      <ext:asPersonalRelationship classCode="PSN" determinerCode="INSTANCE">
       <!-- The system generated id for the SUBJECT OF CARE  -->
       <id root="52b9470e-db0b-45aa-9a81-86e5243b84df"/>
       <!-- Included for CDA conformance only  -->
       <administrativeGenderCode nullFlavor="NA" />
      </ext:asPersonalRelationship>
     </ext:personalRelationship>

    </associatedPerson>
   </associatedEntity>
  </participant>
```

```
<!-- End PATIENT NOMINATED CONTACT as a PERSON - Not a Healthcare or Human Services Provider -->
…
<!-- End CDA Header -->

</ClinicalDocument>
```

6.1.3.3 PATIENT NOMINATED CONTACT as an ORGANISATION

CDA R-MIM Representation

Figure 6.8 PATIENT NOMINATED CONTACT as an ORGANISATION shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The PATIENT NOMINATED CONTACT data group instantiated as 'ORGANISATION' is related to its context of ClinicalDocument by the participant Participation class. A participant is an organisation in the role of associatedEntity (AssociatedEntity class). The entity playing the role is scopingOrganization (Organization class). The department/unit name is mapped to scopingOrganization.name and the organisation name is mapped to the wholeOrganization (Organization class) which represents a whole-part relationship using the OrganizationPartOf role. The organisation entity identifier is represented by the EntityIdentifier class (Australian Digital Health Agency CDA extension) which is related to the wholeOrganization.

Figure 6.8. PATIENT NOMINATED CONTACT as an ORGANISATION

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /ClinicalDocument/		
PATIENT NOMINATED CONTACT	Contact nominated to receive information about the subject of care.	0..*	**participant[contact_organisation]**		Each instance of this participant **SHALL** contain at least one instance of : • ADDRESS (participant/associatedEntity/addr), or • ELECTRONIC COMMUNICATION DETAIL (participant/associatedEntity/telecom).
n/a	n/a	1..1	participant[contact_organisation]/associatedEntity/**id**		Required CDA element. See <id> for available attributes.
PATIENT NOMINATED CONTACT > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	0..0	participant[contact_organisation]/**time**		
PATIENT NOMINATED CONTACT > **LOCATION OF PARTICIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIPATION is not currently mapped.
PATIENT NOMINATED CONTACT > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	participant[contact_organisation]/**@typeCode="IRCP"**	Participation Type **SHALL** have an implementation-specific value equivalent to "Patient Nominated Contact".	
PATIENT NOMINATED CONTACT > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	participant[contact_organisation]/**associatedEntity/@classCode="CON"**		
			participant[contact_organisation]/associatedEntity/**code**	Role **SHOULD** have a value representing the type of Facility e.g. Hospital, Clinic, Community Service Centre, Home care/housekeeping assistance.	See <code> for available attributes.
PATIENT NOMINATED CONTACT > **PARTICIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	participant[contact_organisation]/associatedEntity/**scopingOrganization**		
PATIENT NOMINATED CONTACT > PARTICIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	0..*	participant[contact_organisation]/associatedEntity/scopingOrganization/asOrganizationPartOf/wholeOrganization/<**Entity Identifier**>		See common pattern: Entity Identifier.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PATIENT NOMINATED CONTACT > PARTICIPANT > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	participant[contact_organisation]/associatedEntity/**<Address>**	AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.	See common pattern: Address.
PATIENT NOMINATED CONTACT > PARTICIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	participant[contact_organisation]/associatedEntity/**<Electronic Communication Detail>**		See common pattern: Electronic Communication Detail.
PATIENT NOMINATED CONTACT > PARTICIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as an ORGANISATION.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **ORGANISATION**	Any organisation of interest to, or involved in, the business of healthcare service provision.	1..1	n/a		Not mapped directly, encompassed implicitly in participant[contact_organisation]/associatedEntity/associatedPerson.
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Organisation Name**	The name by which an organisation is known or called.	1..1	participant[contact_organisation]/associatedEntity/scopingOrganization/asOrganizationPartOf/wholeOrganization/**name**		
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Department/Unit**	The name by which a department or unit within a larger organisation is known or called.	0..1	participant[contact_organisation]/associatedEntity/scopingOrganization/**name**		
PATIENT NOMINATED CONTACT > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Organisation Name Usage**	The classification that enables differentiation between recorded names for an organisation or service location.	0..1	participant[contact_organisation]/associatedEntity/scopingOrganization/asOrganizationPartOf/wholeOrganization/name/**@use**	AS 4846-2006: Health Care Provider Organisation Name Usage	
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*)		
PATIENT NOMINATED CONTACT > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..0	See Known Issues.		Prohibition of ENTITLEMENT is not currently mapped.
CDA Header Data Elements			Context: /ClinicalDocument/		
PATIENT NOMINATED CONTACT > PARTICIPANT > **Qualifications**	A list of professional certifications, and certificates recognising having passed a course.	0..0	n/a		This logical data component has no mapping to CDA.

Example 6.6. PATIENT NOMINATED CONTACT as an ORGANISATION XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
<!-- Begin CDA Header -->
 …

<!-- Begin PATIENT NOMINATED CONTACT as an Organisation -->
<participant typeCode="IRCP">
 <associatedEntity classCode="CON">

  <!-- id is used for system purposes such as matching -->
  <id root="7faa90cd-4540-44a5-8565-f06324662fdf"/>

  <!-- Role -->
  <code code="42665001"
   codeSystem="2.16.840.1.113883.6.96"
   codeSystemName="SNOMED CT"
   displayName="Nursing Home"/>

  <!-- ADDRESS -->
  <addr use="WP">
   <streetAddressLine>66 Caregiver Street</streetAddressLine>
   <city>Healthville</city>
   <state>QLD</state>
   <postalCode>5555</postalCode>
   <additionalLocator>32568931</additionalLocator>
   <country>Australia</country>
  </addr>

  <!-- ELECTRONIC COMMUNICATION DETAIL -->
  <telecom use="WP" value="tel:0733333333"/>

  <scopingOrganization>

   <!-- Department/Unit -->
   <name>Nursing Home</name>

   <asOrganizationPartOf>
    <wholeOrganization>

     <!-- Organisation Name -->
     <name use="ORGB">Nursing Home Group</name>

     <!-- Entity Identifier -->
     <ext:asEntityIdentifier classCode="IDENT">
      <ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />
      <ext:assigningGeographicArea classCode="PLC">
       <ext:name>National Identifier</ext:name>
      </ext:assigningGeographicArea>
     </ext:asEntityIdentifier>
```

```
        </wholeOrganization>
      </asOrganizationPartOf>

    </scopingOrganization>

    </associatedEntity>
  </participant>
  <!-- End PATIENT NOMINATED CONTACT as an Organisation -->
  …

  <!-- End CDA Header -->

</ClinicalDocument>
```

6.1.4 PRIMARY CARE PROVIDER

Identification

Name	PRIMARY CARE PROVIDER
Metadata Type	Data Group
Identifier	DG-10296

Relationships

Parent

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

Choices

Note

Mentioned below are the possible mutually exclusive 'PRIMARY CARE PROVIDER' instantiation choices.

Data Type	Name
	PRIMARY CARE PROVIDER as a PERSON
	PRIMARY CARE PROVIDER as an ORGANISATION

6.1.4.1 PRIMARY CARE PROVIDER as a PERSON

CDA R-MIM Representation

Figure 6.9 PRIMARY CARE PROVIDER as a PERSON shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The PRIMARY CARE PROVIDER data group instantiated as 'PERSON' is related to its context of ClinicalDocument by the participant participation class. A participant is a person in the role of associatedEntity (AssociatedEntity class). The entity playing the role is associatedPerson (Person class). The entity identifier of the participant is mapped to the EntityIdentifier class (Australian Digital Health Agency CDA extension) which is associated to the associatedEntity. Employment detail is mapped to the Australian Digital Health Agency CDA extension Employment.
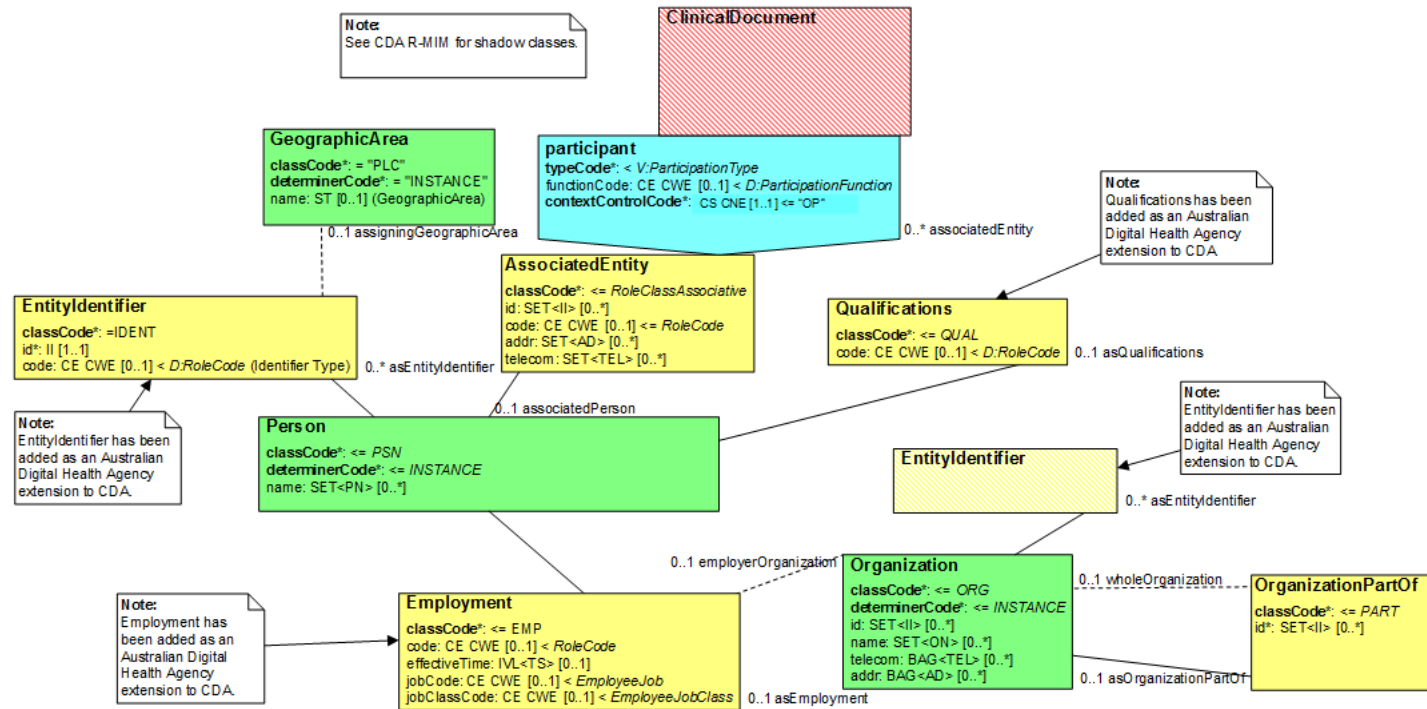
Figure 6.9. PRIMARY CARE PROVIDER as a PERSON

Figure 6.10 PRIMARY CARE PROVIDER as a PERSON - ENTITLEMENT shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.
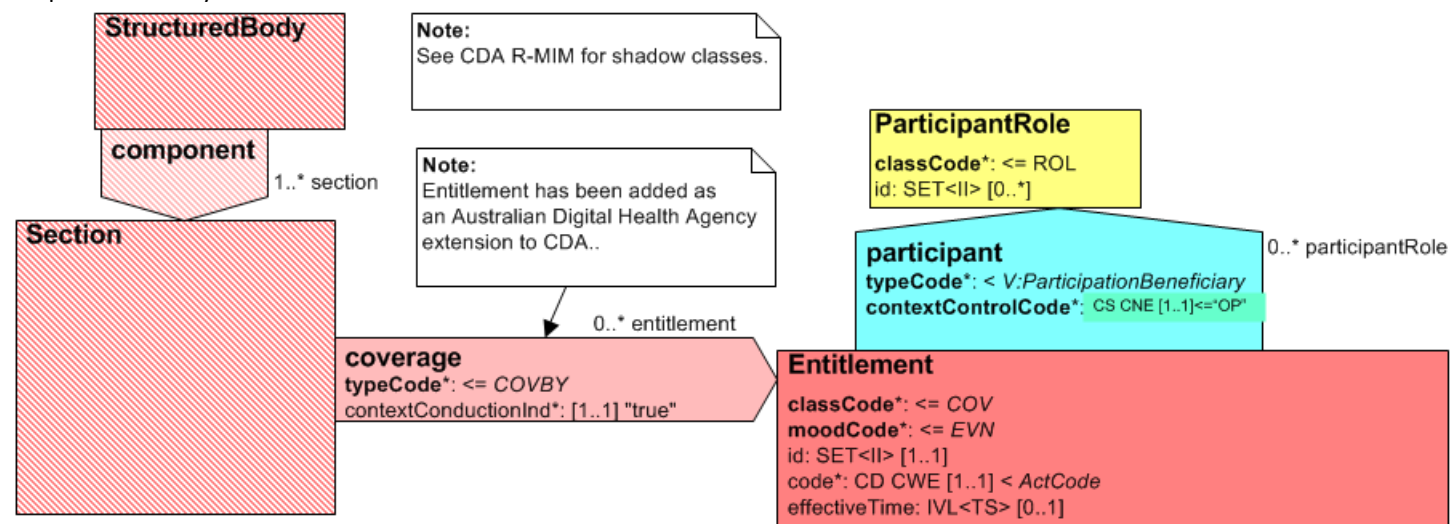
Figure 6.10. PRIMARY CARE PROVIDER as a PERSON - ENTITLEMENT

CDA Mapping

Note

NS = 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.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /ClinicalDocument/		
PRIMARY CARE PROVIDER	Healthcare provider (person or organisation) nominated by the subject of care as being primarily responsible for their ongoing healthcare.	0..1	**participant[care_provider_person]**		
n/a	n/a	1..1	participant[care_provider_person]/associatedEntity/**id**		Required CDA element. See <id> for available attributes.
PRIMARY CARE PROVIDER > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	0..0	participant[care_provider_person]/**time**		
PRIMARY CARE PROVIDER > **LOCATION OF PARTICIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIPATION is not currently mapped.
PRIMARY CARE PROVIDER > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	participant[care_provider_person]/**@typeCode="PART"**	Participation Type **SHALL** have an implementation-specific value equivalent to "Primary Care Provider".	
			participant[care_provider_person]/**functionCode/@code="PCP"**		
PRIMARY CARE PROVIDER > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	participant[care_provider_person]/**associatedEntity/code**	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 publicly available **MAY** be used.	See <code> for available attributes.
			participant[care_provider_person]/**associatedEntity/@classCode**	HL7:RoleClassAssociative (usually ="PROV")	

---

[3] http://www.hl7.org/oid/index.cfm?ref=footer

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PRIMARY CARE PROVIDER > **PARTICIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	participant[care_provider_person]/associatedEntity/**associatedPerson**		
PRIMARY CARE PROVIDER > PARTICIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	0..*	participant[care_provider_person]/associatedEntity/associatedPerson/**<Entity Identifier>**		See common pattern: Entity Identifier.
PRIMARY CARE PROVIDER > PARTICIPANT > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	participant[care_provider_person]/associatedEntity/**<Address>**	AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. Address Purpose (addr/@use) **SHALL** be set to Business (see AS 5017-2006: Health Care Client Identifier Address Purpose).	See common pattern: Address.
PRIMARY CARE PROVIDER > PARTICIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	participant[care_provider_person]/associatedEntity/**<Electronic Communication Detail>**	Electronic Communication Usage Code (telecom/@use) **SHALL** be set to Workplace (see HL7: TelecommunicationAddressUse).	See common pattern: Electronic Communication Detail.
PRIMARY CARE PROVIDER > PARTICIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **PERSON**	An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient).	1..1	n/a		Not mapped directly, encompassed implicitly in participant[care_provider_person]/associatedEntity/associatedPerson.
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **PERSON NAME**	The appellation by which an individual may be identified separately from any other within a social context.	1..*	participant[care_provider_person]/associatedEntity/associatedPerson/**<Person Name>**		See common pattern: Person Name.
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **Relationship to Subject of Care**	The relationship of a participant to a subject of care (patient).	0..0	participant[care_provider_person]/associatedEntity/associatedPerson/**ext:personalRelationship**		
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **EMPLOYMENT DETAIL**	A person's occupation and employer.	1..1	participant[care_provider_person]/associatedEntity/associatedPerson/**ext:asEmployment**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > **EMPLOYER ORGANISATION**	The organisation that the individual is working for in respect to the role they are playing in the nominated participation.	1..*	participant[care_provider_person]/associatedEntity/associatedPerson/ext:asEmployment/**ext:employerOrganization**		There is a known issue in the Participation Data Specification [DH2017a] for this logical data component's cardinality. Furthermore the corresponding CDA elements ext:asEmployment and ext:employerOrganization do not allow the cardinality to be multiple. The cardinality range **SHALL** be interpreted as '1..1'.
			participant[care_provider_person]/associatedEntity/associatedPerson/ext:asEmployment/**@classCode="EMP"**		
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	0..*	participant[care_provider_person]/associatedEntity/associatedPerson/ext:asEmployment/ext:employerOrganization/**asOrganizationPartOf/wholeOrganization/<Entity Identifier>**		See common pattern: Entity Identifier.
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	participant[care_provider_person]/associatedEntity/associatedPerson/ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Address>**	AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. Address Purpose (addr/@use) **SHALL** be set to Business (see AS 5017-2006: Health Care Client Identifier Address Purpose).	See common pattern: Address.
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	participant[care_provider_person]/associatedEntity/associatedPerson/ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Electronic Communication Detail>**	Electronic Communication Usage Code (telecom/@use) **SHALL** be set to Workplace (see HL7: TelecommunicationAddressUse).	See common pattern: Electronic Communication Detail.
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **ORGANISATION**	Any organisation of interest to, or involved in, the business of healthcare service provision.	1..1	n/a		Not mapped directly, encompassed implicitly in associatedPerson/ext:asEmployment/employerOrganization.
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > ORGANISATION > **Organisation Name**	The name by which an organisation is known or called.	1..1	participant[care_provider_person]/associatedEntity/associatedPerson/ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**name**		
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > ORGANISATION > **Department/Unit**	The name by which a department or unit within a larger organisation is known or called.	0..1	participant[care_provider_person]/associatedEntity/associatedPerson/ext:asEmployment/ext:employerOrganization/**name**		

Approved for external use

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > ORGANISATION > **Organisation Name Usage**	The classification that enables differentiation between recorded names for an organisation or service location.	0..1	participant[care_provider_person]/associatedEntity/associatedPerson/ ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/ name/**@use**	AS 4846-2006: Health Care Provider Organisation Name Usage	
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > **Employment Type**	The basis on which the person is employed by the employer organisation.	0..1	participant[care_provider_person]/associatedEntity/associatedPerson/ ext:asEmployment/**ext:jobClassCode**	NS	
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > **Occupation**	A descriptor of the class of job based on similarities in the tasks undertaken.	0..*	participant[care_provider_person]/associatedEntity/associatedPerson/ ext:asEmployment/**ext:jobCode**	*1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 [ABS2009]*	The corresponding CDA element ext:jobCode does not allow the cardinality to be '0..*'/multiple. The cardinality **SHALL** be interpreted as '0..1' instead of '0..*'.
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > **Position In Organisation**	A descriptor of the job or the job role based on the management hierarchy of the organisation.	0..1	participant[care_provider_person]/associatedEntity/associatedPerson/ ext:asEmployment/**ext:code**	NS	See <code> for available attributes.
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **DEMOGRAPHIC DATA**	Additional characteristics of a person that may be useful for identification or other clinical purposes.	0..0	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
			participant[care_provider_person]/associatedEntity/ associatedPerson/**ext:administrativeGenderCode**		
			participant[care_provider_person]/associatedEntity/associatedPerson/**ext:birthTime**		
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*)		
PRIMARY CARE PROVIDER > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..*	**ext:coverage2[care_provider_person]/@typeCode="COVBY"**		
			ext:coverage2[care_provider_person]/**ext:entitlement**		
			ext:coverage2[care_provider_person]/ext:entitlement/**@classCode="COV"**		
			ext:coverage2[care_provider_person]/ext:entitlement/**@moodCode="EVN"**		
			ext:coverage2[care_provider_person]/ ext:entitlement/**ext:participant[care_provider_person]/@typeCode="HLD"**		
			ext:coverage2[care_provider_person]/ext:entitlement/ ext:participant[care_provider_person]/**ext:participantRole/@classCode="ASSIGNED"**		
			ext:coverage2[care_provider_person]/ext:entitlement/ ext:participant[care_provider_person]/ext:participantRole/**ext:id**		This **SHALL** hold the same value as participant[care_provider_person]/associatedEntity/id where participation/@typeCode="PART".

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PRIMARY CARE PROVIDER > PARTICIPANT > ENTITLEMENT > **Entitlement Number**	A number or code issued for the purpose of identifying the entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	1..1	ext:coverage2[care_provider_person]/ext:entitlement/**ext:id**		See <id> for available attributes.
PRIMARY CARE PROVIDER > PARTICIPANT > ENTITLEMENT > **Entitlement Type**	The description of the scope of an entitlement.	1..1	ext:coverage2[care_provider_person]/ext:entitlement/**ext:code**	NCTIS: Admin Codes - Entitlement Type	See <code> for available attributes.
PRIMARY CARE PROVIDER > PARTICIPANT > ENTITLEMENT > **Entitlement Validity Duration**	The time interval for which an entitlement is valid.	0..1	ext:coverage2[care_provider_person]/ext:entitlement/**ext:effectiveTime**		See <time> for available attributes.
CDA Header Data Elements			Context: /ClinicalDocument/		
PRIMARY CARE PROVIDER > PARTICIPANT > **Qualifications**	A list of professional certifications, and certificates recognising having passed a course.	0..1	participant[care_provider_person]/associatedEntity/associatedPerson/**ext:asQualifications**		See Australian Digital Health Agency CDA extension: Qualifications.
			participant[care_provider_person]/associatedEntity/associatedPerson/ext:asQualifications/**@classCode="QUAL"**		
			participant[care_provider_person]/associatedEntity/associatedPerson/ext:asQualifications/**ext:code/originalText**	Qualifications is a text field, so the text list is entered in the originalText field of the code element.	

Example 6.7. PRIMARY CARE PROVIDER as a PERSON XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 <!-- Begin CDA Header -->
 …

 <!-- Begin PRIMARY CARE PROVIDER as a Person -->
<participant typeCode="PART">
 <functionCode code="PCP" />
 <associatedEntity classCode="PROV">

  <!-- id is used for system purposes such as matching -->
  <id root="ee13f045-f669-405e-a40b-4fce1ad895c4"/>

  <!-- Role -->
  <code code="253111"
   codeSystem="2.16.840.1.113883.13.62"
   codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
   displayName="General Medical Practitioner" />

  <!-- ADDRESS -->
  <addr use="WP">
   <streetAddressLine>55 GP Street</streetAddressLine>
   <city>Healthville</city>
   <state>QLD</state>
   <postalCode>5555</postalCode>
   <additionalLocator>32568931</additionalLocator>
   <country>Australia</country>
  </addr>

  <!-- ELECTRONIC COMMUNICATION DETAIL -->
  <telecom use="WP" value="tel:0777777777"/>

  <!-- PERSON NAME -->
  <associatedPerson>
   <name>
    <prefix>Dr.</prefix>
    <family>Generalist</family>
   </name>

  <!-- Entity Identifier -->
  <ext:asEntityIdentifier classCode="IDENT">
   <ext:id assigningAuthorityName="HPI-I" root="1.2.36.1.2001.1003.0.8003619900015717" />
   <ext:assigningGeographicArea classCode="PLC">
    <ext:name>National Identifier</ext:name>
   </ext:assigningGeographicArea>
  </ext:asEntityIdentifier>

  <!-- Begin EMPLOYMENT DETAIL -->
  <ext:asEmployment classCode="EMP">
```

```xml
<!-- Position In Organisation -->
<ext:code>
 <originalText>General Practitioner</originalText>
</ext:code>

<!-- Occupation -->
<ext:jobCode code="253111" codeSystem="2.16.840.1.113883.13.62"
 codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, 2006"
 displayName="General Medical Practitioner" />

<!-- Employment Type -->
<ext:jobClassCode code="FT" codeSystem="2.16.840.1.113883.5.1059" codeSystemName="HL7:EmployeeJobClass"
 displayName="full-time" />

<!-- Begin EMPLOYER ORGANISATION -->
<ext:employerOrganization>

 <!-- Department/Unit -->
 <name>Acme Hospital One</name>

 <asOrganizationPartOf>
  <wholeOrganization>

   <!-- Organisation Name -->
   <name use="ORGB">Acme Hospital Group</name>

   <!-- ELECTRONIC COMMUNICATION DETAIL -->
   <telecom value="tel:0499999999" use="WP" />

   <!-- ADDRESS -->
   <addr use="WP">
    <houseNumber>1</houseNumber>
    <streetName>Clinician</streetName>
    <streetNameType>St</streetNameType>
    <city>Healthville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568931</additionalLocator>
   </addr>

   <!-- Entity Identifier -->
   <ext:asEntityIdentifier classCode="IDENT">
    <ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />
    <ext:assigningGeographicArea classCode="PLC">
     <ext:name>National Identifier</ext:name>
    </ext:assigningGeographicArea>
   </ext:asEntityIdentifier>

  </wholeOrganization>
 </asOrganizationPartOf>
</ext:employerOrganization>
<!-- End EMPLOYER ORGANISATION -->

</ext:asEmployment>
<!-- End EMPLOYMENT DETAIL -->

<!-- Qualifications -->
<ext:asQualifications classCode="QUAL">
 <ext:code>
  <originalText>M.B.B.S</originalText>
 </ext:code>
</ext:asQualifications>
```
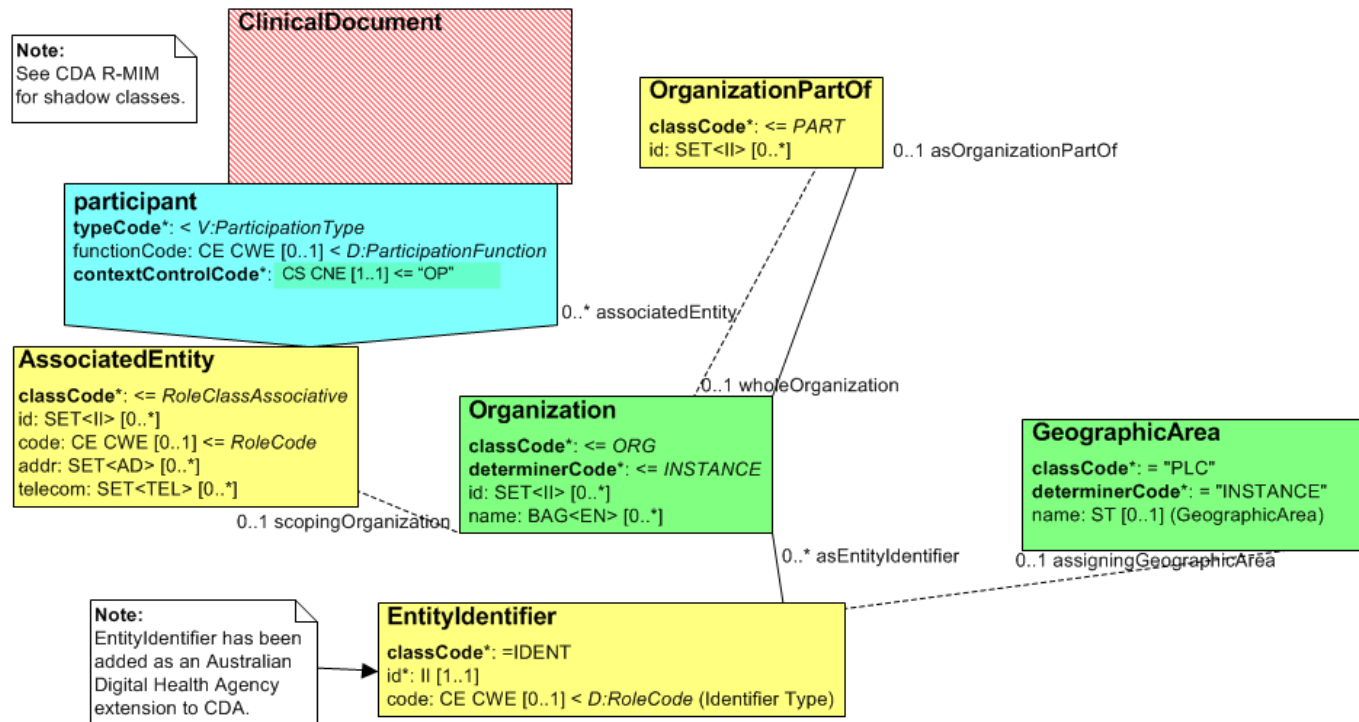
```xml
          </associatedPerson>
        </associatedEntity>
      </participant>
      <!-- End PRIMARY CARE PROVIDER as a Person -->
      …

      <!-- End CDA Header -->

      <!-- Begin CDA Body -->
      <component>
        <structuredBody>
          <!-- Begin Administrative Observations -->
          <component>
            <section>
              <code code="102.16080" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Administrative Observations"/>
              <title>Administrative Observations</title>

              <!-- narrative block -->
              <text>
                <table>
                  <tbody>
                    <tr>
                      <th>Australian Medicare Prescriber Number</th>
                      <td>049960CT</td>
                    </tr>
                  </tbody>
                </table>
              </text>
              …

              <!-- Begin PRIMARY CARE PROVIDER as a Person ENTITLEMENT -->
              <ext:coverage2 typeCode="COVBY">
                <ext:entitlement classCode="COV" moodCode="EVN">
                  <ext:id assigningAuthorityName="Medicare Prescriber number" root="1.2.36.174030967.0.3" extension="049960CT" />
                  <ext:code code="10" codeSystem="1.2.36.1.2001.1001.101.104.16047" codeSystemName="NCTIS Entitlement Type Values"
                    displayName="Medicare Prescriber Number" />
                  <ext:effectiveTime>
                    <low value="200501010101+1100" />
                    <high value="202501010101+1100" />
                  </ext:effectiveTime>
                  <ext:participant typeCode="HLD">
                    <ext:participantRole classCode="ASSIGNED">
                      <!-- Same as the PRIMARY CARE PROVIDER as a Person (participant) id -->
                      <ext:id root="ee13f045-f669-405e-a40b-4fce1ad895c4" />
                    </ext:participantRole>
                  </ext:participant>
                </ext:entitlement>
              </ext:coverage2>
              <!-- End PRIMARY CARE PROVIDER as a Person ENTITLEMENT -->
              …

            </section>
          </component>
          <!-- End Administrative Observations -->
          …

        </structuredBody>
      </component>
      <!-- End CDA Body -->
</ClinicalDocument>
```

6.1.4.2 PRIMARY CARE PROVIDER as an ORGANISATION

CDA R-MIM Representation

Figure 6.11 PRIMARY CARE PROVIDER as an ORGANISATION shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The PRIMARY CARE PROVIDER data group instantiated as 'ORGANISATION' is related to its context of ClinicalDocument by the participant Participation class. A participant is an organisation in the role of associatedEntity (AssociatedEntity class). The entity playing the role is scopingOrganization (Organization class). The department/unit name is mapped to scopingOrganization.name and the organisation name is mapped to the wholeOrganization (Organization class) which represents a whole-part relationship using the OrganizationPartOf role. The organisation entity identifier is represented by the EntityIdentifier class (Australian Digital Health Agency CDA extension) which is associated to the wholeOrganization.

Figure 6.11. PRIMARY CARE PROVIDER as an ORGANISATION

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /ClinicalDocument/		
PRIMARY CARE PROVIDER	Healthcare provider (person or organisation) nominated by the subject of care as being primarily responsible for their ongoing healthcare.	0..1	**participant[care_provider_organisation]**		
n/a	n/a	1..1	participant[care_provider_organisation]/associatedEntity/**id**		Optional CDA element. See <id> for available attributes.
PRIMARY CARE PROVIDER > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	0..0	participant[care_provider_organisation]/**time**		
PRIMARY CARE PROVIDER > **LOCATION OF PARTICIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIPATION is not currently mapped.
PRIMARY CARE PROVIDER > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	participant[care_provider_organisation]/**@typeCode="PART"**	Participation Type **SHALL** have an implementation-specific value equivalent to "Primary Care Provider".	
			participant[care_provider_organisation]/**functionCode/@code="PCP"**		
PRIMARY CARE PROVIDER > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	participant[care_provider_organisation]/**associatedEntity/code**	Role **SHALL** have a value representing the type of Facility e.g. Hospital, Clinic.	See <code> for available attributes.
			participant[care_provider_organisation]/**associatedEntity/@classCode**	HL7:RoleClassAssociative (usually ="PROV")	
PRIMARY CARE PROVIDER > **PARTICIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	participant[care_provider_organisation]/associatedEntity/**scopingOrganization**		
PRIMARY CARE PROVIDER > PARTICIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..*	participant[care_provider_organisation]/associatedEntity/scopingOrganization/asOrganizationPartOf/ wholeOrganization/<**Entity Identifier**>		See common pattern: Entity Identifier.
PRIMARY CARE PROVIDER > PARTICIPANT > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	participant[care_provider_organisation]/associatedEntity/<**Address**>	AUSTRALIAN OR INTERNATIONAL ADDRESS SHALL be instantiated as an AUSTRALIAN ADDRESS.	See common pattern: Address.
PRIMARY CARE PROVIDER > PARTICIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	participant[care_provider_organisation]/associatedEntity/<**Electronic Communication Detail**>		See common pattern: Electronic Communication Detail.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PRIMARY CARE PROVIDER > PARTICIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as an ORGANISATION.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **ORGANISATION**	Any organisation of interest to, or involved in, the business of healthcare service provision.	1..1	n/a		Not mapped directly, encompassed implicitly in participant[care_provider_organisation]/associatedEntity/associatedPerson.
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Organisation Name**	The name by which an organisation is known or called.	1..1	participant[care_provider_organisation]/associatedEntity/scopingOrganization/**asOrganizationPartOf/ wholeOrganization/name**		
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Department/Unit**	The name by which a department or unit within a larger organisation is known or called.	0..1	participant[care_provider_organisation]/associatedEntity/scopingOrganization/**name**		
PRIMARY CARE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Organisation Name Usage**	The classification that enables differentiation between recorded names for an organisation or service location.	0..1	participant[care_provider_organisation]/associatedEntity/scopingOrganization/asOrganizationPartOf/ wholeOrganization/name/**@use**	AS 4846-2006: Health Care Provider Organisation Name Usage	
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*)		
PRIMARY CARE PROVIDER > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..0	See Known Issues.		Prohibition of ENTITLEMENT is not currently mapped.
CDA Header Data Elements			Context: /ClinicalDocument/		
PRIMARY CARE PROVIDER > PARTICIPANT > **Qualifications**·	A list of professional certifications, and certificates recognising having passed a course.	0..0	n/a		This logical data component has no mapping to CDA.

Example 6.8. PRIMARY CARE PROVIDER as an ORGANISATION XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 <!-- Begin CDA Header -->
 …

 <!-- Begin PRIMARY CARE PROVIDER as an ORGANISATION -->
 <participant typeCode="PART">
 <functionCode code="PCP"/>
 <associatedEntity classCode="PROV">

  <!-- id is used for system purposes such as matching -->
  <id root="ee13f045-f669-405e-a40b-4fce1ad895c4"/>

  <!-- Role -->
  <code code="408443003"
   codeSystem="2.16.840.1.113883.6.96"
   codeSystemName="SNOMED CT"
   displayName="General medical practice"/>

  <!-- ADDRESS -->
  <addr use="WP">
   <streetAddressLine>55 GP Street</streetAddressLine>
   <city>Healthville</city>
   <state>QLD</state>
   <postalCode>5555</postalCode>
   <additionalLocator>32568931</additionalLocator>
   <country>Australia</country>
  </addr>

  <!-- ELECTRONIC COMMUNICATION DETAIL -->
  <telecom use="WP" value="tel:0788888888"/>

  <scopingOrganization>
   <!-- Department/Unit Name -->
   <name>Day Surgery</name>

   <asOrganizationPartOf>
    <wholeOrganization>
     <!-- Organisation Name -->
     <name use="ORGB">Logan Hospital</name>

     <!-- Entity Identifier -->
     <ext:asEntityIdentifier classCode="IDENT">
      <ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />
      <ext:assigningGeographicArea classCode="PLC">
       <ext:name>National Identifier</ext:name>
      </ext:assigningGeographicArea>
     </ext:asEntityIdentifier>
```

```
            </wholeOrganization>
          </asOrganizationPartOf>
        </scopingOrganization>
      </associatedEntity>
    </participant>
    <!-- End PRIMARY CARE PROVIDER as an ORGANISATION -->
    …

    <!-- End CDA Header -->

</ClinicalDocument>
```

6.1.5 INTERESTED PARTY

Identification

Name	INTERESTED PARTY
Metadata Type	Data Group
Identifier	DG-10296

Relationships

Parent

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

Choices

Note

Mentioned below are the possible 'INTERESTED PARTY' instantiation choices.

Data Type	Name
	INTERESTED PARTY as a PERSON
	INTERESTED PARTY as an ORGANISATION

6.1.5.1 INTERESTED PARTY as a PERSON

CDA R-MIM Representation

Figure 6.12 INTERESTED PARTY as a PERSON shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The INTERESTED PARTY data group instantiated as 'PERSON' is related to its context of ClinicalDocument by the informationRecipient participation class. A participant is a person in the role of intendedRecipient (IntendedRecipient class). The entity playing the role is informationRecipient (Person class). The entity identifier of the participant is mapped to the EntityIdentifier class (Australian Digital Health Agency CDA extension) which is associated to the informationRecipient.
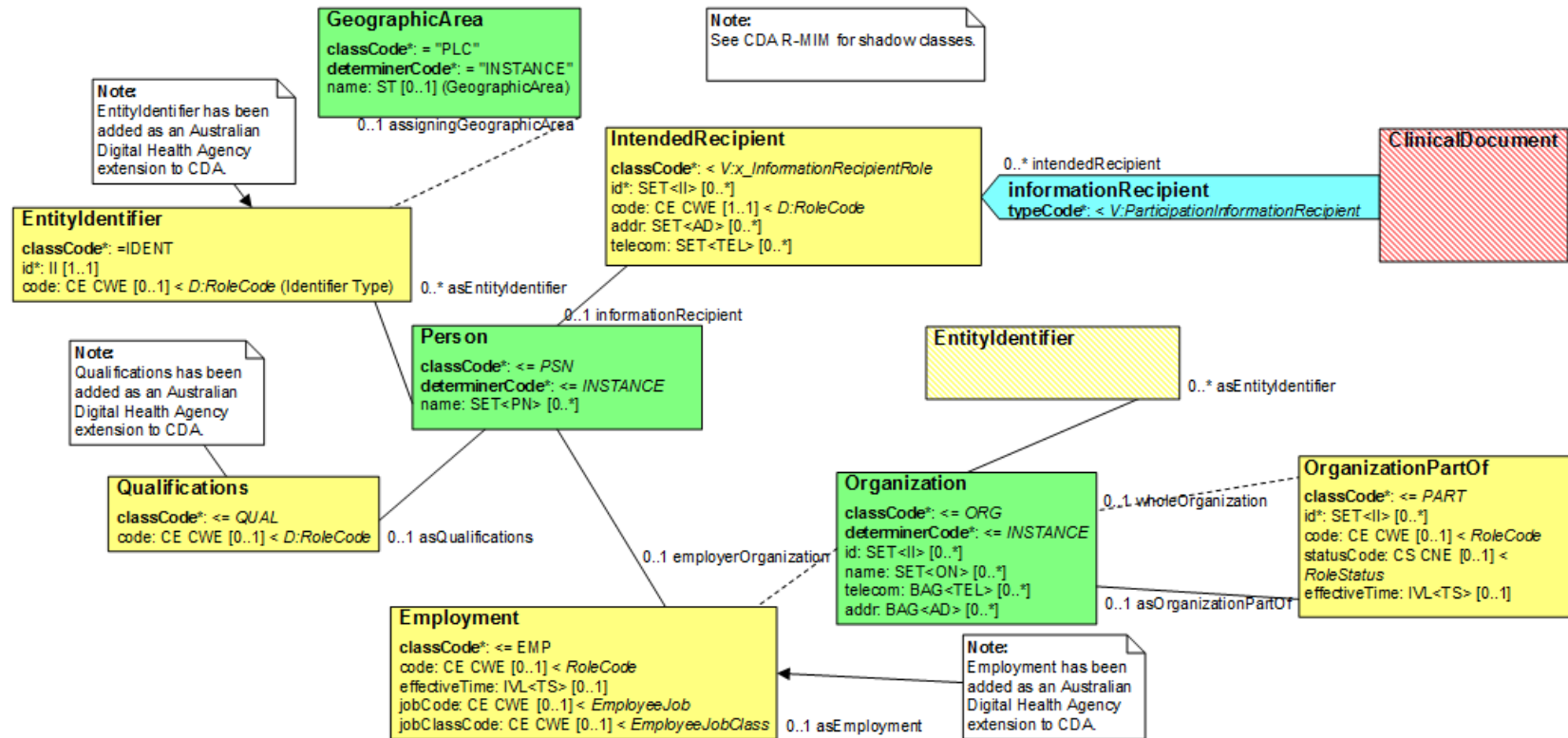
Figure 6.12. INTERESTED PARTY as a PERSON

Figure 6.13 INTERESTED PARTY as a PERSON - ENTITLEMENT shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.
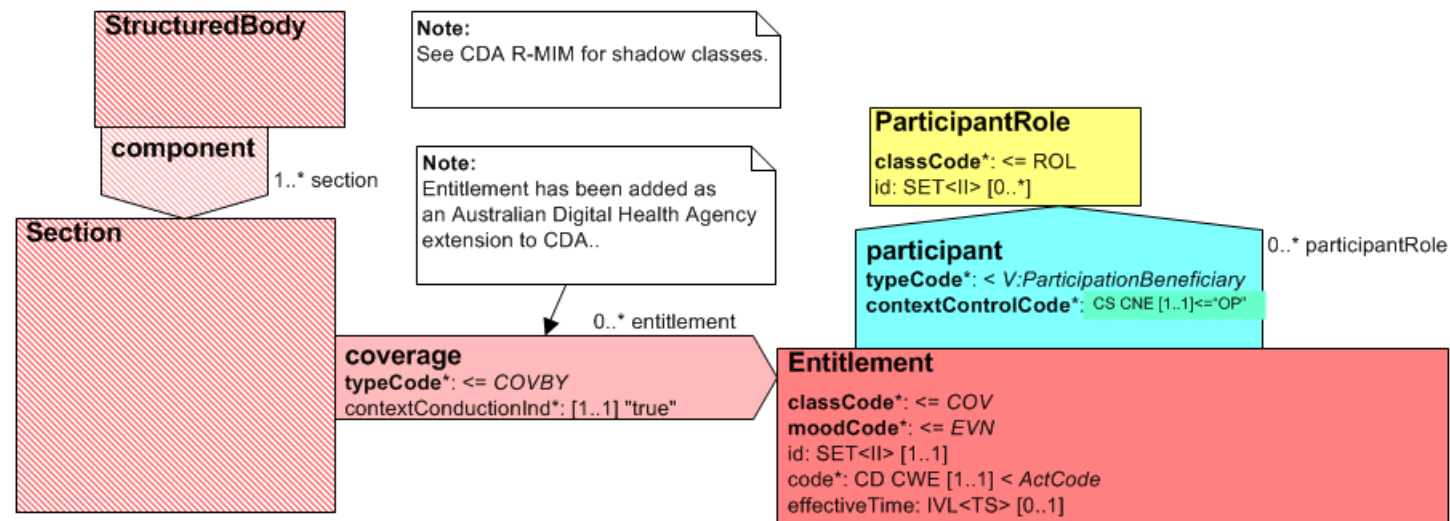
Figure 6.13. INTERESTED PARTY as a PERSON - ENTITLEMENT

CDA Mapping

Note

NS = 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.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /ClinicalDocument/		
INTERESTED PARTY	Party who should receive correspondence from the referral receiver regarding the referral.	0..*	**informationRecipient[interested_party_person]**		
n/a	n/a	1..1	informationRecipient[interested_party_person]/intendedRecipient/**id**		Required CDA element. See <id> for available attributes.
INTERESTED PARTY > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	0..0	informationRecipient[interested_party_person]/**time**		
INTERESTED PARTY > **LOCATION OF PARTICIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIPATION is not currently mapped.
INTERESTED PARTY > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	informationRecipient[interested_party_person]/**@typeCode="TRC"**	Participation Type **SHALL** have an implementation-specific value equivalent to "Party to receive correspondence".	
INTERESTED PARTY > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	informationRecipient[interested_party_person]/**intendedRecipient/@classCode="ASSIGNED"**		
			informationRecipient[interested_party_person]/intendedRecipient/**ext:code**	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 publicly available **MAY** be used.	See <code> for available attributes.

---

[4] http://www.hl7.org/oid/index.cfm?ref=footer

Approved for external use

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
INTERESTED PARTY > **PARTICIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a health-care event/encounter/clinical interaction.	1..1	informationRecipient[interested_party_person]/intendedRecipient/**informationRecipient**		
INTERESTED PARTY > PARTICIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	0..*	informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/**<Entity Identifier>**		See common pattern: Entity Identifier.
INTERESTED PARTY > PARTICIPANT > **AD-DRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	informationRecipient[interested_party_person]/intendedRecipient/**<Address>**	AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. Address Purpose (addr/@use) **SHOULD** be set to Business (see AS 5017-2006: Health Care Client Identifier Address Purpose).	See common pattern: Address.
INTERESTED PARTY > PARTICIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	informationRecipient[interested_party_person]/intendedRecipient/**<Electronic Communication Detail>**	Electronic Communication Usage Code (telecom/@use) **SHOULD** be set to Workplace (see HL7: Telecommu- nicationAddressUse).	See common pattern: Electronic Communication De- tail.
INTERESTED PARTY > PARTICIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE **SHALL** be instan- tiated as a PERSON.	This logical data component has no mapping to CDA. The cardinality of this com- ponent propagates to its children.
INTERESTED PARTY > PARTICIPANT > PER-SON OR ORGANISATION OR DEVICE > **PERSON**	An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient).	1..1	n/a		Not mapped directly, encom- passed implicitly in informa- tionRecipient[inter- ested_party_person]/inten- dedRecipient/informationRe- cipient.
INTERESTED PARTY > PARTICIPANT > PER-SON OR ORGANISATION OR DEVICE > PERSON > **PERSON NAME**	The appellation by which an individual may be identified separately from any other within a social context.	1..*	informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/**<Person Name>**		See common pattern: Per- son Name.
INTERESTED PARTY > PARTICIPANT > PER-SON OR ORGANISATION OR DEVICE > PERSON > **Relationship to Subject of Care**	The relationship of a participant to a subject of care (patient).	0..0	informationRecipient[interested_party_person]/intendedRecipient/ informationRecipient/**ext:personalRelationship**		
INTERESTED PARTY > PARTICIPANT > PER-SON OR ORGANISATION OR DEVICE > PERSON > **EMPLOYMENT DETAIL**	A person's occupation and employer.	1..1	informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/**ext:asEmploy- ment**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
INTERESTED PARTY > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > **EMPLOYER ORGANISATION**	The organisation that the individual is working for in respect to the role they are playing in the nominated participation.	1..*	informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/ext:asEmployment/**ext:employerOrganization**		There is a known issue in the Participation Data Specification [DH2017a] for this logical data component's cardinality. Furthermore the corresponding CDA elements ext:asEmployment and ext:employerOrganization do not allow the cardinality to be multiple. The cardinality range **SHALL** be interpreted as '1..1'.
			informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/ext:asEmployment/**@classCode="EMP"**		
INTERESTED PARTY > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	0..*	informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/ext:asEmployment/ext:employerOrganization/**asOrganizationPartOf/wholeOrganization/<Entity Identifier>**		See common pattern: Entity Identifier.
INTERESTED PARTY > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Address>**		See common pattern: Address.
INTERESTED PARTY > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	1..*	informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Electronic Communication Detail>**		See common pattern: Electronic Communication Detail.
INTERESTED PARTY > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **ORGANISATION**	Any organisation of interest to, or involved in, the business of healthcare service provision.	1..1	n/a		Not mapped directly, encompassed implicitly in informationRecipient/ext:asEmployment/employerOrganization.
INTERESTED PARTY > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > ORGANISATION > **Organisation Name**	The name by which an organisation is known or called.	1..1	informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**name**		
INTERESTED PARTY > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > ORGANISATION > **Department/Unit**	The name by which a department or unit within a larger organisation is known or called.	0..1	informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/ext:asEmployment/ext:employerOrganization/**name**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
INTERESTED PARTY > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > ORGANISATION > **Organisation Name Usage**	The classification that enables differentiation between recorded names for an organisation or service location.	0..1	informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/ ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/name/**@use**	AS 4846-2006: Health Care Provider Organisation Name Usage	
INTERESTED PARTY > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > **Employment Type**	The basis on which the person is employed by the employer organisation.	0..1	informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/ ext:asEmployment/**ext:jobClassCode**	NS	
INTERESTED PARTY > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > **Occupation**	A descriptor of the class of job based on similarities in the tasks undertaken.	0..*	informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/ ext:asEmployment/**ext:jobCode**	1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 [ABS2009]	The corresponding CDA element ext:jobCode does not allow the cardinality to be '0..*'/multiple. The cardinality **SHALL** be interpreted as '0..1' instead of '0..*'.
INTERESTED PARTY > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > EMPLOYMENT DETAIL > **Position In Organisation**	A descriptor of the job or the job role based on the management hierarchy of the organisation.	0..1	informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/ ext:asEmployment/**ext:code**	NS	See <code> for available attributes.
INTERESTED PARTY > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **DEMOGRAPHIC DATA**	Additional characteristics of a person that may be useful for identification or other clinical purposes.	0..0	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
			informationRecipient[interested_party_person]/intendedRecipient/ informationRecipient/**ext:administrativeGenderCode**		
			informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/**ext:birthTime**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See *4 Administrative Observations*)		
INTERESTED PARTY > PARTICIPANT > **ENTI-TLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..*	**ext:coverage2[interested_party_person]/@typeCode="COVBY"**		
			ext:coverage2[interested_party_person]/**ext:entitlement**		
			ext:coverage2[interested_party_person]/ext:entitlement/**@classCode="COV"**		
			ext:coverage2[interested_party_person]/ext:entitlement/**@moodCode="EVN"**		
			ext:coverage2[interested_party_person]/ext:entitlement/**ext:participant[interested_party_person]/@typeCode="HLD"**		
			ext:coverage2[interested_party_person]/ext:entitlement/ext:participant[interested_party_person]/**ext:participantRole/@classCode="ASSIGNED"**		
			ext:coverage2[interested_party_person]/ext:entitlement/ext:participant[interested_party_person]/ext:participantRole/**ext:id**		This **SHALL** hold the same value as informationRecipient[interested_party_person]/intendedRecipient/id where informationRecipient/@typeCode="TRC". See \<id\> for available attributes.
INTERESTED PARTY > PARTICIPANT > ENTI-TLEMENT > **Entitlement Number**	A number or code issued for the purpose of identifying the entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	1..1	ext:coverage2[interested_party_person]/ext:entitlement/**ext:id**		See \<id\> for available attributes.
INTERESTED PARTY > PARTICIPANT > ENTI-TLEMENT > **Entitlement Type**	The description of the scope of an entitlement.	1..1	ext:coverage2[interested_party_person]/ext:entitlement/**ext:code**	NCTIS: Admin Codes - Entitlement Type	See \<code\> for available attributes.
INTERESTED PARTY > PARTICIPANT > ENTI-TLEMENT > **Entitlement Validity Duration**	The time interval for which an entitlement is valid.	0..1	ext:coverage2[interested_party_person]/ext:entitlement/**ext:effectiveTime**		See \<time\> for available attributes.
CDA Header Data Elements			Context: /ClinicalDocument/		
INTERESTED PARTY > PARTICIPANT > **Qualifications**	A list of professional certifications, and certificates recognising having passed a course.	0..1	informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/**ext:asQualifications**		See Australian Digital Health Agency CDA extension: Qualifications.
			informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/ext:asQualifications/**@classCode="QUAL"**		
			informationRecipient[interested_party_person]/intendedRecipient/informationRecipient/ext:asQualifications/**ext:code/originalText**	Qualifications is a text field, so the text list is entered in the originalText field of the code element.	

Example 6.9. INTERESTED PARTY as a PERSON - XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 <!-- Begin CDA Header -->
 …

 <!-- Begin INTERESTED PARTY as a PERSON -->
 <informationRecipient typeCode="TRC">
  <intendedRecipient classCode="ASSIGNED">

   <!-- id is used for system purposes such as matching -->
   <id root="7faa90cd-4540-44a5-8565-f06324662fdf"/>

   <!-- Role -->
   <ext:code code="133932002"
    codeSystem="2.16.840.1.113883.6.96"
    codeSystemName="SNOMED CT"
    codeSystemVersion="20090731"
    displayName="Caregiver (Person)"/>

   <!-- ADDRESS -->
   <addr use="WP">
    <streetAddressLine>66 Caregiver Street</streetAddressLine>
    <city>Healthville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568931</additionalLocator>
    <country>Australia</country>
   </addr>

   <!-- ELECTRONIC COMMUNICATION DETAIL -->
   <telecom use="WP" value="tel:0733333333"/>

   <informationRecipient>
    <!-- PERSON NAME -->
    <name>
     <prefix>Mr.</prefix>
     <family>Caregiver</family>
    </name>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
     <ext:id assigningAuthorityName="HPI-I" root="1.2.36.1.2001.1003.0.8003619900015717" />
     <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
     </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>

    <!-- Begin EMPLOYMENT DETAIL -->
    <ext:asEmployment classCode="EMP">
```

```xml
<!-- Position In Organisation -->
<ext:code>
 <originalText>General Practitioner</originalText>
</ext:code>

<!-- Occupation -->
<ext:jobCode code="253111" codeSystem="2.16.840.1.113883.13.62"
 codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, 2006"
 displayName="General Medical Practitioner" />

<!-- Employment Type -->
<ext:jobClassCode code="FT" codeSystem="2.16.840.1.113883.5.1059" codeSystemName="HL7:EmployeeJobClass"
 displayName="full-time" />

<!-- Begin EMPLOYER ORGANISATION -->
<ext:employerOrganization>

 <!-- Department/Unit -->
 <name>Acme Hospital One</name>

 <asOrganizationPartOf>
  <wholeOrganization>

   <!-- Organisation Name -->
   <name use="ORGB">Acme Hospital Group</name>

   <!-- ELECTRONIC COMMUNICATION DETAIL -->
   <telecom value="tel:0499999999" use="WP" />

   <!-- ADDRESS -->
   <addr use="WP">
    <houseNumber>1</houseNumber>
    <streetName>Clinician</streetName>
    <streetNameType>St</streetNameType>
    <city>Healthville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568931</additionalLocator>
   </addr>

   <!-- Entity Identifier -->
   <ext:asEntityIdentifier classCode="IDENT">
    <ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />
    <ext:assigningGeographicArea classCode="PLC">
     <ext:name>National Identifier</ext:name>
    </ext:assigningGeographicArea>
   </ext:asEntityIdentifier>

  </wholeOrganization>
 </asOrganizationPartOf>
</ext:employerOrganization>
<!-- End EMPLOYER ORGANISATION -->

</ext:asEmployment>
<!-- End EMPLOYMENT DETAIL -->

<!-- Qualifications -->
<ext:asQualifications classCode="QUAL">
 <ext:code>
  <originalText>M.B.B.S</originalText>
 </ext:code>
</ext:asQualifications>
```

```xml
      </informationRecipient>
    </intendedRecipient>
  </informationRecipient>
<!-- End INTERESTED PARTY as a PERSON -->

…
<!-- End CDA Header -->

<!-- Begin CDA Body -->
<component>
  <structuredBody>
    <!-- Begin Administrative Observations -->
    <component>
        <section>
            <id root="55ae28fb-4fd5-4b6e-85dc-728ea9af733c"/>
            <code code="102.16080" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Administrative Observations"/>
            <title>Administrative Observations</title>

            <!-- narrative block -->
            <text>
                <table>
                    <tbody>
                        <tr>
                            <th>Australian Medicare Prescriber Number</th>
                            <td>049960CT</td>
                        </tr>
                    </tbody>
                </table>
            </text>
            …

            <!-- Begin INTERESTED PARTY as a PERSON ENTITLEMENT -->
            <ext:coverage2 typeCode="COVBY">
                <ext:entitlement classCode="COV" moodCode="EVN">
                    <ext:id assigningAuthorityName="Medicare Australia" root="1.2.36.174030967.0.3" extension="049960CT" />
                    <ext:code code="10" codeSystem="1.2.36.1.2001.1001.101.104.16047" codeSystemName="NCTIS Entitlement Type Values"
                        displayName="Medicare Prescriber Number" />
                    <ext:effectiveTime>
                        <low value="200501010101+1100" />
                        <high value="202501010101+1100" />
                    </ext:effectiveTime>
                    <ext:participant typeCode="HLD">
                        <ext:participantRole classCode="ASSIGNED">
                            <!-- Same as the PRIMARY CARE PROVIDER as a Person (participant) id -->
                            <ext:id root="ee13f045-f669-405e-a40b-4fce1ad895c4" />
                        </ext:participantRole>
                    </ext:participant>
                </ext:entitlement>
            </ext:coverage2>
            <!-- End INTERESTED PARTY as a PERSON ENTITLEMENT -->

        </section>
    </component>
    <!-- End Administrative Observations -->
    …

  </structuredBody>
</component>
<!-- End CDA Body -->
</ClinicalDocument>
```

6.1.5.2 INTERESTED PARTY as an ORGANISATION

CDA R-MIM Representation

Figure 6.14 INTERESTED PARTY as an ORGANISATION shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The INTERESTED PARTY data group instantiated as 'ORGANISATION' is related to its context of ClinicalDocument by the participant InformationRecipient class. A participant is an organisation in the role of intendedRecipient (IntendedRecipient class). The entity playing the role is receivedOrganization (Organization class). The department/unit name is mapped to receivedOrganization.name and the organisation name is mapped to the wholeOrganization (Organization class) which represents a whole-part relationship using the OrganizationPartOf role. The organisation entity identifier is represented by the EntityIdentifier class (Australian Digital Health Agency CDA extension) which is associated to the wholeOrganization.

Figure 6.14. INTERESTED PARTY as an ORGANISATION

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /ClinicalDocument/		
INTERESTED PARTY	Party who should receive correspondence from the referral receiver regarding the referral.	0..*	**informationRecipient[interested_party_organisation]**		
n/a	n/a	1..1	informationRecipient[interested_party_organisation]/intendedRecipient/**id**		Required CDA element. See <id> for available attributes.
INTERESTED PARTY > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	0..0	informationRecipient[interested_party_organisation]/**time**		
INTERESTED PARTY > **LOCATION OF PARTICIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIPATION is not currently mapped.
INTERESTED PARTY > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	informationRecipient[interested_party_organisation]/**@typeCode="TRC"**	Participation Type **SHALL** have an implementation-specific value equivalent to "Party to receive correspondence".	
INTERESTED PARTY > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	informationRecipient[interested_party_organisation]/**intendedRecipient/@classCode="ASSIGNED"**		
			informationRecipient[interested_party_organisation]/intendedRecipient/**ext:code**	Role **SHOULD** have a value representing the type of Facility e.g. Hospital, Clinic, Community Service Centre, Home care/housekeeping assistance.	See <code> for available attributes.
INTERESTED PARTY > **PARTICIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	informationRecipient[interested_party_organisation]/intendedRecipient/**receivedOrganization**		
INTERESTED PARTY > PARTICIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..*	informationRecipient[interested_party_organisation]/intendedRecipient/receivedOrganization/ asOrganizationPartOf/wholeOrganization/**<Entity Identifier>**		See common pattern: Entity Identifier.
INTERESTED PARTY > PARTICIPANT > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	informationRecipient[interested_party_organisation]/intendedRecipient/**<Address>**	AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.	See common pattern: Address.
INTERESTED PARTY > PARTICIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	1..*	informationRecipient[interested_party_organisation]/intendedRecipient/**<Electronic Communication Detail>**		See common pattern: Electronic Communication Detail.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
INTERESTED PARTY > PARTICIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as an ORGANISATION.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
INTERESTED PARTY > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **ORGANISATION**	Any organisation of interest to, or involved in, the business of healthcare service provision.	1..1	n/a		Not mapped directly, encompassed implicitly in informationRecipient[interested_party_organisation]/intendedRecipient/associatedPerson.
INTERESTED PARTY > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Organisation Name**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..1	informationRecipient[interested_party_organisation]/intendedRecipient/receivedOrganization/asOrganizationPartOf/wholeOrganization/**name**		
INTERESTED PARTY > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Department/Unit**	The name by which a department or unit within a larger organisation is known or called.	0..1	informationRecipient[interested_party_organisation]/intendedRecipient/receivedOrganization/**name**		
INTERESTED PARTY > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Organisation Name Usage**	The classification that enables differentiation between recorded names for an organisation or service location.	0..1	informationRecipient[interested_party_organisation]/intendedRecipient/receivedOrganization/asOrganizationPartOf/wholeOrganization/name/**@use**	AS 4846-2006: Health Care Provider Organisation Name Usage	
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*)		
INTERESTED PARTY > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..0	See Known Issues.		Prohibition of ENTITLEMENT is not currently mapped.
CDA Header Data Elements			Context: /ClinicalDocument/		
INTERESTED PARTY > PARTICIPANT > **Qualifications**	A list of professional certifications, and certificates recognising having passed a course.	0..0	n/a		This logical data component has no mapping to CDA.

Example 6.10. INTERESTED PARTY as an ORGANISATION - XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 <!-- Begin CDA Header -->
 …

 <!-- Begin INTERESTED PARTY as an ORGANISATION -->
 <informationRecipient typeCode="TRC">
  <intendedRecipient classCode="ASSIGNED">

   <!-- id is used for system purposes such as matching -->
   <id root="7faa90cd-4540-44a5-8565-f06324662fdf"/>

   <!-- Role -->
   <ext:code code="42665001"
    codeSystem="2.16.840.1.113883.6.96"
    codeSystemName="SNOMED CT"
    displayName="Nursing Home"/>

   <!-- ADDRESS -->
   <addr use="WP">
    <streetAddressLine>66 Caregiver Street</streetAddressLine>
    <city>Healthville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568931</additionalLocator>
    <country>Australia</country>
   </addr>

   <!-- ELECTRONIC COMMUNICATION DETAIL -->
   <telecom use="WP" value="tel:0733333333"/>

   <receivedOrganization>

    <!-- Department/Unit -->
    <name>Nursing Home</name>

    <asOrganizationPartOf>
     <wholeOrganization>

      <!-- Organisation Name -->
      <name use="ORGB">Nursing Home Group</name>

      <!-- Entity Identifier -->
      <ext:asEntityIdentifier classCode="IDENT">
       <ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />
       <ext:assigningGeographicArea classCode="PLC">
        <ext:name>National Identifier</ext:name>
       </ext:assigningGeographicArea>
      </ext:asEntityIdentifier>
```

```xml
        </wholeOrganization>
       </asOrganizationPartOf>
      </receivedOrganization>

    </intendedRecipient>
   </informationRecipient>
   <!-- End INTERESTED PARTY as an ORGANISATION -->
   …

   <!-- End CDA Header -->

 </ClinicalDocument>
```

7 Content Data Specification - CDA Mapping

7.1 SERVICE REFERRAL

Identification

Name	SERVICE REFERRAL
Metadata Type	Structured Document
Identifier	SD-17034

Relationships

Children

Data Type	Name	Occurrence
	SERVICE REFERRAL DETAIL	1..1
	CURRENT SERVICES	0..1
	ADVERSE REACTIONS	0..1
	Medications (MEDICATION ORDERS)	0..1
	Past and Current Medical History (MEDICAL HISTORY)	0..1
	DIAGNOSTIC INVESTIGATIONS	0..1

CDA R-MIM Representation

Figure 7.1 SERVICE REFERRAL shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

SERVICE REFERRAL is composed of a ClinicalDocument class, which is the entry point into the CDA R-MIM. The ClinicalDocument is associated with the bodyChoice through the component relationship. The StructuredBody class represents a CDA document body that is comprised of one or more document sections.
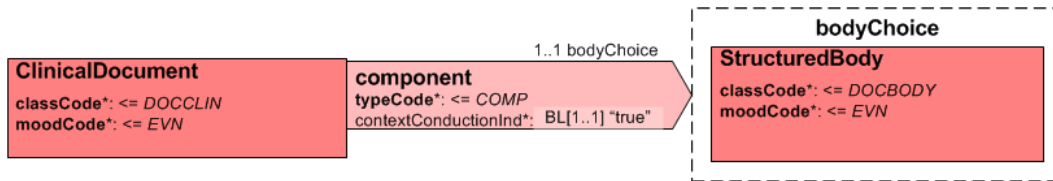
Figure 7.1. SERVICE REFERRAL

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /		
SERVICE REFERRAL	Referral of a subject of care from one healthcare or human services provider to another.	1..1	**ClinicalDocument**		
CDA Body Level 2 Data Elements					
SERVICE REFERRAL (Body)	See above.	1..1	ClinicalDocument/**component/structuredBody**		

Example 7.1. Service Referral Body XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
    …

    <!-- Begin CDA Body -->
    <component>
        <structuredBody>
            …

            <!-- Begin SERVICE REFERRAL DETAIL -->
            <component>
                <section>
                    …
                </component>
            </section>
            <!-- End SERVICE REFERRAL DETAIL -->

            <!-- Begin CURRENT SERVICES -->
            <component>
                <section>
                    …
                </component>
            </section>
            <!-- End CURRENT SERVICES -->

            <!-- Begin ADVERSE REACTIONS -->
            <component>
                <section>
                    …
                </component>
            </section>
            <!-- End ADVERSE REACTIONS -->

            <!-- Begin Medications (MEDICATION ORDERS) -->
            <component>
                <section>
                    …
                </component>
            </section>
            <!-- End Medications (MEDICATION ORDERS) -->

            <!-- Begin Past and Current Medical History (MEDICAL HISTORY) -->
            <component>
                <section>
                    …
                </component>
            </section>
            <!-- End Past and Current Medical History (MEDICAL HISTORY) -->

            <!-- Begin DIAGNOSTIC INVESTIGATIONS -->
```

```xml
            <component>
                <section>
                    …
                </component>
            </section>
            <!-- End DIAGNOSTIC INVESTIGATIONS -->

        </structuredBody>
    </component>
    <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.1 SERVICE REFERRAL DETAIL

Identification

Name	SERVICE REFERRAL DETAIL
Metadata Type	Section
Identifier	S-17032

Relationships

Parent

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

Children

Data Type	Name	Occurrence
	REQUESTED SERVICE	1..*
	Interpreter Required Alert (COMMUNICATION ALERT)	0..1
	Other Alerts (ALERT)	0..*
	RELATED DOCUMENT	0..*

CDA R-MIM Representation

Figure 7.2 SERVICE REFERRAL DETAIL shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The SERVICE REFERRAL DETAIL section is composed of a Section class related to its context ClinicalDocument.structuredBody by a component.
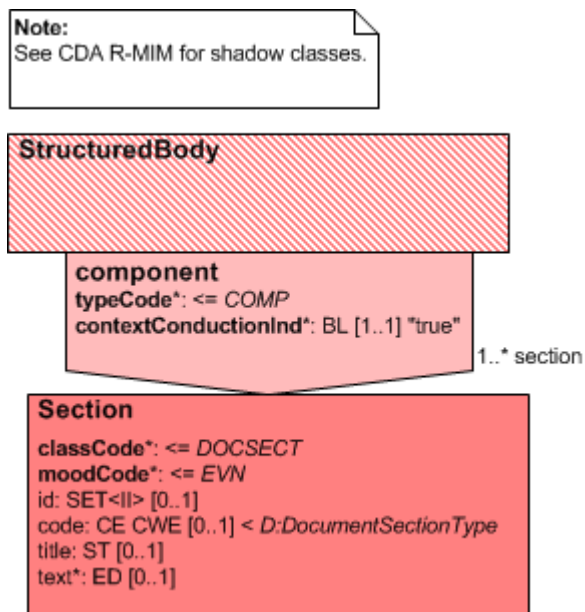
Figure 7.2. SERVICE REFERRAL DETAIL

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: /ClinicalDocument/component/structuredBody/		
SERVICE REFERRAL DETAIL	Information about the healthcare or human services requested for the subject of care.	1..1	component[ref_det]/**section**		
			component[ref_det]/section/**title="Referral Detail"**		
			component[ref_det]/section/**text**		Required CDA element. See Appendix A, *CDA Narratives*.
SERVICE REFERRAL DETAIL > **Service Referral Detail Instance Identifier**	Globally unique identifier for each instance of a Service Referral Detail section.	0..1	component[ref_det]/section/**id**		id/@nullFlavor **SHALL NOT** be present. See <id> for available attributes.
SERVICE REFERRAL DETAIL > **Section Type**	Type of section.	1..1	component[ref_det]/section/**code**		code/@nullFlavor **SHALL NOT** be present.
			component[ref_det]/section/code/**@code="101.17032"**		
			component[ref_det]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[ref_det]/section/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			component[ref_det]/section/code/**@displayName="Service Referral Detail"**		
SERVICE REFERRAL DETAIL > **REQUESTED SERVICE**	Details of the services requested for the subject of care.	1..*	See: REQUESTED SERVICE		
SERVICE REFERRAL DETAIL > **Interpreter Required Alert (COMMUNICATION ALERT)**	Information about language, or languages, spoken by the subject of care, when a need for an interpreter has been identified.	0..1	See: Interpreter Required Alert (COMMUNICATION ALERT)		
SERVICE REFERRAL DETAIL > **Other Alerts (ALERT)**	Information warning that special consideration or action is required when providing care to, or interacting with, the subject.	0..*	See: Other Alerts (ALERT)		
SERVICE REFERRAL DETAIL > **RELATED DOCUMENT**	Information about a document of interest.	0..*	See: RELATED DOCUMENT		This logical data component could not be mapped to CDA Header elements and is instead mapped as a child of SERVICE REFERRAL DETAIL.

Example 7.2. SERVICE REFERRAL DETAIL XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

<!-- Begin CDA Body -->
<component>
 <structuredBody>
  …

  <!-- Begin Administrative Observations -->
  <component>
   <section>
        <code code="102.16080" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Administrative Observations"/>
        <title>Administrative Observations</title>
        …

        <!-- Begin Interpreter Required Alert (COMMUNICATION ALERT) -->
        <entry>
            <observation>
            …
            </observation>
        </entry>
        <!-- End Interpreter Required Alert (COMMUNICATION ALERT) -->
        …

   </section>
  </component>
  <!-- End Administrative Observations -->

  <!-- Begin SERVICE REFERRAL DETAIL -->
  <component typeCode="COMP">
   <section classCode="DOCSECT" moodCode="EVN">
    <!-- Service Referral Detail Instance Identifier -->
    <id root="2474a204-aa83-450f-a916-ad248f7b9d11" />
    <!-- Section Type -->
    <code code="101.17032"
     codeSystem="1.2.36.1.2001.1001.101"
     codeSystemName="NCTIS Data Components"
     displayName="Service Referral Detail" />
    <title>Referral Detail</title>

    <!-- narrative block -->
    <text>
     <paragraph>URGENT</paragraph>
     <paragraph>Dear service provider, </paragraph>
     <paragraph>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 weight
     bear on it today. I suspect he has a fracture of his right tibia and fibula.</paragraph>
     <paragraph>X-ray of right ankle performed today</paragraph>
     <paragraph>This is urgent because the patient has had sudden onset of severe headache, with
```

```
    minor neurological impairment and is at risk of quick deterioration.</paragraph>
    <paragraph>Alerts:</paragraph>
    <paragraph>At risk of infection</paragraph>
    <paragraph>Warnings:</paragraph>
    <paragraph>ON WARFARIN</paragraph>
    <paragraph>Interpreter required - French</paragraph>
    <paragraph>Actions:</paragraph>
    <paragraph>MRI of cervical spine requested 10am 13/10/2010</paragraph>
   </text>

   <!-- Begin REQUESTED SERVICE -->
   <entry>
    <act>
     …
    </act>
   </entry>
   <!-- End REQUESTED SERVICE -->

   <!-- Begin Other Alerts (ALERT) -->
   <entry>
    <observation>
     …
    </observation>
   </entry>
   <!-- End Other Alerts (ALERT) -->

   <!-- Begin RELATED DOCUMENT -->
   <entry>
    <act>
     …
    </act>
   </entry>
   <!-- End RELATED DOCUMENT -->

   </section>
  </component>
  <!-- End SERVICE REFERRAL DETAIL -->
  …

 </structuredBody>
</component>
<!-- End CDA Body -->
</ClinicalDocument>
```

7.1.1.1 REQUESTED SERVICE

Identification

Name	REQUESTED SERVICE
Metadata Type	Data Group
Identifier	DG-20158

Relationships

Parent

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

Children

Data Type	Name	Occurrence
	SERVICE PROVIDER	0..1

CDA R-MIM Representation

Figure 7.3 REQUESTED SERVICE shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The REQUESTED SERVICE data group is represented by an Act class that is related to its containing Section class by an entry. The moodCode of that Act class represents the Service Booking Status, the code attribute represents Service Category, and the effectiveTime attribute represents Service Commencement Window. Request Urgency is represented by the priorityCode of that Act class.

There are five Act classes related to the containing Act (REQUESTED SERVICE) class by entryRelationships: Reason for Service, Request Urgency Notes, Subject of Care Instruction Description, Request Validity Period, and Requested Service DateTime. Reason for Service Description is represented by the text attribute of its containing Act (Reason for Service) class.

Service Description is represented by an Observation class that is related to its containing Act (REQUESTED SERVICE) class by an entry.

Figure 7.3. REQUESTED SERVICE

CDA Mapping

Note

NS = 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.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[ref_det]/section/		
REQUESTED SERVICE	Details of the services requested for the subject of care.	1..*	**entry[service]**		
			entry[service]/**act**		Each instance of this entry[service] **SHALL** contain at least one instance of : • Reason for Service (entryRelationship[rsn_svc]/act/code), or • Reason for Service Description (entryRelationship[rsn_svc]/act/text), or • Service Category (act/code), or • Service Description (act/entryRelationship[svc_desc]/observation/value). act/@nullFlavor **SHALL NOT** be present.
			entry[service]/act/**@classCode="ACT"**		

---

[1] http://www.hl7.org/oid/index.cfm?ref=footer

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
REQUESTED SERVICE > **Reason for Service**	Reason for the services being requested or provided.	0..1	entry[service]/act/**entryRelationship[rsn_svc]**		
			entry[service]/act/entryRelationship[rsn_svc]/**@typeCode="COMP"**		
			entry[service]/act/entryRelationship[rsn_svc]/**act**		
			entry[service]/act/entryRelationship[rsn_svc]/act/**@classCode="ACT"**		
			entry[service]/act/entryRelationship[rsn_svc]/act/**@moodCode="EVN"**		
			entry[service]/act/entryRelationship[rsn_svc]/act/**code**	NS	See <code> for available attributes. code/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".
REQUESTED SERVICE > **Reason for Service Description**	Narrative about the reason for the services being requested or provided.	0..1	entry[service]/act/entryRelationship[rsn_svc]/act/**text:ST**		text/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".
REQUESTED SERVICE > **Service Category**	Specialty of the services requested or provided.	0..1	entry[service]/act/**code**	NS	Service Category (entry[service]/act/code) **SHALL** be present. The *Detailed Clinical Model Identifier* (i.e. @code="102.20158"; @codeSystem="1.2.36.1.2001.1001.101"; @displayName="Requested Service") is provided as a default option; if an appropriate service category is available then that code shall be used instead. See <code> for available attributes. code/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
REQUESTED SERVICE > **Service Description**	Description of the services requested or provided.	0..1	entry[service]/act/**entryRelationship[svc_desc]**		
			entry[service]/act/entryRelationship[svc_desc]/**@typeCode="COMP"**		
			entry[service]/act/entryRelationship[svc_desc]/**observation**		
			entry[service]/act/entryRelationship[svc_desc]/observation/**@classCode="OBS"**		
			entry[service]/act/entryRelationship[svc_desc]/observation/**@moodCode="EVN"**		
			entry[service]/act/entryRelationship[svc_desc]/observation/**code**		
			entry[service]/act/entryRelationship[svc_desc]/observation/code/**@code="103.20117"**		
			entry[service]/act/entryRelationship[svc_desc]/observation/code/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			entry[service]/act/entryRelationship[svc_desc]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[service]/act/entryRelationship[svc_desc]/observation/code/**@displayName="Service Description"**		
			entry[service]/act/entryRelationship[svc_desc]/observation/**value:CD**	NS	See <code> for available attributes. value/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".
REQUESTED SERVICE > **Request Urgency**	Assessment of the criticality of a rapid response.	0..1	entry[service]/act/**priorityCode**		priorityCode/@nullFlavor **SHALL NOT** be present.
			entry[service]/act/priorityCode/**@code="01"**		
			entry[service]/act/priorityCode/**@codeSystem="1.2.36.1.2001.1001.101.104.16127"**		
			entry[service]/act/priorityCode/**@codeSystemName**	The value **SHOULD** be "NCTIS Request Urgency Values".	Optional CDA element.
			entry[service]/act/priorityCode/**@displayName="Urgent"**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
REQUESTED SERVICE > **Request Urgency Notes**	Narrative about the request urgency that is not captured in other fields.	0..1	entry[service]/act/**entryRelationship[rqst_ugcy_nt]**		
			entry[service]/act/entryRelationship[rqst_ugcy_nt]/**@typeCode="COMP"**		
			entry[service]/act/entryRelationship[rqst_ugcy_nt]/**act**		
			entry[service]/act/entryRelationship[rqst_ugcy_nt]/act/**@classCode="INFRM"**		
			entry[service]/act/entryRelationship[rqst_ugcy_nt]/act/**@moodCode="EVN"**		
			entry[service]/act/entryRelationship[rqst_ugcy_nt]/act/**code**		
			entry[service]/act/entryRelationship[rqst_ugcy_nt]/act/code/**@code="103.17022"**		
			entry[service]/act/entryRelationship[rqst_ugcy_nt]/act/code/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			entry[service]/act/entryRelationship[rqst_ugcy_nt]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[service]/act/entryRelationship[rqst_ugcy_nt]/act/code/**@displayName="Request Urgency Notes"**		
			entry[service]/act/entryRelationship[rqst_ugcy_nt]/act/**text:ST**		
REQUESTED SERVICE > **Service Commencement Window**	Period of time during which it would be ideal for the subject to be seen, in the opinion of the requester.	0..1	entry[service]/act/**effectiveTime:IVL_TS**		See <time> for available attributes.
REQUESTED SERVICE > **Service Booking Status**	Indication of the status of the requested or provided services.	1..1	entry[service]/act/**@moodCode**	Service Booking Status Value **SHALL** equal "APT", "ARQ", "EVN", or "RQO". See HL7 v3 CDA: Act.moodCode for definitions.	The value **SHOULD NOT** be "EVN" in this context.
REQUESTED SERVICE > **SERVICE PROVIDER**	Provider (individual or organisation) to whom the subject of care is being referred.	0..1	See: SERVICE PROVIDER		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
REQUESTED SERVICE > **Request Validity Period**	Period during which the request is valid.	0..1	entry[service]/act/**entryRelationship[rqst_val_prd]**		
			entry[service]/act/entryRelationship[rqst_val_prd]/**@typeCode="COMP"**		
			entry[service]/act/entryRelationship[rqst_val_prd]/**act**		
			entry[service]/act/entryRelationship[rqst_val_prd]/act/**@classCode="INFRM"**		
			entry[service]/act/entryRelationship[rqst_val_prd]/act/**@moodCode="EVN"**		
			entry[service]/act/entryRelationship[rqst_val_prd]/act/**code**		
			entry[service]/act/entryRelationship[rqst_val_prd]/act/code/**@code="103.16132"**		
			entry[service]/act/entryRelationship[rqst_val_prd]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[service]/act/entryRelationship[rqst_val_prd]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[service]/act/entryRelationship[rqst_val_prd]/act/code/**@displayName="Request Validity Period"**		
			entry[service]/act/entryRelationship[rqst_val_prd]/act/**effectiveTime**		See <time> for available attributes.
REQUESTED SERVICE > **Requested Service DateTime**	Period or date (and optionally time) of completion of the Requested Service action.	1..1	entry[service]/act/**entryRelationship[serv_date]**		
			entry[service]/act/entryRelationship[serv_date]/**@typeCode="COMP"**		
			entry[service]/act/entryRelationship[serv_date]/**act**		
			entry[service]/act/entryRelationship[serv_date]/act/**@classCode="ACT"**		
			entry[service]/act/entryRelationship[serv_date]/act/**@moodCode="EVN"**		
			entry[service]/act/entryRelationship[serv_date]/act/**code**		
			entry[service]/act/entryRelationship[serv_date]/act/code/**@code="103.16635"**		
			entry[service]/act/entryRelationship[serv_date]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[service]/act/entryRelationship[serv_date]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[service]/act/entryRelationship[serv_date]/act/code/**@displayName="Requested Service DateTime"**		
			entry[service]/act/entryRelationship[serv_date]/act/**effectiveTime**		See <time> for available attributes.
REQUESTED SERVICE > **Requested Service Instance Identifier**	Globally unique identifier for each instance of a Requested Service action.	0..1	entry[service]/act/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
REQUESTED SERVICE > **Detailed Clinical Model Identifier**	Globally unique identifier for this detailed clinical model.	1..1	n/a		Not mapped directly, encompassed implicitly in the combination of entry [service]/act/@moodCode and entry [service]/act/@code.

Example 7.3. REQUESTED SERVICE XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
    xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
    …
    >
    …

    <!-- Begin CDA Body -->
    <component>
        <structuredBody>
            …

            <!-- Begin SERVICE REFERRAL DETAIL -->
            <component>
                <section>
                    …

                    <!-- Begin REQUESTED SERVICE -->
                    <entry>
                        <!-- Service Booking Status uses act/@moodCode -->
                        <act classCode="ACT" moodCode="RQO">

                            <!-- Requested Service Instance Identifier -->
                            <id root="418add22-bc03-4373-9fc9-81c4d9454778" />

                            <!-- Service Category -->
                            <code code="102.20158" codeSystem="1.2.36.1.2001.1001.101"
                                codeSystemName="NCTIS Data Components"
                                displayName="Requested Service" />

                            <!-- Service Commencement Window -->
                            <effectiveTime>
                                <low value="201010131000+1000" />
                                <high value="201010131030+1000" />
                            </effectiveTime>

                            <!-- Request Urgency -->
                            <priorityCode code="01" codeSystem="1.2.36.1.2001.1001.101.104.16127"
                                codeSystemName="NCTIS Request Urgency Values"
                                displayName="Urgent" />

                            <!-- SERVICE PROVIDER -->
                            <performer typeCode="PRF">
                                …
                            </performer>

                            <!-- Begin Reason for Service -->
                            <entryRelationship typeCode="COMP">
                                <act classCode="ACT" moodCode="EVN">
                                    <code code="426721006"
                                        codeSystem="2.16.840.1.113883.6.96"
                                        codeSystemVersion="20160531"
                                        codeSystemName="SNOMED CT"
```

```xml
                        displayName="X-ray of right ankle" />

                    <!-- Reason for Service Description -->
                    <text xsi:type="ST">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 weight
                        bear on it today. I suspect he has a fracture of his right tibia and fibula.</text>
                </act>
            </entryRelationship>
            <!-- End Reason for Service -->

            <!-- Begin Service Description -->
            <entryRelationship typeCode="COMP">
                <observation classCode="OBS" moodCode="EVN">
                    <code code="103.20117" codeSystem="1.2.36.1.2001.1001.101"
                        codeSystemName="NCTIS Data Components"
                        displayName="Service Description" />
                    <value xsi:type="CD" code="241646009"
                        codeSystem="2.16.840.1.113883.6.96"
                        codeSystemName="SNOMED CT"
                        displayName="MRI of cervical spine"/>
                </observation>
            </entryRelationship>
            <!-- End Service Description -->

            <!-- Begin Request Urgency Notes -->
            <entryRelationship typeCode="COMP">
                <act classCode="INFRM" moodCode="EVN">
                    <code code="103.17022" codeSystem="1.2.36.1.2001.1001.101"
                        codeSystemName="NCTIS Data Components"
                        displayName="Request Urgency Notes" />
                    <text xsi:type="ST">This is urgent because the patient has had sudden onset of severe headache, with
                        minor neurological impairment and is at risk of quick deterioration.</text>
                </act>
            </entryRelationship>
            <!-- End Request Urgency Notes -->

            <!-- Begin Request Validity Period -->
            <entryRelationship typeCode="COMP">
                <act classCode="INFRM" moodCode="EVN">
                    <code code="103.16132" codeSystem="1.2.36.1.2001.1001.101"
                        codeSystemName="NCTIS Data Components"
                        displayName="Request Validity Period" />
                    <effectiveTime>
                        <low value="201010131000+1000" />
                        <high value="201010131030+1000" />
                    </effectiveTime>
                </act>
            </entryRelationship>
            <!-- End Request Validity Period -->

            <!-- Begin Requested Service DateTime -->
            <entryRelationship typeCode="COMP">
                <act classCode="ACT" moodCode="EVN">
                    <code code="103.16635" codeSystem="1.2.36.1.2001.1001.101"
                        codeSystemName="NCTIS Data Components"
                        displayName="Requested Service DateTime" />
                    <effectiveTime>
                        <high value="201010131000+1000" />
                    </effectiveTime>
                </act>
            </entryRelationship>
            <!-- End Requested Service DateTime -->
        </act>
```

```
                </entry>
                <!-- End REQUESTED SERVICE -->
                …

            </section>
        </component>
        <!-- End SERVICE REFERRAL DETAIL -->
        …

        </structuredBody>
    </component>
    <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.1.1.1 SERVICE PROVIDER

Identification

Name	SERVICE PROVIDER
Metadata Type	Data Group
Identifier	DG-10296

Relationships

Parent

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

Choices

Note

Mentioned below are the possible mutually exclusive 'SERVICE PROVIDER' instantiation choices.

Data Type	Name
	SERVICE PROVIDER as a PERSON
	SERVICE PROVIDER as an ORGANISATION

7.1.1.1.1.1 SERVICE PROVIDER as a PERSON

CDA R-MIM Representation

Figure 7.4 SERVICE PROVIDER as a PERSON shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The SERVICE PROVIDER data group instantiated as 'PERSON' is related to its containing Act class by the performer participation class. A performer is a person in the role of assignedEntity (AssignedEntity class). The entity playing the role is assignedPerson (Person class). The entity identifier of the participant is mapped to the EntityIdentifier class (Australian Digital Health Agency CDA Extension) which is associated to the assignedEntity. Employment detail is mapped to the Australian Digital Health Agency CDA Extension Employment.

Figure 7.4. SERVICE PROVIDER as a PERSON

shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

Figure 7.5. SERVICE PROVIDER as a PERSON - Entitlement

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[ref_det]/section/entry[service]/act/		
SERVICE PROVIDER	Provider (individual or organisation) to whom the subject of care is being referred.	0..1	**performer[srd_rs_service_provider_person]**		This **SHALL** be filled with the referee to whom the subject of care is being referred. SERVICE PROVIDER as a PERSON **SHALL** be recorded as SERVICE PROVIDER as a PERSON (performer) and as InformationRecipient.
SERVICE PROVIDER > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	0..0	performer[srd_rs_service_provider_person]**/time**		
SERVICE PROVIDER > **LOCATION OF PARTICIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIPATION is not currently mapped.
SERVICE PROVIDER > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	performer[srd_rs_service_provider_person]**/@typeCode="PRF"**	Participation Type **SHALL** have an implementation-specific value equivalent to "Referee".	
SERVICE PROVIDER > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	performer[srd_rs_service_provider_person]**/assignedEntity/code**	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 publicly available **MAY** be used.	See <code> for available attributes.
n/a	n/a	1..1	performer[srd_rs_service_provider_person]/assignedEntity/**id**		Required CDA element. See <id> for available attributes.
SERVICE PROVIDER > **PARTICIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	performer[srd_rs_service_provider_person]/assignedEntity/**assignedPerson**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SERVICE PROVIDER > PARTICIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..*	performer[srd_rs_service_provider_person]/assignedEntity/assignedPerson/**<Entity Identifier>**		See common pattern: Entity Identifier.
SERVICE PROVIDER > PARTICIPANT > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	performer[srd_rs_service_provider_person]/assignedEntity/**<Address>**	AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. Address Purpose (addr/@use) **SHALL** be set to Business (see AS 5017-2006: Health Care Client Identifier Address Purpose).	See common pattern: Address.
SERVICE PROVIDER > PARTICIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	performer[srd_rs_service_provider_person]/assignedEntity/**<Electronic Communication Detail>**	Electronic Communication Usage Code (telecom/@use) **SHALL** be set to Workplace (see HL7: TelecommunicationAddressUse).	See common pattern: Electronic Communication Detail.
SERVICE PROVIDER > PARTICIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **PERSON**	An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient).	1..1	n/a		Not mapped directly, encompassed implicitly in performer[srd_rs_service_provider_person]/assignedEntity/assignedPerson.
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **PERSON NAME**	The appellation by which an individual may be identified separately from any other within a social context.	1..*	performer[srd_rs_service_provider_person]/assignedEntity/assignedPerson/**<Person Name>**		See common pattern: Person Name.
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **Relationship to Subject of Care**	The relationship of a participant to a subject of care (patient).	0..0	performer[srd_rs_service_provider_person]/assignedEntity/assignedPerson/**ext:personalRelationship**		
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **EMPLOYMENT DETAIL**	A person's occupation and employer.	1..1	performer[srd_rs_service_provider_person]/assignedEntity/assignedPerson/**<Employment>**		See common pattern: Employment.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **DEMOGRAPHIC DATA**	Additional characteristics of a person that may be useful for identification or other clinical purposes.	0..0	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
			performer[srd_rs_service_provider_person]/assignedEntity/assignedPerson/**ext:administrativeGenderCode**		
			performer[srd_rs_service_provider_person]/assignedEntity/assignedPerson/**ext:birthTime**		
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See *4 Administrative Observations*)		
SERVICE PROVIDER > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..*	**ext:coverage2[srd_rs_service_provider_person]/@typeCode="COVBY"**		
			ext:coverage2[srd_rs_service_provider_person]/**ext:entitlement**		
			ext:coverage2[srd_rs_service_provider_person]/ext:entitlement/**@classCode="COV"**		
			ext:coverage2[srd_rs_service_provider_person]/ext:entitlement/**@moodCode="EVN"**		
			ext:coverage2[srd_rs_service_provider_person]/ext:entitlement/**ext:participant/@typeCode="HLD"**		
			ext:coverage2[srd_rs_service_provider_person]/ext:entitlement/ext:participant/**ext:participantRole/@classCode="ASSIGNED"**		
			ext:coverage2[srd_rs_service_provider_person]/ext:entitlement/ext:participant/ext:participantRole/**ext:id**		This **SHALL** hold the same value as performer[srd_rs_service_provider_person]/assignedEntity/id.
SERVICE PROVIDER > PARTICIPANT > ENTITLEMENT > **Entitlement Number**	A number or code issued for the purpose of identifying the entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	1..1	ext:coverage2[srd_rs_service_provider_person]/ext:entitlement/**ext:id**		See <id> for available attributes.
SERVICE PROVIDER > PARTICIPANT > ENTITLEMENT > **Entitlement Type**	The description of the scope of an entitlement.	1..1	ext:coverage2[srd_rs_service_provider_person]/ext:entitlement/**ext:code**	NCTIS: Admin Codes - Entitlement Type	
SERVICE PROVIDER > PARTICIPANT > ENTITLEMENT > **Entitlement Validity Duration**	The time interval for which an entitlement is valid.	0..1	ext:coverage2[srd_rs_service_provider_person]/ext:entitlement/**ext:effectiveTime**		See <time> for available attributes.
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[ref_det]/section/entry[service]/act/		
SERVICE PROVIDER > PARTICIPANT > **Qualifications**	A list of professional certifications, and certificates recognising having passed a course.	0..1	performer[srd_rs_service_provider_person]/assignedEntity/assignedPerson/**ext:asQualifications**		See Australian Digital Health Agency CDA extension: Qualifications.
			performer[srd_rs_service_provider_person]/assignedEntity/assignedPerson/ext:asQualifications/**@classCode="QUAL"**		
			performer[srd_rs_service_provider_person]/assignedEntity/assignedPerson/ext:asQualifications/**ext:code/originalText**	Qualifications is a text field, so the text list is entered in the originalText field of the code element.	

Example 7.4. SERVICE PROVIDER as a PERSON XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
<!-- Begin CDA Header -->
 …
<!-- Begin informationRecipient -->
<informationRecipient typeCode="PRCP">
 <intendedRecipient classCode="ASSIGNED">
  <!-- id is used for system purposes such as matching and SHALL hold the same value as the SERVICE PROVIDER as a PERSON -->
  <id root="142e4bc3-2b31-4dc8-90ac-32c3fbeb6ae0"/>
  …
 </intendedRecipient>
</informationRecipient>
<!-- End informationRecipient -->
 …

<!-- End CDA Header -->

<!-- Begin CDA Body -->
<component>
 <structuredBody>
  …

  <!-- Begin SERVICE REFERRAL DETAIL -->
  <component typeCode="COMP">
   <section classCode="DOCSECT" moodCode="EVN">
    …

    <!-- Begin REQUESTED SERVICE :: Cleaning Services -->
    <entry>
     <act classCode="ACT" moodCode="INT">
      …

      <!-- Begin SERVICE PROVIDER as a PERSON -->
      <performer typeCode="PRF">
       <assignedEntity classCode="ASSIGNED">
        <!-- id is used for system purposes such as matching -->
        <id root="142e4bc3-2b31-4dc8-90ac-32c3fbeb6ae0"/>

        <!-- Role -->
        <code code="811311" codeSystem="2.16.840.1.113883.13.62"
         codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
         displayName="Domestic Cleaner"/>

        <!-- ADDRESS -->
        <addr use="WP">
         <streetAddressLine>55 Provider Road</streetAddressLine>
         <city>Healthville</city>
         <state>QLD</state>
         <postalCode>5555</postalCode>
```

```xml
 <additionalLocator>32568931</additionalLocator>
 <country>Australia</country>
</addr>

<!-- ELECTRONIC COMMUNICATION DETAIL -->
<telecom use="WP" value="tel:0722222222"/>

<assignedPerson>
 <!-- PERSON NAME -->
 <name use="L">
  <prefix>Mr.</prefix>
  <family>Cleaner</family>
 </name>

 <!-- Entity Identifier -->
 <ext:asEntityIdentifier classCode="IDENT">
  <ext:id assigningAuthorityName="HPI-I"
   root="1.2.36.1.2001.1003.0.8003619900015717"/>
  <ext:assigningGeographicArea classCode="PLC">
   <ext:name>National Identifier</ext:name>
  </ext:assigningGeographicArea>
 </ext:asEntityIdentifier>

 <!-- Begin EMPLOYMENT DETAIL -->
 <ext:asEmployment classCode="EMP">

  <!-- Position In Organisation -->
  <ext:code>
   <originalText>Owner</originalText>
  </ext:code>

  <!-- Occupation -->
  <ext:jobCode code="811311"
   codeSystem="2.16.840.1.113883.13.62"
   codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
   displayName="Domestic Cleaner"/>

  <!-- Employment Type -->
  <ext:jobClassCode code="FT"
   codeSystem="2.16.840.1.113883.5.1059"
   codeSystemName="HL7:EmployeeJobClass"
   displayName="full-time"/>

  <!-- Begin EMPLOYER ORGANISATION -->
  <ext:employerOrganization>
   <!-- Department/Unit -->
   <name>Joyful Cleaning</name>

   <asOrganizationPartOf>
    <wholeOrganization>
     <!-- Organisation Name -->
     <name use="ORGB">Acme Cleaning Services</name>

     <!-- ELECTRONIC COMMUNICATION DETAIL -->
     <telecom value="tel:0499999999" use="WP"/>

     <!-- ADDRESS -->
     <addr use="WP">
      <streetAddressLine>1055 Provider Road</streetAddressLine>
      <city>Healthville</city>
      <state>QLD</state>
      <postalCode>5555</postalCode>
      <additionalLocator>32568931</additionalLocator>
```

```
            <country>Australia</country>
          </addr>

          <!-- Entity Identifier -->
          <ext:asEntityIdentifier classCode="IDENT">
           <ext:id assigningAuthorityName="ACN"
            root="1.2.36.87493897"/>
           <ext:code code="XX"
            codeSystem="2.16.840.1.113883.12.203"/>
          </ext:asEntityIdentifier>
         </wholeOrganization>
        </asOrganizationPartOf>
        <!-- End EMPLOYER ORGANISATION -->

       </ext:employerOrganization>
      </ext:asEmployment>
      <!-- End EMPLOYMENT DETAIL -->

      <!-- Qualifications -->
      <ext:asQualifications classCode="QUAL">
       <ext:code>
        <originalText>CPP30316 - Certificate III in Cleaning Operations</originalText>
       </ext:code>
      </ext:asQualifications>
     </assignedPerson>
    </assignedEntity>
   </performer>
   <!-- End SERVICE PROVIDER as a PERSON -->
    …

   </act>
  </entry>
  <!-- End REQUESTED SERVICE -->
   …

 </section>
 </component>
 <!-- End SERVICE REFERRAL DETAIL -->
  …

 </structuredBody>
 </component>
 <!-- End CDA Body -->
</ClinicalDocument>
```
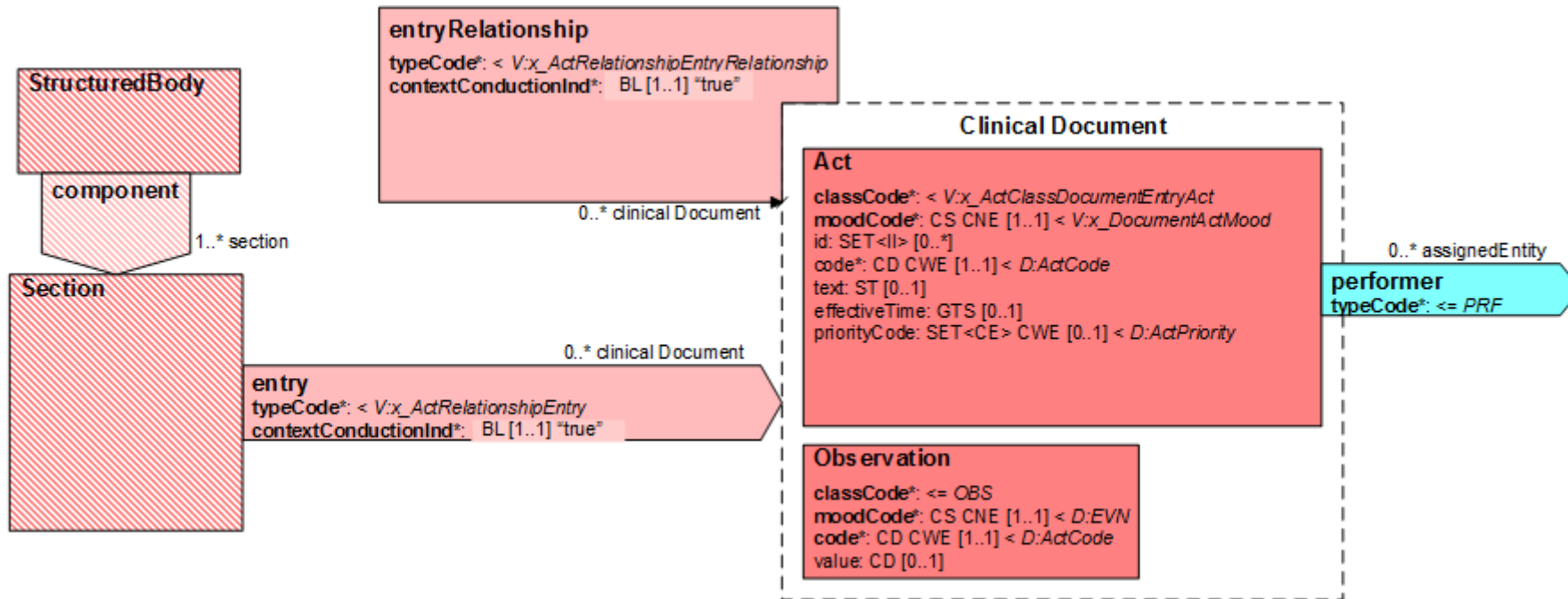
7.1.1.1.1.2 SERVICE PROVIDER as an ORGANISATION

CDA R-MIM Representation

Figure 7.6 SERVICE PROVIDER as an ORGANISATION shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The SERVICE PROVIDER data group instantiated as 'ORGANISATION' is related to its containing Act class by the participant Performer class. A participant is an organisation in the role of assignedEntity (AssignedEntity class). The entity playing the role is representedOrganization (Organization class). The department/unit name is mapped to representedOrganization.name and the organisation name is mapped to the wholeOrganization (Organization class) which represents a whole-part relationship using the OrganizationPartOf role. The organisation entity identifier is represented by the EntityIdentifier class (Australian Digital Health Agency CDA extension) which is associated to the wholeOrganization.

Figure 7.6. SERVICE PROVIDER as an ORGANISATION

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[ref_det]/section/entry[service]/act/		
SERVICE PROVIDER	Provider (individual or organisation) to whom the subject of care is being referred.	0..1	**performer[srd_rs_service_provider_organisation]**		This **SHALL** be filled with the referee to whom the subject of care is being referred. SERVICE PROVIDER as an ORGANISATION **SHALL** be recorded as SERVICE PROVIDER as an ORGANISATION (performer) and as InformationRecipient.
SERVICE PROVIDER > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	0..0	performer[srd_rs_service_provider_organisation]/**time**		See common pattern: time.
SERVICE PROVIDER > **LOCATION OF PARTI-CIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIPATION is not currently mapped.
SERVICE PROVIDER > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	performer[srd_rs_service_provider_organisation]/**@typeCode="PRF"**	Participation Type **SHALL** have an implementation-specific value equivalent to "Referee".	
SERVICE PROVIDER > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	performer[srd_rs_service_provider_organisation]/**assignedEntity/code**	Role **SHOULD** have a value representing the type of Facility e.g. Hospital, Clinic, Community Service Centre, Home care/housekeeping assistance.	See <code> for available attributes.
n/a	n/a	1..1	performer[srd_rs_service_provider_organisation]/assignedEntity/**id**		Required CDA element. See <id> for available attributes.
SERVICE PROVIDER > **PARTICIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	performer[srd_rs_service_provider_organisation]/assignedEntity/**representedOrganization**		
SERVICE PROVIDER > PARTICIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..*	performer[srd_rs_service_provider_organisation]/assignedEntity/representedOrganization/ asOrganizationPartOf/wholeOrganization/**<Entity Identifier>**		See common pattern: Entity Identifier.
SERVICE PROVIDER > PARTICIPANT > **AD-DRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	performer[srd_rs_service_provider_organisation]/assignedEntity/**<Address>**	AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.	See common pattern: Address.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SERVICE PROVIDER > PARTICIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	1..*	performer[srd_rs_service_provider_organisation]/assignedEntity/**<Electronic Communication Detail>**		See common pattern: Electronic Communication Detail.
SERVICE PROVIDER > PARTICIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a ORGANISATION.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **ORGANISATION**	Any organisation of interest to, or involved in, the business of healthcare service provision.	1..1	n/a		Not mapped directly, encompassed implicitly in performer[srd_rs_service_provider_organisation]/assignedEntity/representedOrganization.
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Organisation Name**	The name by which an organisation is known or called.	1..1	performer[srd_rs_service_provider_organisation]/assignedEntity/representedOrganization/**asOrganizationPartOf/wholeOrganization/name**		
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Department/Unit**	The name by which a department or unit within a larger organisation is known or called.	0..1	performer[srd_rs_service_provider_organisation]/assignedEntity/representedOrganization/**name**		
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Organisation Name Usage**	The classification that enables differentiation between recorded names for an organisation or service location.	0..1	performer[srd_rs_service_provider_organisation]/assignedEntity/representedOrganization/asOrganizationPartOf/wholeOrganization/name/**@use**	AS 4846-2006: Health Care Provider Organisation Name Usage	
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*)		
SERVICE PROVIDER > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..0	See Known Issues.		Prohibition of ENTITLEMENT is not currently mapped.
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[ref_det]/section/entry[service]/act/		
SERVICE PROVIDER > PARTICIPANT > **Qualifications**	A list of professional certifications, and certificates recognising having passed a course.	0..0	n/a		This logical data component has no mapping to CDA.

Example 7.5. SERVICE PROVIDER as an ORGANISATION XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
<!-- Begin CDA Header -->
 …
<!-- Begin informationRecipient -->
<informationRecipient typeCode="PRCP">
 <intendedRecipient classCode="ASSIGNED">
  <!-- id is used for system purposes such as matching and SHALL hold the same value as the SERVICE PROVIDER as an ORGANISATION -->
  <id root="142e4bc3-2b31-4dc8-90ac-32c3fbeb6ae0"/>
   …
 </intendedRecipient>
</informationRecipient>
<!-- End informationRecipient -->
 …

<!-- Begin CDA Body -->
<component>
 <structuredBody>
   …

  <!-- Begin SERVICE REFERRAL DETAIL -->
  <component typeCode="COMP">
   <section classCode="DOCSECT" moodCode="EVN">
    …

    <!-- Begin REQUESTED SERVICE :: Cleaning Services -->
    <entry>
     <act classCode="ACT" moodCode="INT">
      …

      <!-- Begin SERVICE PROVIDER as an ORGANISATION -->
      <performer typeCode="PRF">
       <assignedEntity classCode="ASSIGNED">
        <!-- id is used for system purposes such as matching -->
        <id root="142e4bc3-2b31-4dc8-90ac-32c3fbeb6ae0"/>

        <!-- Role -->
        <code>
         <originalText>Household Cleaning Services</originalText>
        </code>

        <!-- ADDRESS -->
        <addr use="WP">
         <streetAddressLine>55 Provider Road</streetAddressLine>
         <city>Healthville</city>
         <state>QLD</state>
         <postalCode>5555</postalCode>
         <additionalLocator>32568931</additionalLocator>
         <country>Australia</country>
```

```
        </addr>

        <!-- ELECTRONIC COMMUNICATION DETAIL -->
        <telecom use="WP" value="tel:0722222222"/>

        <representedOrganization>
         <!-- Department/Unit Name -->
         <name>Joyful Cleaning</name>

         <asOrganizationPartOf>
          <wholeOrganization>
           <!-- Organisation Name -->
           <name use="ORGB">Acme Cleaning Services</name>

           <!-- Entity Identifier -->
           <ext:asEntityIdentifier classCode="IDENT">
            <ext:id assigningAuthorityName="ACN"
             root="1.2.36.87493897"/>
            <ext:code code="XX"
             codeSystem="2.16.840.1.113883.12.203"/>
           </ext:asEntityIdentifier>

          </wholeOrganization>
         </asOrganizationPartOf>

        </representedOrganization>
       </assignedEntity>
      </performer>
      <!-- End SERVICE PROVIDER as an ORGANISATION -->
       …

     </act>
    </entry>
    <!-- End REQUESTED SERVICE -->
     …

   </section>
  </component>
  <!-- End SERVICE REFERRAL DETAIL -->
   …

 </structuredBody>
 </component>
 <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.1.2 RELATED DOCUMENT

Identification

Name	RELATED DOCUMENT
Metadata Type	Data Group
Identifier	DG-16971

Relationships

Parent

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

CDA R-MIM Representation

Figure 7.7 RELATED DOCUMENT shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The RELATED DOCUMENT data group is represented by an Act class that is related to its containing Section class by an entry. Document Target is represented by an externalDocument class related to its containing Act (RELATED DOCUMENT) class by a reference. That reference represents Link Nature. Document Identifier is represented by the id attribute of the externalDocument class. Document Type is represented by the code attribute of the externalDocument class. Document Title is represented by an Act class related to its containing Act (RELATED DOCUMENT) class by an entryRelationship.
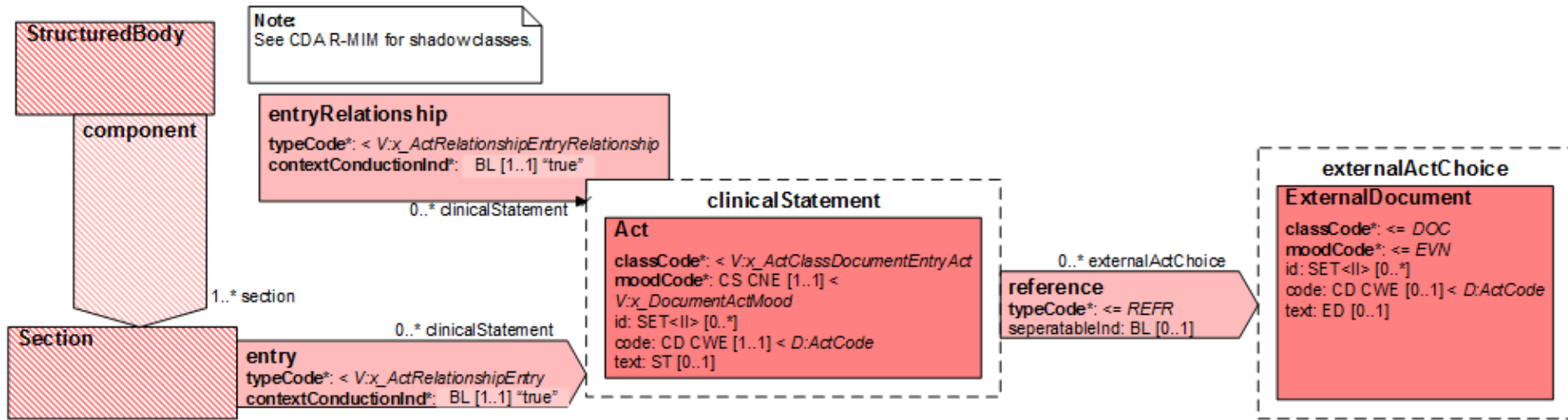
Figure 7.7. RELATED DOCUMENT

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[ref_det]/section/		
RELATED DOCUMENT	Information about a document of interest.	0..*	**entry[doc_detail]**		This logical data component could not be mapped to CDA Header elements and is instead mapped as a child of SERVICE REFERRAL DETAIL.
			entry[doc_detail]/**act**		
			entry[doc_detail]/act/**@classCode="ACT"**		
			entry[doc_detail]/act/**@moodCode="EVN"**		
			entry[doc_detail]/act/**id**		See <id> for available attributes. Optional CDA element.
			entry[doc_detail]/act/**code**		
			entry[doc_detail]/act/code/**@code="102.16971"**		
			entry[doc_detail]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[doc_detail]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[doc_detail]/act/code/**@displayName="Related Document"**		
RELATED DOCUMENT > **Link Nature**	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.	1..1	entry[doc_detail]/act/**reference[document]**		"LINK-E0" (is a related document-ation) is mapped to typeCode="REFR".
			entry[doc_detail]/act/reference[document]/**seperatableInd/@value="true"**		
			entry[doc_detail]/act/reference[document]/**@typeCode="REFR"**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
RELATED DOCUMENT > **Document Target**	'Linked to' or identified document.	1..1	entry[doc_detail]/act/reference[document]/**externalDocument**		externalDocument/@nullFlavor **SHALL NOT** be present.
			entry[doc_detail]/act/reference[document]/externalDocument/**@classCode="DOC"**		
			entry[doc_detail]/act/reference[document]/externalDocument/**@moodCode="EVN"**		
			entry[doc_detail]/act/reference[document]/externalDocument/**text:ED**		The link **SHALL** also be present in the corresponding CDA Narrative in a <linkHtml> element. text/@nullFlavor **SHALL NOT** be present.
			entry[doc_detail]/act/reference[document]/externalDocument/text/**@mediaType**		
			entry[doc_detail]/act/reference[document]/externalDocument/text/**@integrityCheck**		
			entry[doc_detail]/act/reference[document]/externalDocument/text/**reference**		reference/@nullFlavor **SHALL NOT** be present.
			entry[doc_detail]/act/reference[document]/externalDocument/text/reference/**@value**		
RELATED DOCUMENT > **DOCUMENT DETAILS**	Information about a document of interest.	1..1	n/a		This logical data component has no mapping to CDA.
RELATED DOCUMENT > DOCUMENT DETAILS > **Document Type**	Type of the document of interest.	0..1	entry[doc_detail]/act/reference[document]/externalDocument/**code**		code/@nullFlavor **SHALL NOT** be present. See <code> for available attributes.
RELATED DOCUMENT > DOCUMENT DETAILS > **Document Title**	Title of the document of interest.	1..1	entry[doc_detail]/act/**entryRelationship[title]/@typeCode="COMP"**		
			entry[doc_detail]/act/entryRelationship[title]/**act**		
			entry[doc_detail]/act/entryRelationship[title]/act/**@classCode="ACT"**		
			entry[doc_detail]/act/entryRelationship[title]/act/**@moodCode="EVN"**		
			entry[doc_detail]/act/entryRelationship[title]/act/**code**		
			entry[doc_detail]/act/entryRelationship[title]/act/code/**@code="103.16966"**		
			entry[doc_detail]/act/entryRelationship[title]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[doc_detail]/act/entryRelationship[title]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[doc_detail]/act/entryRelationship[title]/act/code/**@displayName="Document Title"**		
			entry[doc_detail]/act/entryRelationship[title]/act/**text:ST**		text/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".

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SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
RELATED DOCUMENT > DOCUMENT DETAILS > **Document Identifier**	Unique identifier of the document of interest.	0..1	entry[doc_detail]/act/reference[document]/externalDocument/**id**		The unique identifier of the target document. See <id> for available attributes.

Example 7.6. RELATED DOCUMENT XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
    xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
    …
    >
    …

    <!-- Begin CDA Body -->
    <component>
        <structuredBody>
            …

            <!-- Begin SERVICE REFERRAL DETAIL -->
            <component typeCode="COMP">
                <section classCode="DOCSECT" moodCode="EVN">
                    …

                    <!-- narrative block -->
                    <text>
                        <paragraph>
                            <linkHtml href="attachment.pdf">Substitute Decision Maker</linkHtml>
                        </paragraph>
                        …
                    </text>

                    <!-- Begin RELATED DOCUMENT -->
                    <entry typeCode="COMP">
                        <act classCode="ACT" moodCode="EVN">
                            <!-- Technical Identifier to uniquely identify this act -->
                            <id root="9ec7bc6c-6dbd-4f13-9d4f-ee9be7d87e8b" />
                            <code code="102.16971" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Related Document" />

                            <!-- Begin Document Title -->
                            <entryRelationship typeCode="COMP">
                                <act classCode="ACT" moodCode="EVN">
                                    <code code="103.16966"
                                        codeSystem="1.2.36.1.2001.1001.101"
                                        codeSystemName="NCTIS Data Components"
                                        displayName="Document Title"/>
                                    <text xsi:type="ST">Substitute Decision Maker</text>
                                </act>
                            </entryRelationship>
                            <!-- End Document Title -->

                            <!--  Begin Link Nature / Link Role -->
                            <reference typeCode="REFR">
                                <seperatableInd value="true" />
                                <!--  End Link Nature / Link Role -->

                                <externalDocument classCode="DOC" moodCode="EVN">
                                    <!-- Document Identifier (optional) -->
                                    <id root="e225a4ac-6fd1-4a00-9893-38264f165ebb" />
```

```xml
                    <!-- Document Type -->
                    <code code="100.16998" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Advance Care Planning Document" />

                    <!-- Document Target as encapsulated data -->
                    <text integrityCheck="IiZNlyLY4gyewfICeWhFe2NcDDw=" mediaType="application/pdf">
                        <reference value="attachment.pdf" />
                    </text>

                </externalDocument>
            </reference>

        </act>
    </entry>
    <!-- End RELATED DOCUMENT -->

    </section>
</component>
<!-- End SERVICE REFERRAL DETAIL -->
…

    </structuredBody>
</component>
<!-- End CDA Body -->

</ClinicalDocument>
```

7.1.1.3 Interpreter Required Alert (COMMUNICATION ALERT)

Identification

Name	Interpreter Required Alert (COMMUNICATION ALERT)
Metadata Type	Data Group
Identifier	DG-17026

Relationships

Parent

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

CDA R-MIM Representation

Figure 7.8 Interpreter Required Alert (COMMUNICATION ALERT) - Body Data Elements shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The Interpreter Required Alert (COMMUNICATION ALERT) maps to an Observation in the Administrative Observations section (see 4 Administrative Observations).

Figure 7.8. Interpreter Required Alert (COMMUNICATION ALERT) - Body Data Elements

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See *4 Administrative Observations*)		
Interpreter Required Alert (COMMUNICATION ALERT)	Information about language, or languages, spoken by the subject of care, when a need for an interpreter has been identified.	0..1	**entry[interpreter_required_alert]**		
			entry[interpreter_required_alert]/**observation**		
			entry[interpreter_required_alert]/observation/**@classCode="OBS"**		
			entry[interpreter_required_alert]/observation/**@moodCode="EVN"**		
Interpreter Required Alert (COMMUNICATION ALERT) > **Alert Description**	Details of the alert.	1..1	entry[interpreter_required_alert]/observation/**code**		See <code> for available attributes. code/@nullFlavor **SHALL NOT** be present.
			entry[interpreter_required_alert]/observation/code/**@code="102.17040"**		
			entry[interpreter_required_alert]/observation/code/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			entry[interpreter_required_alert]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[interpreter_required_alert]/observation/code/**@displayName="Interpreter Required"**		
Interpreter Required Alert (COMMUNICATION ALERT) > **Preferred Language**	Language that the subject prefers to use for communication.	1..*	entry[interpreter_required_alert]/observation/**value:CS**		The value attribute **SHOULD** be specified using the format defined in RFC 3066[5] value/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".
Interpreter Required Alert (COMMUNICATION ALERT) > **Communication Alert Instance Identifier**	Globally unique identifier for each instance of a Communication Alert administrative entry.	0..1	entry[interpreter_required_alert]/observation/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
Interpreter Required Alert (COMMUNICATION ALERT) > **Detailed Clinical Model Identifier**	Globally unique identifier for this detailed clinical model.	1..1	n/a		Not mapped directly, encompassed implicitly in Alert Description (entry[interpreter_required_alert]/observation/code).

---

[5] https://www.ietf.org/rfc/rfc3066.txt

Example 7.7. Interpreter Required Alert (COMMUNICATION ALERT) - XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3" xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin Administrative Observations -->
   <component>
    <section>
     <code code="102.16080" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Administrative Observations"/>
     <title>Administrative Observations</title>
     …

     <!-- Begin Interpreter Required Alert (COMMUNICATION ALERT) -->
     <entry>
      <observation classCode="OBS" moodCode="EVN">
       <!-- Communication Alert Instance Identifier -->
       <id root="5465fda4-bc11-4380-91f5-ea5da1efec28" />

       <!-- Alert Description -->
       <code code="102.17040"
        codeSystem="1.2.36.1.2001.1001.101"
        codeSystemName="NCTIS Data Components"
        displayName="Interpreter Required" />

       <!-- Preferred Language -->
       <value xsi:type="CS" code="fr-CN"/>

      </observation>
     </entry>
     <!-- End Interpreter Required Alert (COMMUNICATION ALERT) -->
     …

    </section>
   </component>
   <!-- End Administrative Observations -->
   …

  </structuredBody>
 </component>
 <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.1.4 Other Alerts (ALERT)

Identification

Name	Other Alerts (ALERT)
Metadata Type	Data Group
Identifier	DG-15518

Relationships

Parent

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

CDA R-MIM Representation

Figure 7.9 Other Alerts (ALERT) shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The Other Alerts (ALERT) data group is represented by an Observation class that is related to its containing Section class by an entry. The code attribute of that Observation class represents Alert Type, and the value attribute represents Alert Description.
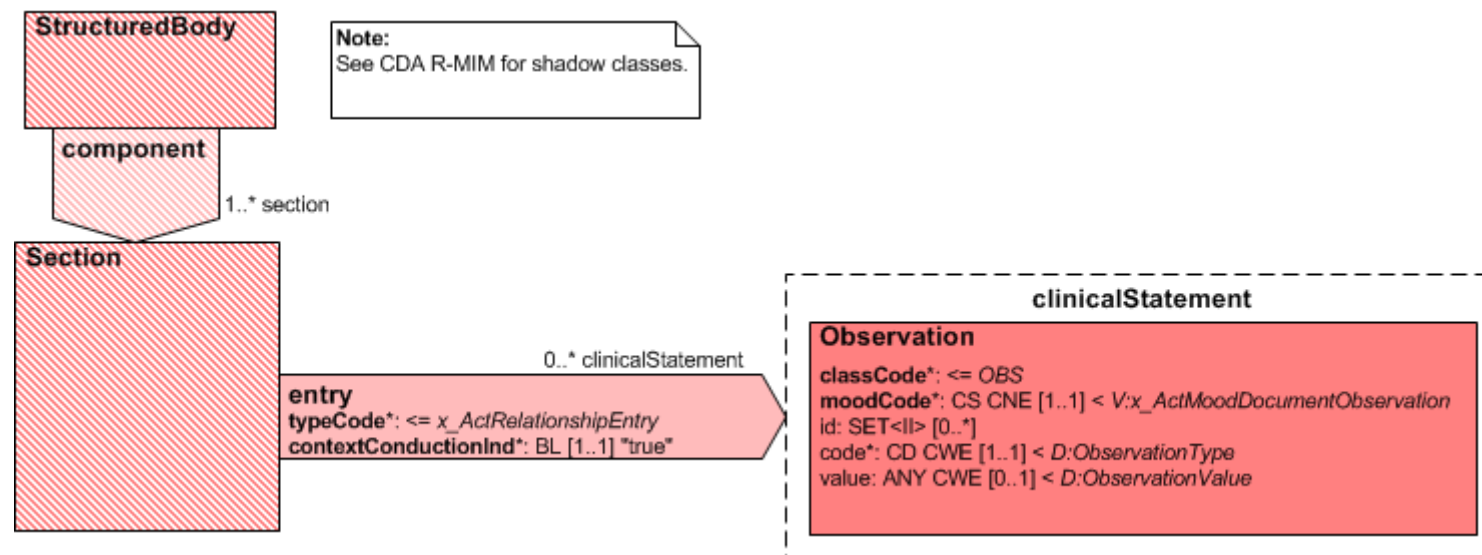
Figure 7.9. Other Alerts (ALERT)

CDA Mapping

Note

NS = 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.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[ref_det]/section/		
Other Alerts (ALERT)	Information warning that special consideration or action is required when providing care to, or interacting with, the subject.	0..*	**entry[alrt]**		
			entry[alrt]/**observation**		
			entry[alrt]/observation/**@classCode="ALRT"**		
			entry[alrt]/observation/**@moodCode="EVN"**		
Other Alerts (ALERT) > **Alert Type**	Category of alert.	1..1	entry[alrt]/observation/**code**	NS	See <code> for available attributes. code/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".
Other Alerts (ALERT) > **Alert Description**	Details of the alert.	1..1	entry[alrt]/observation/**value:CD**	NS	See <code> for available attributes. value/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".
Other Alerts (ALERT) > **Alert Instance Identifier**	Globally unique identifier for each instance of an Alert evaluation.	0..1	entry[alrt]/observation/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
Other Alerts (ALERT) > **Detailed Clinical Model Identifier**	Globally unique identifier for this detailed clinical model.	1..1	n/a		Not mapped directly, encompassed implicitly by CDA in @classCode="ALRT"

---

[6] http://www.hl7.org/oid/index.cfm?ref=footer

Example 7.8. Other Alerts (ALERT) XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema, the specification or schema will take precedence. -->

<ClinicalDocument
    xmlns="urn:hl7-org:v3"
    xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
    …
    >
    …

    <!-- Begin CDA Body -->
    <component>
        <structuredBody>
            …
            <!-- Begin SERVICE REFERRAL DETAIL -->
            <component>
                <section>
                    …

                    <!-- Begin Other Alerts (ALERT) -->
                    <entry>
                        <!-- Detailed Clinical Model Identifier uses @classCode -->
                        <observation classCode="ALRT" moodCode="EVN">

                            <!-- Alert Instance Identifier -->
                            <id root="9de43aca-91aa-4ba8-8ed4-ed5d2be5d88f"/>

                            <!-- Alert Type -->
                            <code code="736911000168103"
                                codeSystem="2.16.840.1.113883.6.96"
                                codeSystemName="SNOMED CT"
                                codeSystemVersion="http://snomed.info/sct/32506021000036107/version/20160229"
                                displayName="Clinical alert"/>

                            <!-- Alert Description -->
                            <value code="78648007"
                                codeSystem="2.16.840.1.113883.6.96"
                                codeSystemName="SNOMED CT"
                                codeSystemVersion="http://snomed.info/sct/32506021000036107/version/20160229"
                                displayName="At risk for infection"
                                xsi:type="CD"/>

                        </observation>
                    </entry>
                    <!-- End Other Alerts (ALERT) -->

                    <!-- Begin Other Alerts (ALERT) -->
                    <entry>
                     <!-- Detailed Clinical Model Identifier uses @classCode -->
                     <observation classCode="ALRT" moodCode="EVN">
                      <id root="5e7cd8cb-4659-4b80-86ec-cb35ca1a5e44"/>

                      <!-- Alert Type - "drug" indicates that this is a flag related to the patient's medications -->
                      <code code="drug" codeSystem="2.16.840.1.113883.4.642.1.113"
                        codeSystemName="Flag Category" displayName="Drug"/>
```

```xml
                    <!-- Alert Description -->
                    <value xsi:type="CD">
                     <originalText>ON WARFARIN</originalText>
                    </value>

                   </observation>
                  </entry>
                  <!-- End Other Alerts (ALERT) -->
                  …

               </section>
              </component>
              <!-- End SERVICE REFERRAL DETAIL -->
              …

           </structuredBody>
          </component>
          <!-- End CDA Body -->
         </ClinicalDocument>
```

7.1.2 CURRENT SERVICES

Identification

Name	CURRENT SERVICES
Metadata Type	Section
Identifier	S-21021

Relationships

Parent

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

Children

Data Type	Name	Occurrence
	Current Service (REQUESTED SERVICE)	1..*

CDA R-MIM Representation

Figure 7.10 CURRENT SERVICES shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The CURRENT SERVICES section is composed of a Section class related to its context ClinicalDocument.structuredBody by a component.

Figure 7.10. CURRENT SERVICES

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: /ClinicalDocument/component/structuredBody/		
CURRENT SERVICES	Information about any health and community services that are currently being delivered to the subject of care, that are relevant to the referral.	0..1	component[crnt_servs]/**section**		
			component[crnt_servs]/section/**title="Current Services"**		
			component[crnt_servs]/section/**text**		Required CDA element. See Appendix A, *CDA Narratives*.
CURRENT SERVICES > **Current Services Instance Identifier**	Globally unique identifier for each instance of a Current Services section.	0..1	component[crnt_servs]/section/**id**		id/@nullFlavor **SHALL NOT** be present. See <id> for available attributes.
CURRENT SERVICES > **Section Type**	Type of section.	1..1	component[crnt_servs]/section/**code**		code/@nullFlavor **SHALL NOT** be present.
			component[crnt_servs]/section/code/**@code="101.21021"**		
			component[crnt_servs]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[crnt_servs]/section/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			component[crnt_servs]/section/code/**@displayName="Current Services"**		
CURRENT SERVICES > **Current Service (REQUESTED SERVICE)**	Details of the services provided to the subject of care.	1..*	See: Current Service (REQUESTED SERVICE)		

Example 7.9. CURRENT SERVICES XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin CURRENT SERVICES -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     <!-- Current Services Instance Identifier -->
     <id root="ca4cf757-0a18-4b94-8f3f-055be7bb651e" />
     <!-- Section Type -->
     <code code="101.21021"
      codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components"
      displayName="Current Services" />
     <title>Current Services</title>

     <!-- narrative block -->
     <text>
      <paragraph>MRI of cervical spine performed 13 Oct 2010.</paragraph>
     </text>

     <!-- Begin Current Service (REQUESTED SERVICE) -->
     <entry>
      <act>
       …
      </act>
     </entry>
     <!-- End Current Service (REQUESTED SERVICE) -->

    </section>
   </component>
   <!-- End CURRENT SERVICES -->
   …

  </structuredBody>
 </component>
 <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.2.1 Current Service (REQUESTED SERVICE)

Identification

Name	Current Service (REQUESTED SERVICE)
Metadata Type	Data Group
Identifier	DG-20158

Relationships

Parent

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

Children

Data Type	Name	Occurrence
	SERVICE PROVIDER	1..1

CDA R-MIM Representation

Figure 7.11 Current Service (REQUESTED SERVICE) shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The Current Service (REQUESTED SERVICE) data group is represented by an Act class that is related to its containing Section class by an entry. The moodCode of that Act class represents the Service Booking Status, and the code attribute represents Service Category.

There are two Act classes related to the containing Act (REQUESTED SERVICE) class by entryRelationships: Service Comment, and Requested Service DateTime.

Service Description is represented by an Observation class that is related to its containing Act (REQUESTED SERVICE) class by an entry.

Figure 7.11. Current Service (REQUESTED SERVICE)

Approved for external use
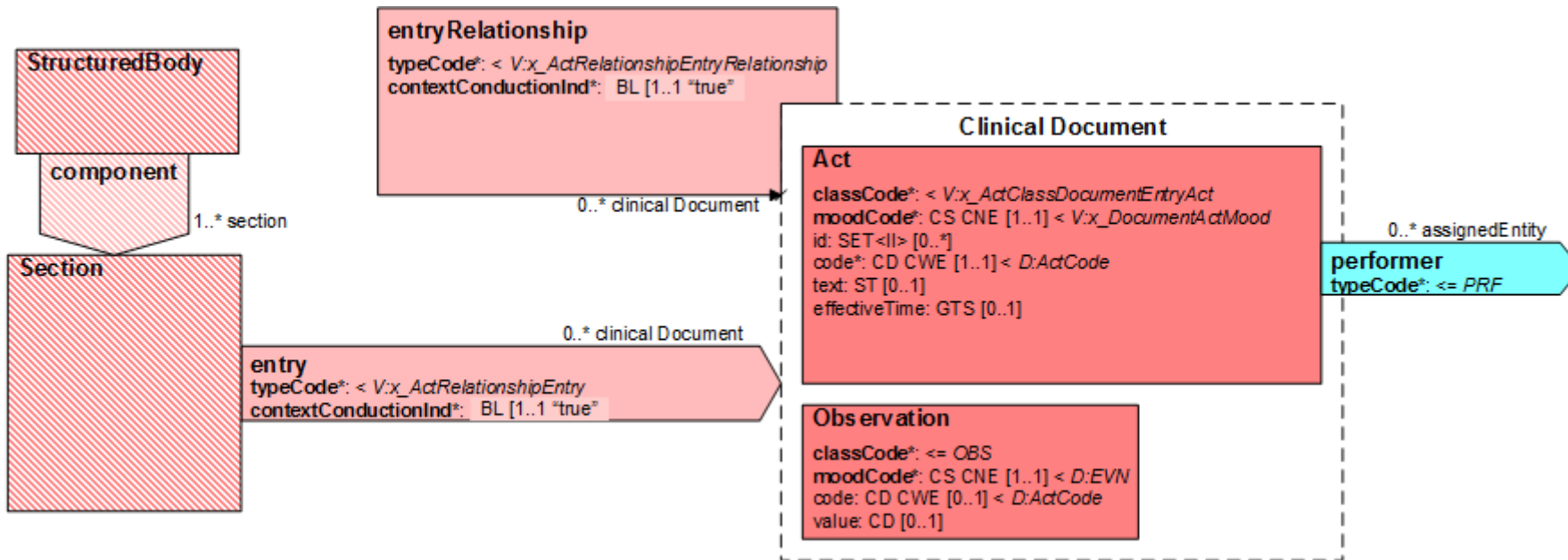
CDA Mapping

Note

NS = In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the <u>HL7 code set registration procedure</u>[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.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[crnt_servs]/section/		
Current Service (REQUESTED SERVICE)	Details of the services provided to the subject of care.	1..*	**entry[current_service]**		
			entry[current_service]/**act**		Each instance of this entry[current_service] **SHALL** contain at least one instance of : • Service Category (act/code), or • Service Description (act/entryRelationship[svc_desc]/observation/value).
			entry[current_service]/act/**@classCode="ACT"**		
Current Service (REQUESTED SERVICE) > **Service Category**	Specialty of the services requested or provided.	0..1	entry[current_service]/act/**code**	NS	Service Category (entry[current_service]/act/code) **SHALL** be present. The *Detailed Clinical Model Identifier* (i.e. @code="102.20158"; @codeSystem="1.2.36.1.2001.1001.101"; @displayName="Requested Service") is provided as a default option; if an appropriate service category is available then that code shall be used instead. See <code> for available attributes. code/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".

---

[7] http://www.hl7.org/oid/index.cfm?ref=footer

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Current Service (REQUESTED SERVICE) > **Service Description**	Description of the services requested or provided.	0..1	entry[current_service]/act/**entryRelationship[svc_desc]**		
			entry[current_service]/act/entryRelationship[svc_desc]/**@typeCode="COMP"**		
			entry[current_service]/act/entryRelationship[svc_desc]/**observation**		
			entry[current_service]/act/entryRelationship[svc_desc]/observation/**@classCode="OBS"**		
			entry[current_service]/act/entryRelationship[svc_desc]/observation/**@moodCode="EVN"**		
			entry[current_service]/act/entryRelationship[svc_desc]/observation/**code**		
			entry[current_service]/act/entryRelationship[svc_desc]/observation/code/**@code="103.20117"**		
			entry[current_service]/act/entryRelationship[svc_desc]/observation/code/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			entry[current_service]/act/entryRelationship[svc_desc]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[current_service]/act/entryRelationship[svc_desc]/observation/code/**@displayName= "Service Description"**		
			entry[current_service]/act/entryRelationship[svc_desc]/observation/**value:CD**	NS	See <code> for available attributes. value/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".
Current Service (REQUESTED SERVICE) > **Service Booking Status**	Indication of the status of the requested or provided services.	1..1	entry[current_service]/act/**@moodCode="EVN"**	HL7 v3 CDA: Act.moodCode	
Current Service (REQUESTED SERVICE) > **Service Comment**	Additional narrative about the services that is not captured in other fields.	0..1	entry[current_service]/act/**entryRelationship[svc_cmnt]**		
			entry[current_service]/act/entryRelationship[svc_cmnt]/**@typeCode="COMP"**		
			entry[current_service]/act/entryRelationship[svc_cmnt]/**act**		
			entry[current_service]/act/entryRelationship[svc_cmnt]/act/**@classCode="INFRM"**		
			entry[current_service]/act/entryRelationship[svc_cmnt]/act/**@moodCode="EVN"**		
			entry[current_service]/act/entryRelationship[svc_cmnt]/act/**code**		
			entry[current_service]/act/entryRelationship[svc_cmnt]/act/code/**@code="103.17035"**		
			entry[current_service]/act/entryRelationship[svc_cmnt]/act/code/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			entry[current_service]/act/entryRelationship[svc_cmnt]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[current_service]/act/entryRelationship[svc_cmnt]/act/code/**@displayName="Service Comment"**		
			entry[current_service]/act/entryRelationship[svc_cmnt]/act/**text:ST**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Current Service (REQUESTED SERVICE) > **SERVICE PROVIDER**	Provider of the service.	1..1	See: SERVICE PROVIDER		
Current Service (REQUESTED SERVICE) > **Requested Service DateTime**	Period or date (and optionally time) of completion of the Requested Service action.	1..1	entry[current_service]/act/**entryRelationship[serv_date]**		
			entry[current_service]/act/entryRelationship[serv_date]/**@typeCode="COMP"**		
			entry[current_service]/act/entryRelationship[serv_date]/**act**		
			entry[current_service]/act/entryRelationship[serv_date]/act/**@classCode="ACT"**		
			entry[current_service]/act/entryRelationship[serv_date]/act/**@moodCode="EVN"**		
			entry[current_service]/act/entryRelationship[serv_date]/act/**code**		
			entry[current_service]/act/entryRelationship[serv_date]/act/code/**@code="103.16635"**		
			entry[current_service]/act/entryRelationship[serv_date]/act/code/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			entry[current_service]/act/entryRelationship[serv_date]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[current_service]/act/entryRelationship[serv_date]/act/code/**@displayName="Requested Service DateTime"**		
			entry[current_service]/act/entryRelationship[serv_date]/act/**effectiveTime**		See <time> for available attributes.
Current Service (REQUESTED SERVICE) > **Requested Service Instance Identifier**	Globally unique identifier for each instance of a Requested Service action.	0..1	entry[current_service]/act/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
Current Service (REQUESTED SERVICE) > **Detailed Clinical Model Identifier**	Globally unique identifier for this detailed clinical model.	1..1	n/a		Not mapped directly, encompassed implicitly in the combination of entry [current_service]/act/@moodCode and entry [current_service]/act/@code.

Example 7.10. Current Service (REQUESTED SERVICE) XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
    xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
        …
    >
        …

    <!-- Begin CDA Body -->
    <component>
        <structuredBody>
            …

        <!-- Begin CURRENT SERVICES -->
        <component>
            <section classCode="DOCSECT" moodCode="EVN">
                …

            <!-- Begin Current Service (REQUESTED SERVICE) -->
            <entry>
                <!-- Service Booking Status uses act/@moodCode -->
                <act classCode="ACT" moodCode="EVN">

                    <!-- Current Service Instance Identifier -->
                    <id root="00a870e2-bc6f-4e4d-8a75-6acc369d3658" />

                    <!-- Service Category -->
                    <code code="102.20158" codeSystem="1.2.36.1.2001.1001.101"
                     codeSystemName="NCTIS Data Components"
                     displayName="Requested Service" />

                    <!-- SERVICE PROVIDER -->
                    <performer typeCode="PRF">
                     …
                    </performer>

                    <!-- Begin Service Description -->
                    <entryRelationship typeCode="COMP">
                        <observation classCode="OBS" moodCode="EVN">
                            <code code="103.20117" codeSystem="1.2.36.1.2001.1001.101"
                                codeSystemName="NCTIS Data Components"
                                displayName="Service Description" />
                            <value xsi:type="CD" code="241646009" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="MRI of cervical spine"/>
                        </observation>
                    </entryRelationship>
                    <!-- End Service Description -->

                    <!-- Begin Service Comment -->
                    <entryRelationship typeCode="COMP">
                        <act classCode="INFRM" moodCode="EVN">
                            <code code="103.17035" codeSystem="1.2.36.1.2001.1001.101"
                                codeSystemName="NCTIS Data Components"
                                displayName="Service Comment" />
                            <text>Text goes here.</text>
```

```xml
                    </act>
                </entryRelationship>
                <!-- End Service Comment -->

                <!-- Begin Requested Service DateTime -->
                <entryRelationship typeCode="COMP">
                    <act classCode="ACT" moodCode="EVN">
                        <code code="103.16635" codeSystem="1.2.36.1.2001.1001.101"
                            codeSystemName="NCTIS Data Components"
                            displayName="Requested Service DateTime" />
                        <effectiveTime value="201010131000+1000" />
                    </act>
                </entryRelationship>
                <!-- End Requested Service DateTime -->


            </act>
        </entry>
        <!-- End Current Service (REQUESTED SERVICE) -->
        …

    </section>
  </component>
  <!-- End CURRENT SERVICES -->
    …

  </structuredBody>
 </component>
 <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.2.1.1 SERVICE PROVIDER

Identification

Name	SERVICE PROVIDER
Metadata Type	Data Group
Identifier	DG-10296

Relationships

Parent

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

CDA R-MIM Representation

Figure 7.12 SERVICE PROVIDER shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The SERVICE PROVIDER data group is related to its containing Act class by the participant Performer class. A participant is an organisation in the role of assignedEntity (AssignedEntity class). The entity playing the role is representedOrganization (Organization class). The department/unit name is mapped to representedOrganization.name and the organisation name is mapped to the wholeOrganization (Organization class) which represents a whole-part relationship using the OrganizationPartOf role. The organisation entity identifier is represented by the EntityIdentifier class (Australian Digital Health Agency CDA extension) which is associated to the wholeOrganization.
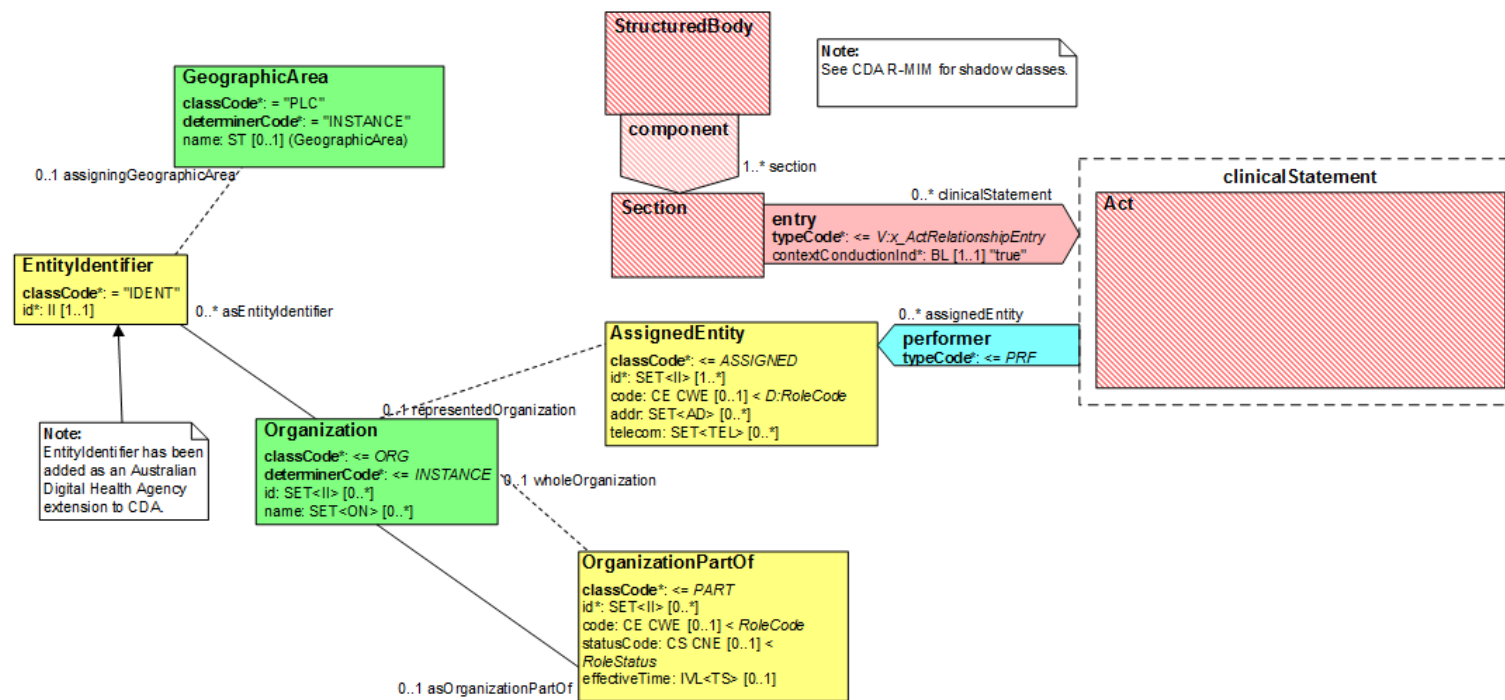
Figure 7.12. SERVICE PROVIDER

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[crnt_serv]/section/entry[current_service]/act/		
SERVICE PROVIDER	Provider of the service.	1..1	**performer[cs_rs_service_provider_organisation]**		
n/a	n/a	1..1	performer[cs_rs_service_provider_organisation]/assignedEntity/**id**		Required CDA element. See <id> for available attributes.
SERVICE PROVIDER > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	0..1	performer[cs_rs_service_provider_organisation]/**time**		See <time> for available attributes.
SERVICE PROVIDER > **LOCATION OF PARTICIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIPATION is not currently mapped.
SERVICE PROVIDER > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	performer[cs_rs_service_provider_organisation]/**@typeCode="PRF"**	Participation Type **SHALL** have an implementation-specific value equivalent to "Service Provider".	
SERVICE PROVIDER > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	performer[cs_rs_service_provider_organisation]/**assignedEntity/code**	Role **SHOULD** have a value representing the type of Facility e.g. Hospital, Clinic, Community Service Centre, Home care/housekeeping assistance.	See <code> for available attributes.
SERVICE PROVIDER > **PARTICIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	performer[cs_rs_service_provider_organisation]/assignedEntity/**representedOrganization**		
SERVICE PROVIDER > PARTICIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	0..*	performer[cs_rs_service_provider_organisation]/assignedEntity/representedOrganization/asOrganizationPartOf/wholeOrganization/**<Entity Identifier>**		See common pattern: Entity Identifier.
SERVICE PROVIDER > PARTICIPANT > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	performer[cs_rs_service_provider_organisation]/assignedEntity/**<Address>**	AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.	See common pattern: Address.
SERVICE PROVIDER > PARTICIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	performer[cs_rs_service_provider_organisation]/assignedEntity/**<Electronic Communication Detail>**		See common pattern: Electronic Communication Detail.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SERVICE PROVIDER > PARTICIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a ORGANISATION.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **ORGANISATION**	Any organisation of interest to, or involved in, the business of healthcare service provision.	1..1	n/a		Not mapped directly, encompassed implicitly in performer[cs_rs_service_provider_organisation]/assignedEntity/representedOrganization/asOrganizationPartOf/wholeOrganization.
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Organisation Name**	The name by which an organisation is known or called.	1..1	performer[cs_rs_service_provider_organisation]/assignedEntity/representedOrganization/**asOrganizationPartOf/wholeOrganization/name**		
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Department/Unit**	The name by which a department or unit within a larger organisation is known or called.	0..1	performer[cs_rs_service_provider_organisation]/assignedEntity/representedOrganization/**name**		
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Organisation Name Usage**	The classification that enables differentiation between recorded names for an organisation or service location.	0..1	performer[cs_rs_service_provider_organisation]/assignedEntity/representedOrganization/asOrganizationPartOf/wholeOrganization/name/**@use**	AS 4846-2006: Health Care Provider Organisation Name Usage	
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*)		
SERVICE PROVIDER > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..0	See Known Issues.		Prohibition of ENTITLEMENT is not currently mapped.
CDA Header Data Elements			Context: /ClinicalDocument/component/structuredBody/component[crnt_serv]/section/entry[current_service]/act/		
SERVICE PROVIDER > PARTICIPANT > **Qualifications**	A list of professional certifications, and certificates recognising having passed a course.	0..0	n/a		This logical data component has no mapping to CDA.

Example 7.11. SERVICE PROVIDER XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

<!-- Begin CDA Body -->
<component>
 <structuredBody>
  …

  <!-- Begin CURRENT SERVICES -->
  <component typeCode="COMP">
   <section classCode="DOCSECT" moodCode="EVN">
    …

    <!-- Begin Current Service (REQUESTED SERVICE) -->
    <entry>
     <act classCode="ACT" moodCode="EVN">
      …

      <!-- Begin SERVICE PROVIDER -->
      <performer typeCode="PRF">
       <!-- Participation Period -->
       <time value="201510201235+1000"/>

       <assignedEntity classCode="ASSIGNED">
        <!-- id is used for system purposes such as matching -->
        <id root="db7c3d78-79e9-4d06-874e-890241cfce14"/>
        <!-- Role -->
        <code code="309964003" codeSystem="2.16.840.1.113883.6.96"
         codeSystemName="SNOMED CT"
         displayName="Radiology department"/>

        <!-- ADDRESS -->
        <addr use="WP">
         <streetAddressLine>55 Radiology Drive</streetAddressLine>
         <city>Healthville</city>
         <state>QLD</state>
         <postalCode>5555</postalCode>
         <additionalLocator>32568931</additionalLocator>
         <country>Australia</country>
        </addr>

        <!-- ELECTRONIC COMMUNICATION DETAIL -->
        <telecom use="WP" value="tel:0788888888"/>

        <representedOrganization>
         <!-- Department/Unit Name -->
         <name>Radiology Dept</name>
```

```xml
            <asOrganizationPartOf>
             <wholeOrganization>
              <!-- Organisation Name -->
              <name use="ORGB">Acme Hospital Group</name>

              <!-- Entity Identifier -->
              <ext:asEntityIdentifier classCode="IDENT">
               <ext:id assigningAuthorityName="HPI-O"
                root="1.2.36.1.2001.1003.0.8003621566684455"/>
               <ext:assigningGeographicArea classCode="PLC">
                <ext:name>National Identifier</ext:name>
               </ext:assigningGeographicArea>
              </ext:asEntityIdentifier>

             </wholeOrganization>
            </asOrganizationPartOf>
           </representedOrganization>
          </assignedEntity>
         </performer>
         <!-- End SERVICE PROVIDER -->

        </act>
       </entry>
       <!-- End Current Service (REQUESTED SERVICE) -->

      </section>
     </component>
     <!-- end CURRENT SERVICES -->
     …

   </structuredBody>
  </component>
  <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.3 ADVERSE REACTIONS

Identification

Name	ADVERSE REACTIONS
Metadata Type	Section
Identifier	S-20113

Relationships

Parent

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

Children

Data Type	Name	Occurrence
	EXCLUSION STATEMENT - ADVERSE REACTIONS	0..1
	ADVERSE REACTION	0..*

CDA R-MIM Representation

Figure 7.13 ADVERSE REACTIONS shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The ADVERSE REACTIONS section is composed of a Section class related to its context ClinicalDocument.structuredBody by a component.
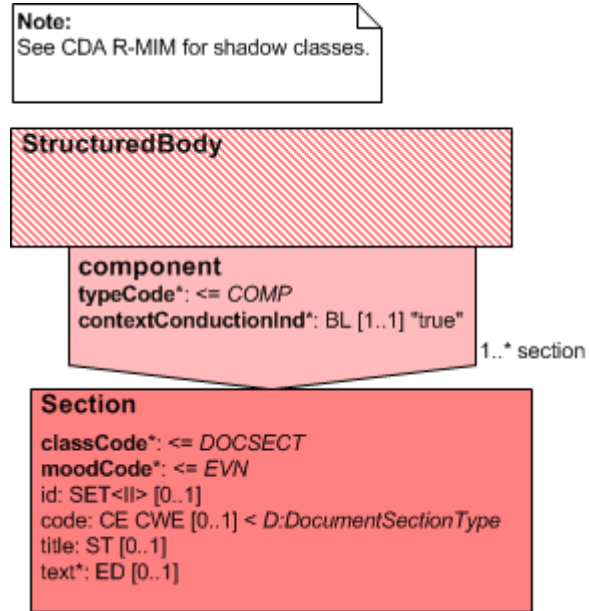

Figure 7.13. ADVERSE REACTIONS

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: /ClinicalDocument/component/structuredBody/		
ADVERSE REACTIONS	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.	0..1	component[adv_reacts]/**section**		This component[adv_reacts] **SHALL NOT** contain both an instance of EXCLUSION STATEMENT - ADVERSE REACTIONS and an instance of ADVERSE REACTION. Each instance of this component[adv_reacts] **SHALL** contain at least one instance of : • EXCLUSION STATEMENT - ADVERSE REACTIONS, or • ADVERSE REACTION.
			component[adv_reacts]/section/**title="Adverse Reactions"**		
			component[adv_reacts]/section/**text**		Required CDA element. See Appendix A, *CDA Narratives*.
ADVERSE REACTIONS > **Adverse Reactions Instance Identifier**	Globally unique identifier for each instance of an Adverse Reactions section.	0..1	component[adv_reacts]/section/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
ADVERSE REACTIONS > **Section Type**	Type of section.	1..1	component[adv_reacts]/section/**code**		code/@nullFlavor **SHALL NOT** be present.
			component[adv_reacts]/section/code/**@code="101.20113"**		
			component[adv_reacts]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[adv_reacts]/section/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			component[adv_reacts]/section/code/**@displayName="Adverse Reactions"**		
ADVERSE REACTIONS > **EXCLUSION STATEMENT - ADVERSE REACTIONS**	Statements about adverse reactions that need to be positively recorded as absent or excluded.	0..1	See: EXCLUSION STATEMENT - ADVERSE REACTIONS		
ADVERSE REACTIONS > **ADVERSE REACTION**	Harmful or undesirable effect associated with exposure to any substance or agent.	0..*	See: ADVERSE REACTION		

Example 7.12. ADVERSE REACTIONS XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
    …

   <!-- Begin ADVERSE REACTIONS -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     <!-- Adverse Reactions Instance Identifier -->
     <id root="8d0de85e-bc57-46ea-a2d6-d92ead08dd15" />
     <!-- Section Type -->
     <code code="101.20113"
      codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components"
      displayName="Adverse Reactions" />
     <title>Adverse Reactions</title>

     <!-- narrative block -->
     <text>
      <table>
       <thead>
        <tr>
         <th>Substance/Agent</th>
         <th>Manifestations</th>
         <th>Adverse Reaction Type</th>
        </tr>
       </thead>
       <tbody>
        <tr>
         <td>Penicillin -class of antibiotic-</td>
         <td>
          <list>
           <item>Urticaria</item>
           <item>Trunk structure</item>
           <item>Entire lower limb</item>
           <item>Nausea &#38; and vomiting</item>
          </list>
         </td>
         <td>Urticaria</td>
        </tr>
        <tr>
         <td>Metoprolol</td>
         <td>
          <list>
           <item>Chronic obstructive airways disease NOS</item>
          </list>
```

```
        </td>
        <td>Urticaria</td>
       </tr>
      </tbody>
     </table>
    </text>
    …

    <!-- NOTE: This Exclusion Statement is provided for illustrative purpose only. This section cannot contain both an entry for Exclusion Statement and any other entry. -->
    <!-- Begin EXCLUSION STATEMENT - ADVERSE REACTIONS -->
    <entry>
     <observation>

      …
     </observation>
    </entry>
    <!-- End EXCLUSION STATEMENT - ADVERSE REACTIONS -->

    …

    <!-- Begin ADVERSE REACTION -->
    <entry>
     <act>

      …
     </act>
    </entry>
    <!-- End ADVERSE REACTION -->

    …

   </section>
  </component>
  <!-- End ADVERSE REACTIONS -->

  …

 </structuredBody>
 </component>
 <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.3.1 EXCLUSION STATEMENT - ADVERSE REACTIONS

Identification

Name	EXCLUSION STATEMENT - ADVERSE REACTIONS
Metadata Type	Data Group
Identifier	DG-16137

Relationships

Parent

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

CDA R-MIM Representation

Figure 7.14 EXCLUSION STATEMENT - ADVERSE REACTIONS shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The EXCLUSION STATEMENT - ADVERSE REACTIONS data group is represented by an Observation class that is related to its containing Section class by an entry.

Figure 7.14. EXCLUSION STATEMENT - ADVERSE REACTIONS

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[adv_reacts]/section/		
EXCLUSION STATEMENT - ADVERSE REACTIONS	Statements about adverse reactions that need to be positively recorded as absent or excluded.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children. See Known Issues.
EXCLUSION STATEMENT - ADVERSE REACTIONS > **Global Statement**	Statement about the absence or exclusion.	1..1	**entry[gbl_adv]**		
			entry[gbl_adv]/**observation**		
			entry[gbl_adv]/observation/**@classCode="OBS"**		
			entry[gbl_adv]/observation/**@moodCode="EVN"**		
			entry[gbl_adv]/observation/**id**		Optional CDA element. See <id> for available attributes.
			entry[gbl_adv]/observation/**code**		code/@nullFlavor **SHALL NOT** be present.
			entry[gbl_adv]/observation/code/**@code="103.16302.231.1.1"**		
			entry[gbl_adv]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[gbl_adv]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[gbl_adv]/observation/code/**@displayName="Global Statement"**		
			entry[gbl_adv]/observation/**value:CD**	NCTIS: Admin Codes - Global Statement Values	See <code> for available attributes. value/@nullFlavor **SHALL NOT** be present.
EXCLUSION STATEMENT - ADVERSE REACTIONS > **Detailed Clinical Model Identifier**	Globally unique identifier for this detailed clinical model.	1..1	n/a		This logical data component has no mapping to CDA. See Known Issues.

Example 7.13. EXCLUSION STATEMENT - ADVERSE REACTIONS XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
  …
  >
  …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin ADVERSE REACTIONS -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin EXCLUSION STATEMENT - ADVERSE REACTIONS -->
     <entry>
      <!-- Begin Global Statement -->
      <observation classCode="OBS" moodCode="EVN">
       <!-- id is used for system purposes such as matching -->
       <id root="55d57cf0-2c70-11e2-81c1-0800600c9a66" />
       <code code="103.16302.231.1.1" codeSystem="1.2.36.1.2001.1001.101"
        codeSystemName="NCTIS Data Components"
        displayName="Global Statement" />
       <value code="01" codeSystem="1.2.36.1.2001.1001.101.104.16299"
        codeSystemName="NCTIS Global Statement Values"
        displayName="None known" xsi:type="CD" />
      </observation>
      <!-- End Global Statement -->
     </entry>
     <!-- End EXCLUSION STATEMENT - ADVERSE REACTIONS -->

    </section>
   </component>
   <!-- End ADVERSE REACTIONS -->
   …

  </structuredBody>
 </component>
 <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.3.2 ADVERSE REACTION

Identification

Name	ADVERSE REACTION
Metadata Type	Data Group
Identifier	DG-15517

Relationships

Parent

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

CDA R-MIM Representation

Figure 7.15 ADVERSE REACTION shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The ADVERSE REACTION data group is represented by an Act class that is related to its containing Section class by an entry. Substance/Agent is represented by a ParticipantRole class related to the containing Act class by a participant.

Reaction Event is represented by an Observation class and is related to the containing Act class by an entryRelationship. Manifestation is represented by an Observation class related to the containing Observation (Reaction Event) class. Reaction Type is represented by the value attribute of the Manifestation Observation class.
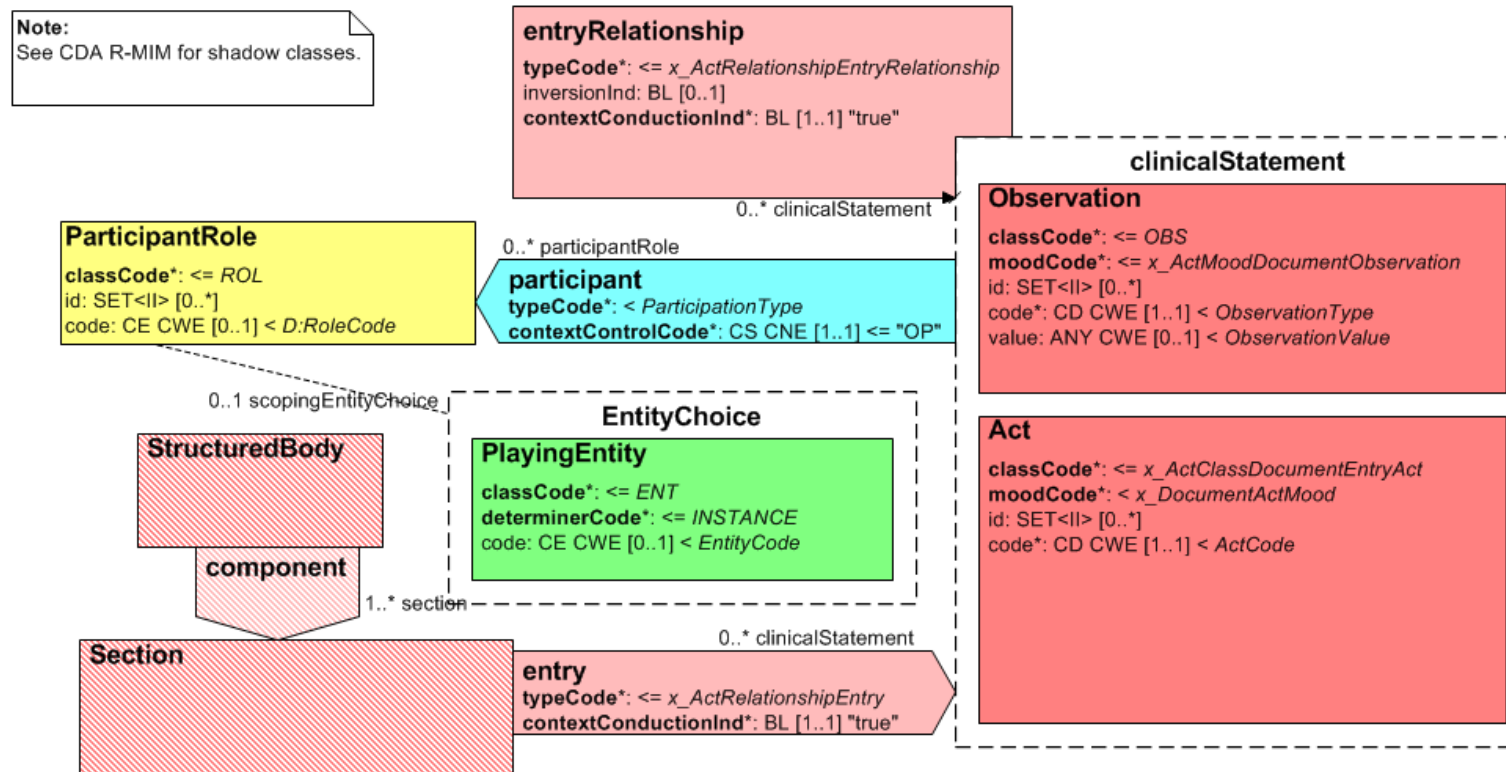
Figure 7.15. ADVERSE REACTION

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[adv_reacts]/section/		
ADVERSE REACTION	Harmful or undesirable effect associated with exposure to any substance or agent.	0..*	**entry[adv_react]**		
			entry[adv_react]/**act**		
			entry[adv_react]/act/**@classCode="ACT"**		
			entry[adv_react]/act/**@moodCode="EVN"**		
ADVERSE REACTION > **Adverse Reaction Instance Identifier**	Globally unique identifier for each instance of an Adverse Reaction evaluation.	0..1	entry[adv_react]/act/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
ADVERSE REACTION > **Detailed Clinical Model Identifier**	Globally unique identifier for this detailed clinical model.	1..1	entry[adv_react]/act/**code**		code/@nullFlavor **SHALL NOT** be present.
			entry[adv_react]/act/code/**@code="102.15517"**		
			entry[adv_react]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[adv_react]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[adv_react]/act/code/**@displayName="Adverse Reaction"**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
ADVERSE REACTION > **Substance/Agent**	Identification of a substance, agent, or a class of substance, that is considered to be responsible for the adverse reaction.	1..1	entry[adv_react]/act/**participant**		
			entry[adv_react]/act/participant/**@typeCode="CAGNT"**		
			entry[adv_react]/act/participant/**participantRole/playingEntity/code**	SNOMED CT-AU: • 142321000036106 |*Adverse reaction agent reference set*| • 32570211000036100 |*Substance foundation reference set*| Australian Medicines Terminology (AMT): • 929360061000036106 |*Medicinal product reference set*| • 929360081000036101 |*Medicinal product pack reference set*| • 929360071000036103 |*Medicinal product unit of use reference set*| • 929360021000036102 |*Trade product reference set*| • 929360041000036105 |*Trade product pack reference set*| • 929360031000036100 |*Trade product unit of use reference set*| • 929360051000036108 |*Containered trade product pack reference set*|	See <code> for available attributes. code/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
ADVERSE REACTION > **REACTION EVENT**	Details about each adverse reaction event.	0..1	entry[adv_react]/act/**entryRelationship[rct_evnt]/@typeCode="CAUS"**		This REACTION EVENT (entryRelationship[rct_evnt]/observation) **SHALL** contain at least one instance of:
			entry[adv_react]/act/entryRelationship[rct_evnt]/**observation**		
			entry[adv_react]/act/entryRelationship[rct_evnt]/observation/**@classCode="OBS"**		
			entry[adv_react]/act/entryRelationship[rct_evnt]/observation/**@moodCode="EVN"**		• Manifestation (entryRelationship[mfst]), or
					• Reaction Type (entryRelationship[rct_evnt]/observation/value).
			entry[adv_react]/act/entryRelationship[rct_evnt]/observation/**code**		
			entry[adv_react]/act/entryRelationship[rct_evnt]/observation/code/**@code="102.16474"**		
			entry[adv_react]/act/entryRelationship[rct_evnt]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[adv_react]/act/entryRelationship[rct_evnt]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[adv_react]/act/entryRelationship[rct_evnt]/observation/code/**@displayName="Reaction Event"**		
ADVERSE REACTION > REACTION EVENT > **Manifestation**	Presentation or exhibition of signs and symptoms of the adverse reaction expressed as a single word, phrase or brief description.	0..*	entry[adv_react]/act/entryRelationship[rct_evnt]/observation/**entryRelationship[mfst]/@typeCode="MFST"**		
			entry[adv_react]/act/entryRelationship[rct_evnt]/observation/entryRelationship[mfst]/**@inversionInd="true"**		
			entry[adv_react]/act/entryRelationship[rct_evnt]/observation/entryRelationship[mfst]/**observation**		
			entry[adv_react]/act/entryRelationship[rct_evnt]/observation/entryRelationship[mfst]/observation/**@classCode="OBS"**		
			entry[adv_react]/act/entryRelationship[rct_evnt]/observation/entryRelationship[mfst]/observation/**@moodCode="EVN"**		
			entry[adv_react]/act/entryRelationship[rct_evnt]/observation/entryRelationship[mfst]/observation/**id**		Optional CDA element. See <id> for available attributes.
			entry[adv_react]/act/entryRelationship[rct_evnt]/observation/entryRelationship[mfst]/observation/**code**	SNOMED CT-AU • 142341000036103 |*Clinical manifestation reference set*| • 32570071000036102 |*Clinical finding foundation reference set*|	See <code> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
ADVERSE REACTION > REACTION EVENT > **Reaction Type**	Type of reaction, as determined by the clinician.	0..1	entry[adv_react]/act/entryRelationship[rct_evnt]/observation/**value:CD**	SNOMED CT-AU: • 11000036103 |*Adverse reaction type reference set*| value/@code **SHALL NOT** be Drug interaction "79899007", Drug interaction with drug "404204005", or Drug interaction with food "95907004". value/@code **SHOULD NOT** be Non-allergic reaction "609406000".	See <code> for available attributes. value/@nullFlavor **SHALL NOT** be present.

Example 7.14. ADVERSE REACTION XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
    xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
    …
    >
    …

    <!-- Begin CDA Body -->
    <component>
        <structuredBody>
            …

            <!-- Begin ADVERSE REACTIONS -->
            <component typeCode="COMP">
                <section classCode="DOCSECT" moodCode="EVN">
                    …

                    <!-- Begin ADVERSE REACTION -->
                    <entry>
                        <act classCode="ACT" moodCode="EVN">
                            <!-- Adverse Reaction Instance Identifier -->
                            <id root="5424c5ca-73a4-448f-ac81-b452681d1d22" />
                            <!-- Detailed Clinical Model Identifier -->
                            <code code="102.15517"
                                codeSystem="1.2.36.1.2001.1001.101"
                                codeSystemName="NCTIS Data Components"
                                displayName="Adverse Reaction" />

                            <!-- Begin Substance/Agent -->
                            <participant typeCode="CAGNT">
                                <participantRole>
                                    <playingEntity>
                                        <code code="385420005"
                                            codeSystem="2.16.840.1.113883.6.96"
                                            codeSystemName="SNOMED CT"
                                            displayName="Contrast media" />
                                    </playingEntity>
                                </participantRole>
                            </participant>
                            <!-- End Substance/Agent -->

                            <!-- Begin REACTION EVENT -->
                            <entryRelationship typeCode="CAUS">
                                <observation classCode="OBS" moodCode="EVN">
                                    <code code="102.16474"
                                        codeSystem="1.2.36.1.2001.1001.101"
                                        codeSystemName="NCTIS Data Components"
                                        displayName="Reaction Event" />

                                    <!-- Reaction Type -->
                                    <value code="419076005"
                                        codeSystem="2.16.840.1.113883.6.96"
                                        codeSystemName="SNOMED CT"
```

```xml
                                displayName="Allergic reaction" xsi:type="CD" />

                    <entryRelationship inversionInd="true" typeCode="MFST">
                        <observation classCode="OBS" moodCode="EVN">
                            <id root="f8effa16-6732-4777-ad1b-649305f9fcd2" />

                            <!-- Manifestation -->
                            <code code="39579001"
                                codeSystem="2.16.840.1.113883.6.96"
                                codeSystemName="SNOMED CT"
                                displayName="Anaphylaxis" />

                        </observation>
                    </entryRelationship>

                </observation>
            </entryRelationship>
            <!-- End REACTION EVENT -->
        </act>
    </entry>
    <!-- End ADVERSE REACTION -->

        </section>
    </component>
    <!-- End ADVERSE REACTIONS -->
    …

    </structuredBody>
</component>
<!-- End CDA Body -->
</ClinicalDocument>
```

7.1.4 Medications (MEDICATION ORDERS)

Identification

Name	Medications (MEDICATION ORDERS)
Metadata Type	Section
Identifier	S-16146

Relationships

Parent

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

Children

Data Type	Name	Occurrence
	EXCLUSION STATEMENT - MEDICATIONS	0..1
	Known Medication (MEDICATION INSTRUCTION)	0..*

CDA R-MIM Representation

Figure 7.16 Medications (MEDICATION ORDERS) shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The Medications (MEDICATION ORDERS) section is composed of a Section class related to its context ClinicalDocument.structuredBody by a component.
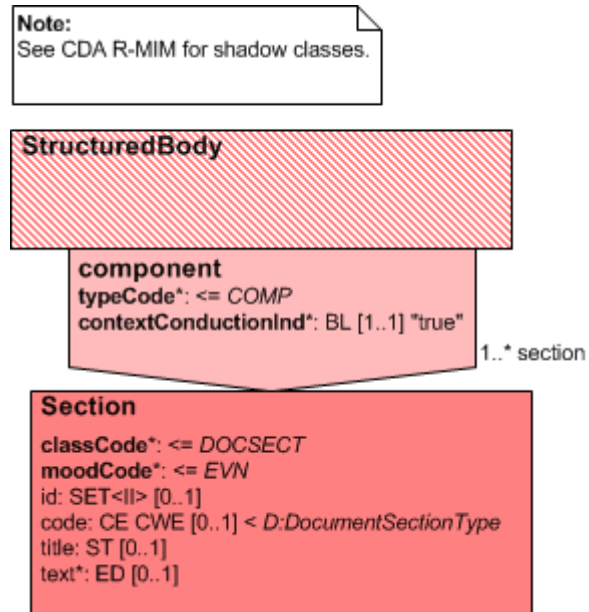
Figure 7.16. Medications (MEDICATION ORDERS)

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: /ClinicalDocument/component/structuredBody/		
Medications (MEDICATION ORDERS)	Medicines that the subject of care is using at the time of referral.	0..1	component[meds]/**section**		This component[meds] **SHALL NOT** contain both an instance of EXCLUSION STATEMENT - MEDICATIONS and an instance of Known Medication (MEDICATION INSTRUCTION).
			component[meds]/section/**title="Medications"**		
					Each instance of this component[meds] **SHALL** contain at least one instance of :
					• Known Medication (MEDICATION INSTRUCTION), or
					• EXCLUSION STATEMENT - MEDICATIONS.
			component[meds]/section/**text**		Required CDA element. See Appendix A, *CDA Narratives*.
Medications (MEDICATION ORDERS) > **Medication Orders Instance Identifier**	Globally unique identifier for each instance of a Medication Orders section.	0..1	component[meds]/section/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
Medications (MEDICATION ORDERS) > **Section Type**	Type of section.	1..1	component[meds]/section/**code**		code/@nullFlavor **SHALL NOT** be present.
			component[meds]/section/code/**@code="101.16146"**		
			component[meds]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[meds]/section/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			component[meds]/section/code/**@displayName="Medication Orders"**		
Medications (MEDICATION ORDERS) > **EXCLUSION STATEMENT - MEDICATIONS**	Statement to positively assert that the patient has not been prescribed or is not taking certain medication.	0..1	See: EXCLUSION STATEMENT - MEDICATIONS		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Medications (MEDICATION ORDERS) > **Known Medication (MEDICATION INSTRUCTION)**	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.	0..*	See: Known Medication (MEDICATION INSTRUCTION)		

Example 7.15. Medications (MEDICATION ORDERS) XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
    …

   <!-- Begin Medications (MEDICATION ORDERS) -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     <!-- Medication Orders Instance Identifier -->
     <id root="036eb3bf-bf44-44f9-b168-01a83b9aa0b9" />
     <!-- Section Type -->
     <code code="101.16146"
      codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components"
      displayName="Medication Orders" />
     <title>Medications</title>

     <!-- narrative block -->
     <text>
      <table>
       <caption>Current Medications</caption>
       <thead>
        <tr>
         <th>Medication</th>
         <th>Directions</th>
         <th>Dispensed</th>
         <th>Clinical Indication</th>
         <th>Comments</th>
        </tr>
       </thead>
       <tbody>
        <tr>
         <td>paracetamol 500 mg + codeine phosphate 30 mg tablet</td>
         <td>1 tablet once daily oral</td>
         <td>2 tablets</td>
         <td>Pneumonia</td>
         <td>Additional Comments</td>
        </tr>
        <tr>
         <td>paracetamol 500 mg + codeine phosphate 30 mg tablet</td>
         <td>2 tablets daily oral</td>
         <td>4 tablets</td>
         <td>Stress</td>
         <td>Stress</td>
        </tr>
       </tbody>
```

```
    </table>
   </text>

   <!-- NOTE: This Exclusion Statement is provided for illustrative purpose only. This section cannot contain both an entry for Exclusion Statement and any other entry. -->
   <!-- Begin EXCLUSION STATEMENT - MEDICATIONS -->
   <entry>
    <observation>
     …
    </observation>
   </entry>
   <!-- End EXCLUSION STATEMENT - MEDICATIONS -->

   <!-- Begin Known Medication (MEDICATION INSTRUCTION) -->
   <entry>
    <substanceAdministration>
     …
    </substanceAdministration>
   </entry>
   <!-- End Known Medication (MEDICATION INSTRUCTION) -->
   …

   </section>
  </component>
  <!-- End Medications (MEDICATION ORDERS) -->
  …

 </structuredBody>
</component>
<!-- End CDA Body -->
</ClinicalDocument>
```

7.1.4.1 EXCLUSION STATEMENT - MEDICATIONS

Identification

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

Relationships

Parent

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

CDA R-MIM Representation

Figure 7.17 EXCLUSION STATEMENT - MEDICATIONS shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The EXCLUSION STATEMENT - MEDICATIONS data group is represented by an Observation class that is related to its containing Section class by an entry.
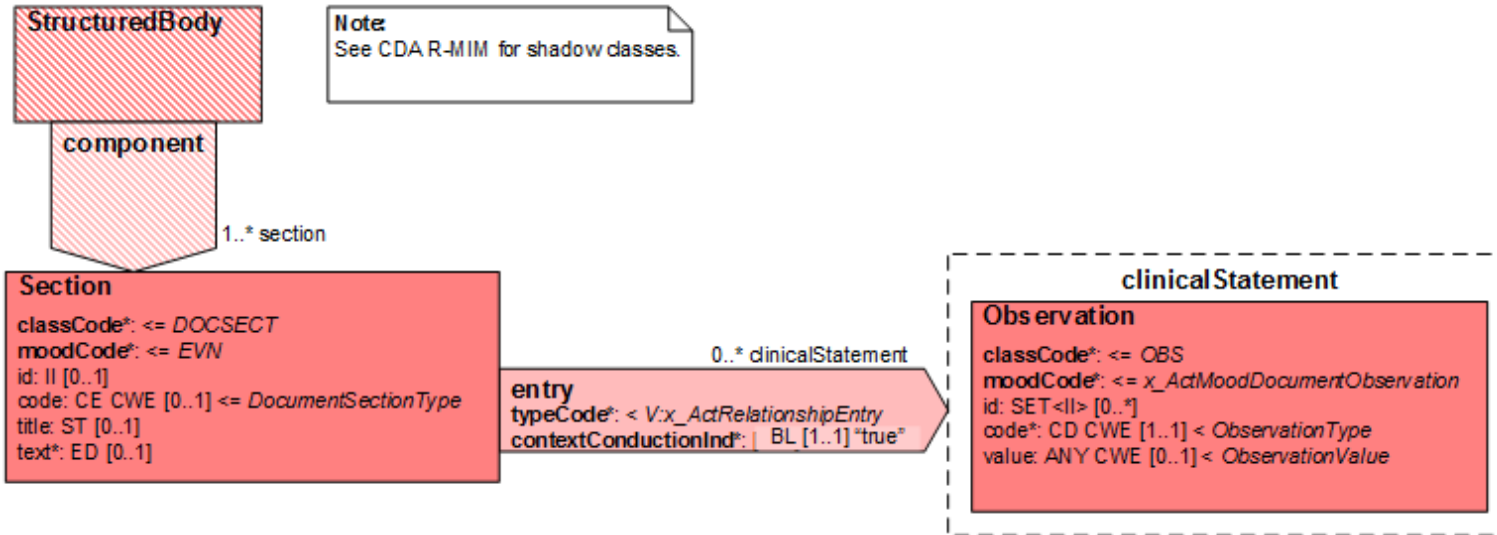
Figure 7.17. EXCLUSION STATEMENT - MEDICATIONS

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[meds]/section/		
EXCLUSION STATEMENT - MEDICATIONS	Statement to positively assert that the patient has not been prescribed or is not taking certain medication.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children. See Known Issues.
EXCLUSION STATEMENT - MEDICATIONS > **Global Statement**	Statement about the absence or exclusion.	1..1	**entry[gbl_meds]**		
			entry[gbl_meds]/**observation**		
			entry[gbl_meds]/observation/**@classCode="OBS"**		
			entry[gbl_meds]/observation/**@moodCode="EVN"**		
			entry[gbl_meds]/observation/**id**		Optional CDA element. See <id> for available attributes.
			entry[gbl_meds]/observation/**code**		code/@nullFlavor **SHALL NOT** be present.
			entry[gbl_meds]/observation/code/**@code="103.16302.231.1.2"**		
			entry[gbl_meds]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[gbl_meds]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[gbl_meds]/observation/code/**@displayName="Global Statement"**		
			entry[gbl_meds]/observation/**value:CD**	NCTIS: Admin Codes - Global Statement Values	See <code> for available attributes. value/@nullFlavor **SHALL NOT** be present.
EXCLUSION STATEMENT - MEDICATIONS > **Detailed Clinical Model Identifier**	Globally unique identifier for this detailed clinical model.	1..1	n/a		This logical data component has no mapping to CDA. See Known Issues.

Example 7.16. EXCLUSION STATEMENT - MEDICATIONS XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin Medications (MEDICATION ORDERS) -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin EXCLUSION STATEMENT - MEDICATIONS -->
     <entry>
      <!-- Begin Global Statement -->
      <observation classCode="OBS" moodCode="EVN">
       <!-- id is used for system purposes such as matching -->
       <id root="55d57cf0-2c70-11e2-81c1-0801600c9a66" />
       <code code="103.16302.231.1.2" codeSystem="1.2.36.1.2001.1001.101"
        codeSystemName="NCTIS Data Components"
        displayName="Global Statement" />
       <value code="01" codeSystem="1.2.36.1.2001.1001.101.104.16299"
        codeSystemName="NCTIS Global Statement Values"
        displayName="None known" xsi:type="CD" />
      </observation>
      <!-- End Global Statement -->
     </entry>
     <!-- End EXCLUSION STATEMENT - MEDICATIONS -->

    </section>
   </component>
   <!-- End Medications (MEDICATION ORDERS) -->
   …

  </structuredBody>
 </component>
 <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.4.2 Known Medication (MEDICATION INSTRUCTION)

Identification

Name	Known Medication (MEDICATION INSTRUCTION)
Metadata Type	Data Group
Identifier	DG-16211

Relationships

Parent

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

CDA R-MIM Representation

Figure 7.18 Known Medication (MEDICATION INSTRUCTION) shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The Known Medication (MEDICATION INSTRUCTION) data group is represented by a SubstanceAdministration class that is related to its containing Section class by an entry. The text attribute of that SubstanceAdministration class represents Directions.

Clinical Indication is represented by a reason Act class related to the containing SubstanceAdministration class by an entryRelationship. Medication Instruction Comment is represented by an Act class related the containing SubstanceAdministration class by an entryRelationship. Therapeutic Good Identification is represented by the code attribute of manufacturedMaterial.
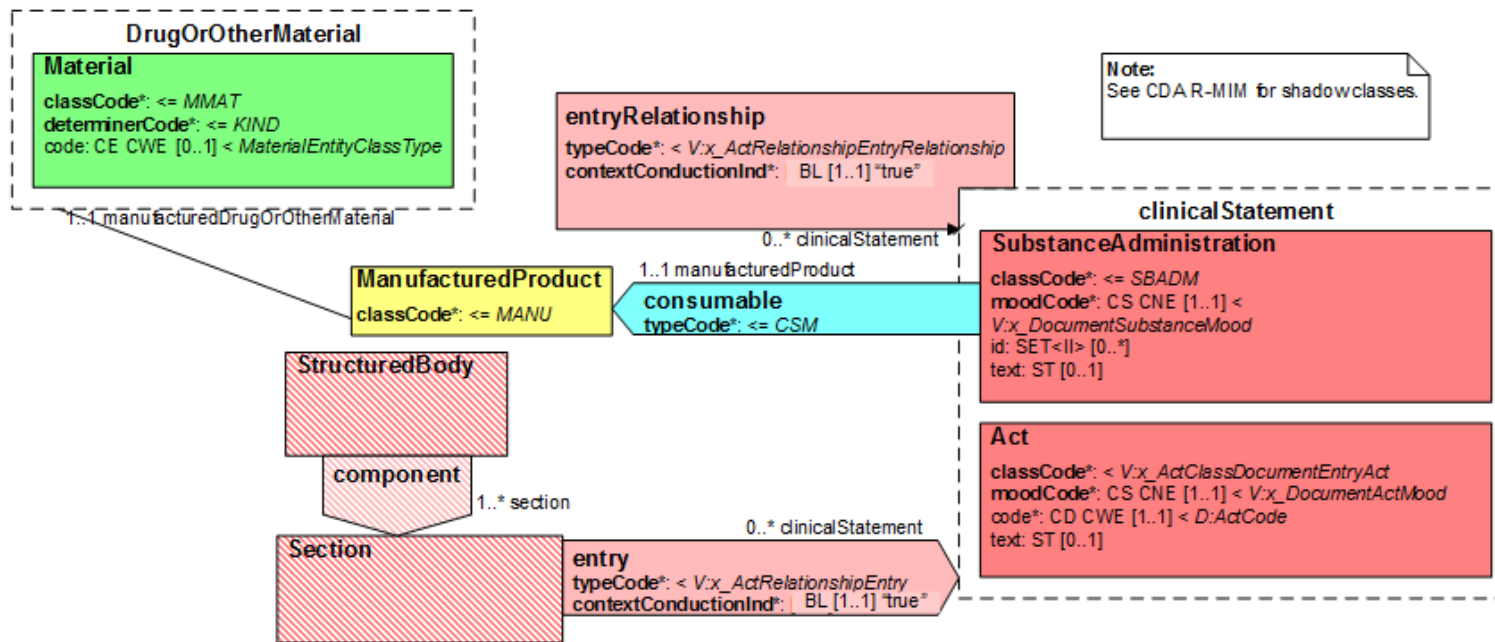
Figure 7.18. Known Medication (MEDICATION INSTRUCTION)

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[meds]/section/		
Known Medication (MEDICATION INSTRUC-TION)	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.	0..*	**entry[med_inst]**		
			entry[med_inst]/**substanceAdministration**		
			entry[med_inst]/substanceAdministration/**@moodCode="EVN"**		
			entry[med_inst]/substanceAdministration/**@classCode="SBADM"**		
Known Medication (MEDICATION INSTRUC-TION) > **Medication Instruction Instance Identifier**	Globally unique object identifier for each instance of a Medication Instruction instruction.	0..1	entry[med_inst]/substanceAdministration/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
Known Medication (MEDICATION INSTRUC-TION) > **Therapeutic Good Identification**	Medicine, vaccine or other therapeutic good being ordered for, administered to or used by the subject.	1..1	entry[med_inst]/substanceAdministration/**consumable/manufacturedProduct/manufacturedMaterial/code**	Australian Medicines Terminology (AMT): • 929360061000036106 |*Medicinal product reference set*| • 929360081000036101 |*Medicinal product pack reference set*| • 929360071000036103 |*Medicinal product unit of use reference set*| • 929360021000036102 |*Trade product reference set*| • 929360041000036105 |*Trade product pack reference set*| • 929360031000036100 |*Trade product unit of use reference set*| • 929360051000036108 |*Containered trade product pack reference set*|	See <code> for available attributes. code/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".
Known Medication (MEDICATION INSTRUC-TION) > **Directions**	Complete narrative description of how much, when and how to use the medicine, vaccine or other therapeutic good.	1..1	entry[med_inst]/substanceAdministration/**text:ST**		text/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Known Medication (MEDICATION INSTRUCTION) > **Clinical Indication**	Reason for ordering the medicine, vaccine or other therapeutic good.	0..1	entry[med_inst]/substanceAdministration/**entryRelationship[cln_ind]/@typeCode="RSON"**		
			entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/**act**		
			entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/**@classCode="INFRM"**		
			entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/**@moodCode="EVN"**		
			entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/**code**		
			entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/code/**@code="103.10141"**		
			entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/code/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/code/**@displayName= "Clinical Indication"**		
			entry[med_inst]/substanceAdministration/entryRelationship[cln_ind]/act/**text:ST**		
Known Medication (MEDICATION INSTRUCTION) > **Medication Instruction Comment**	Additional information that may be needed to ensure the continuity of supply, rationale for current dose and timing, or safe and appropriate use.	0..1	entry[med_inst]/substanceAdministration/**entryRelationship[cmts]/@typeCode="COMP"**		
			entry[med_inst]/substanceAdministration/entryRelationship[cmts]/**act**		
			entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/**@classCode="INFRM"**		
			entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/**@moodCode="EVN"**		
			entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/**code**		
			entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/code/**@code="103.16044"**		
			entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/code/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/code/**@displayName= "Additional Comments"**		
			entry[med_inst]/substanceAdministration/entryRelationship[cmts]/act/**text:ST**		
Known Medication (MEDICATION INSTRUCTION) > **Detailed Clinical Model Identifier**	Globally unique identifier for this detailed clinical model.	1..1	n/a		Not mapped directly, encompassed implicitly by CDA in entry[med_inst]/substanceAdministration.

Example 7.17. Known Medication (MEDICATION INSTRUCTION) XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

<!-- Begin CDA Body -->
<component>
  <structuredBody>
   …

   <!-- Begin Medications (MEDICATION ORDERS) -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin Known Medication (MEDICATION INSTRUCTION) -->
     <entry>
      <substanceAdministration classCode="SBADM" moodCode="EVN">
       <!-- Medication Instruction Instance Identifier -->
       <id root="8e1f99e4-6dd1-407f-b031-6cf41aec3145" />

       <!-- Directions -->
       <text xsi:type="ST">2 tablets daily after breakfast</text>

       <consumable>
        <manufacturedProduct>
         <manufacturedMaterial>
          <!-- Medicine (Therapeutic Good Identification) -->
          <code code="6647011000036101"
           codeSystem="2.16.840.1.113883.6.96"
           codeSystemName="SNOMED CT"
           displayName="Panadeine Forte tablet: uncoated" />
         </manufacturedMaterial>
        </manufacturedProduct>
       </consumable>

       <!-- Begin Clinical Indication -->
       <entryRelationship typeCode="RSON">
        <act classCode="INFRM" moodCode="EVN">
         <code code="103.10141"
          codeSystem="1.2.36.1.2001.1001.101"
          codeSystemName="NCTIS Data Components"
          displayName="Clinical Indication" />
         <text xsi:type="ST">Pain control.</text>
        </act>
       </entryRelationship>
       <!-- End Clinical Indication -->

       <!-- Begin Medication Instruction Comment -->
       <entryRelationship typeCode="COMP">
        <act classCode="INFRM" moodCode="EVN">
```

```xml
            <code code="103.16044"
              codeSystem="1.2.36.1.2001.1001.101"
              codeSystemName="NCTIS Data Components"
              displayName="Additional Comments" />
            <text xsi:type="ST">Dosage to be reviewed in 10 days.</text>
          </act>
        </entryRelationship>
        <!-- End Medication Instruction Comment -->

      </substanceAdministration>
     </entry>
     <!-- End Known Medication (MEDICATION INSTRUCTION) -->
     …

    </section>
   </component>
   <!-- End Medications (MEDICATION ORDERS) -->
    …

  </structuredBody>
 </component>
 <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.5 Past and Current Medical History (MEDICAL HISTORY)

Identification

Name	Past and Current Medical History (MEDICAL HISTORY)
Metadata Type	Section
Identifier	S-16117

Relationships

Parent

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

Children

Data Type	Name	Occurrence
	PROBLEM/DIAGNOSIS	0..*
	PROCEDURE	0..*
	UNCATEGORISED MEDICAL HISTORY ITEM	0..*

CDA R-MIM Representation

Figure 7.19 Past and Current Medical History (MEDICAL HISTORY) shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The Past and Current Medical History (MEDICAL HISTORY) section is composed of a Section class related to its context ClinicalDocument.structuredBody by a component.

Note:
See CDA R-MIM for shadow classes.

StructuredBody

component
typeCode*: <= COMP
contextConductionInd*: BL [1..1] "true"

1..* section

Section

classCode*: <= DOCSECT
moodCode*: <= EVN
id: SET<II> [0..1]
code: CE CWE [0..1] < D:DocumentSectionType
title: ST [0..1]
text*: ED [0..1]

Figure 7.19. Past and Current Medical History (MEDICAL HISTORY)

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: /ClinicalDocument/component/structuredBody/		
Past and Current Medical History (MEDICAL HISTORY)	Information about the subject of care's problems, diagnoses and medical or surgical procedures.	0..1	component[med_hist]/**section**		Each instance of this component[med_hist] **SHALL** contain at least one instance of :
			component[med_hist]/section/**title="Medical History"**		• PROBLEM/DIAGNOSIS, or
					• PROCEDURE, or
					• UNCATEGORISED MEDICAL HISTORY ITEM.
			component[med_hist]/section/**text**		Required CDA element. See Appendix A, *CDA Narratives*.
Past and Current Medical History (MEDICAL HISTORY) > **Medical History Instance Identifier**	Globally unique identifier for each instance of a Medical History section.	0..1	component[med_hist]/section/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
Past and Current Medical History (MEDICAL HISTORY) > **Section Type**	Type of section.	1..1	component[med_hist]/section/**code**		code/@nullFlavor **SHALL NOT** be present.
			component[med_hist]/section/code/**@code="101.16117"**		
			component[med_hist]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[med_hist]/section/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			component[med_hist]/section/code/**@displayName="Medical History"**		
Past and Current Medical History (MEDICAL HISTORY) > **PROBLEM/DIAGNOSIS**	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.	0..*	See: PROBLEM/DIAGNOSIS		
Past and Current Medical History (MEDICAL HISTORY) > **PROCEDURE**	Clinical activity carried out for therapeutic, evaluative, investigative, screening or diagnostic purposes.	0..*	See: PROCEDURE		
Past and Current Medical History (MEDICAL HISTORY) > **UNCATEGORISED MEDICAL HISTORY ITEM**	Medical history entry that has not been categorised as either Procedure or Problem/Diagnosis.	0..*	See: UNCATEGORISED MEDICAL HISTORY ITEM		

Example 7.18. Past and Current Medical History (MEDICAL HISTORY) XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin Past and Current Medical History (MEDICAL HISTORY) -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     <!-- Medical History Instance Identifier -->
     <id root="1fe3b06c-ed70-46a4-855b-146b1cea26f8" />
     <!-- Section Type -->
     <code code="101.16117" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Medical History" />
     <title>Medical History</title>

     <!-- narrative block -->
     <text>
      <paragraph>Clinical Intervention Descriptions</paragraph>
      <table>
       <thead>
        <tr>
         <th>Value(s)</th>
        </tr>
       </thead>
       <tbody>
        <tr>
         <td>Primary cemented total knee replacement</td>
        </tr>
        <tr>
         <td>Insulin C-peptide measurement</td>
        </tr>
        <tr>
         <td>Transfusion of packed red blood cells</td>
        </tr>
       </tbody>
      </table>
      <paragraph>Problems/Diagnose</paragraph>
      <table>
       <thead>
        <tr>
         <th>Type</th>
         <th>Description</th>
        </tr>
       </thead>
       <tbody>
        <tr>
         <td>Accidental bisacodyl overdose</td>
```

```xml
       <td>Infection by Spirura</td>
      </tr>
      <tr>
       <td>Principal diagnosis</td>
       <td>Systemic aspergillosis</td>
      </tr>
     </tbody>
    </table>
   </text>

   <!-- Begin PROBLEM/DIAGNOSIS -->
   <entry>
    <observation>
     …
    </observation>
   </entry>
   <!-- End PROBLEM/DIAGNOSIS -->

   <!-- Begin PROCEDURE -->
   <entry>
    <procedure>
     …
    </procedure>
   </entry>
   <!-- End PROCEDURE -->

   <!-- Begin UNCATEGORISED MEDICAL HISTORY ITEM -->
   <entry>
    <act>
     …
    </act>
   </entry>
   <!-- End UNCATEGORISED MEDICAL HISTORY ITEM -->

   </section>
  </component>
  <!-- End Past and Current Medical History (MEDICAL HISTORY) -->
   …

 </structuredBody>
 </component>
 <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.5.1 PROBLEM/DIAGNOSIS

Identification

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

Relationships

Parent

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

CDA R-MIM Representation

Figure 7.20 PROBLEM/DIAGNOSIS shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The PROBLEM/DIAGNOSIS data group is represented by an Observation class related to its containing Section class by an entry. The value attribute of that Observation class represents Problem/Diagnosis Identification, and the effectiveTime attribute represents Date of Onset.

Date of Resolution/Remission is mapped to an Observation class related to its containing Observation (PROBLEM/DIAGNOSIS) class by an entryRelationship. Problem/Diagnosis Comment is represented by an Act class related to its containing Observation (PROBLEM/DIAGNOSIS) class by an entryRelationship.
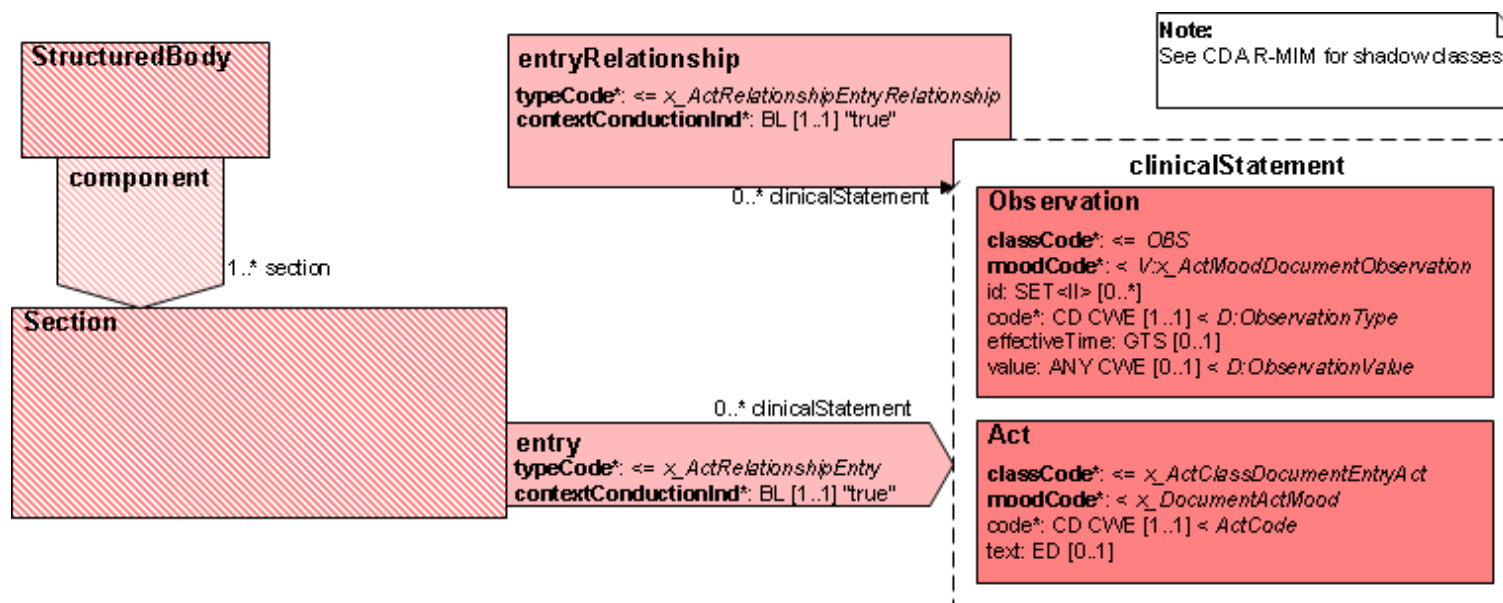
Figure 7.20. PROBLEM/DIAGNOSIS

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[med_hist]/section/		
PROBLEM/DIAGNOSIS	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.	0..*	**entry[prob]**		
			entry[prob]/**observation**		
			entry[prob]/observation/**@classCode="OBS"**		
			entry[prob]/observation/**@moodCode="EVN"**		
PROBLEM/DIAGNOSIS > **Problem/Diagnosis Instance Identifier**	Globally unique identifier for each instance of a Problem/Diagnosis evaluation.	0..1	entry[prob]/observation/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
PROBLEM/DIAGNOSIS > **Detailed Clinical Model Identifier**	Globally unique identifier for this detailed clinical model.	1..1	entry[prob]/observation/**code**		code/@nullFlavor **SHALL NOT** be present.
			entry[prob]/observation/code/**@code="282291009"**		
			entry[prob]/observation/code/**@codeSystem="2.16.840.1.113883.6.96"**		
			entry[prob]/observation/code/**@codeSystemName**	The value **SHOULD** be "SNOMED CT". See CodeSystem OIDs.	Optional CDA element.
			entry[prob]/observation/code/**@displayName="Diagnosis interpretation"**		
PROBLEM/DIAGNOSIS > **Problem/Diagnosis Identification**	Identification of the problem or diagnosis.	1..1	entry[prob]/observation/**value:CD**	SNOMED CT-AU: • 32570581000036105 |*Problem/Diagnosis reference set*|	See <code> for available attributes. value/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".
PROBLEM/DIAGNOSIS > **Date of Onset**	Estimated or actual date the problem or diagnosis began, as indicated or identified by the clinician.	0..1	entry[prob]/observation/**effectiveTime**		The value **SHALL NOT** include a time. See <time> for available attributes.
			entry[prob]/observation/effectiveTime/**low**		
			entry[prob]/observation/effectiveTime/low/**@value**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PROBLEM/DIAGNOSIS > **Date of Resolution/Remission**	Estimated or actual date the problem or diagnosis resolved or went into remission, as indicated or identified by the clinician.	0..1	entry[prob]/observation/**entryRelationship[crt]/@typeCode="SUBJ"**		
			entry[prob]/observation/entryRelationship[crt]/observation/**@classCode="OBS"**		
			entry[prob]/observation/entryRelationship[crt]/observation/**@moodCode="EVN"**		
			entry[prob]/observation/entryRelationship[crt]/observation/code/**@code="103.15510"**		
			entry[prob]/observation/entryRelationship[crt]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[prob]/observation/entryRelationship[crt]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[prob]/observation/entryRelationship[crt]/observation/code/**@displayName="Date of Resolution/Remission"**		
			entry[prob]/observation/entryRelationship[crt]/observation/**value:TS**		The value **SHALL NOT** include a time. See <time> for available attributes.
PROBLEM/DIAGNOSIS > **Problem/Diagnosis Comment**	Additional narrative about the problem or diagnosis not captured in other fields.	0..1	entry[prob]/observation/**entryRelationship[cmt]/@typeCode="COMP"**		
			entry[prob]/observation/entryRelationship[cmt]/**act**		
			entry[prob]/observation/entryRelationship[cmt]/act/**@classCode="INFRM"**		
			entry[prob]/observation/entryRelationship[cmt]/act/**@moodCode="EVN"**		
			entry[prob]/observation/entryRelationship[cmt]/act/**code**		
			entry[prob]/observation/entryRelationship[cmt]/act/code/**@code="103.16545"**		
			entry[prob]/observation/entryRelationship[cmt]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[prob]/observation/entryRelationship[cmt]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[prob]/observation/entryRelationship[cmt]/act/code/**@displayName="Problem/Diagnosis Comment"**		
			entry[prob]/observation/entryRelationship[cmt]/act/**text:ST**		

Example 7.19. PROBLEM/DIAGNOSIS XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin Past and Current Medical History (MEDICAL HISTORY) -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- NOTE: Though no other child component sections are shown the normative constraints on the contents of this component[med_hist]/section are specified in the mapping table. -->
     <!-- Begin PROBLEM/DIAGNOSIS -->
     <entry>
      <observation classCode="OBS" moodCode="EVN">
       <!-- Problem/Diagnosis Instance Identifier -->
       <id root="ab0d25a4-4120-43cf-9216-bcf67554f590" />
       <!-- Detailed Clinical Model Identifier -->
       <code code="282291009"
        codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMED CT"
        displayName="Diagnosis interpretation" />

       <!-- Date of Onset -->
       <effectiveTime>
        <low value="20110410" />
       </effectiveTime>

       <!-- Problem/Diagnosis Identification -->
       <value code="85189001"
        codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMED CT"
        displayName="Acute appendicitis" xsi:type="CD" />

       <!-- Begin Date of Resolution/Remission -->
       <entryRelationship typeCode="SUBJ">
        <observation classCode="OBS" moodCode="EVN">
         <code code="103.15510"
          codeSystem="1.2.36.1.2001.1001.101"
          codeSystemName="NCTIS Data Components"
          displayName="Date of Resolution/Remission" />
         <value value="20110427" xsi:type="TS" />
        </observation>
       </entryRelationship>
       <!-- End Date of Resolution/Remission -->

       <!-- Begin Problem/Diagnosis Comment -->
```

```xml
        <entryRelationship typeCode="COMP">
         <act classCode="INFRM" moodCode="EVN">
          <code code="103.16545"
           codeSystem="1.2.36.1.2001.1001.101"
           codeSystemName="NCTIS Data Components"
           displayName="Problem/Diagnosis Comment" />
          <text xsi:type="ST">Problem/Diagnosis Comment goes here.</text>
         </act>
        </entryRelationship>
        <!-- End Problem/Diagnosis Comment -->

       </observation>
      </entry>
      <!-- End PROBLEM/DIAGNOSIS -->

      …

     </section>
    </component>
    <!-- End Past and Current Medical History (MEDICAL HISTORY) -->

     …

  </structuredBody>
 </component>
 <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.5.2 PROCEDURE

Identification

Name	Procedure
Metadata Type	Data Group
Identifier	DG-15514

Relationships

Parent

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

CDA R-MIM Representation

Figure 7.21 PROCEDURE shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The PROCEDURE data group is described by a Procedure class related to its containing Section class by an entry. The code attribute of that Procedure class represents Procedure Name, and the effectiveTime attribute represents Procedure DateTime. Procedure Comment is represented by an Act class related to its containing Procedure class by an entryRelationship.
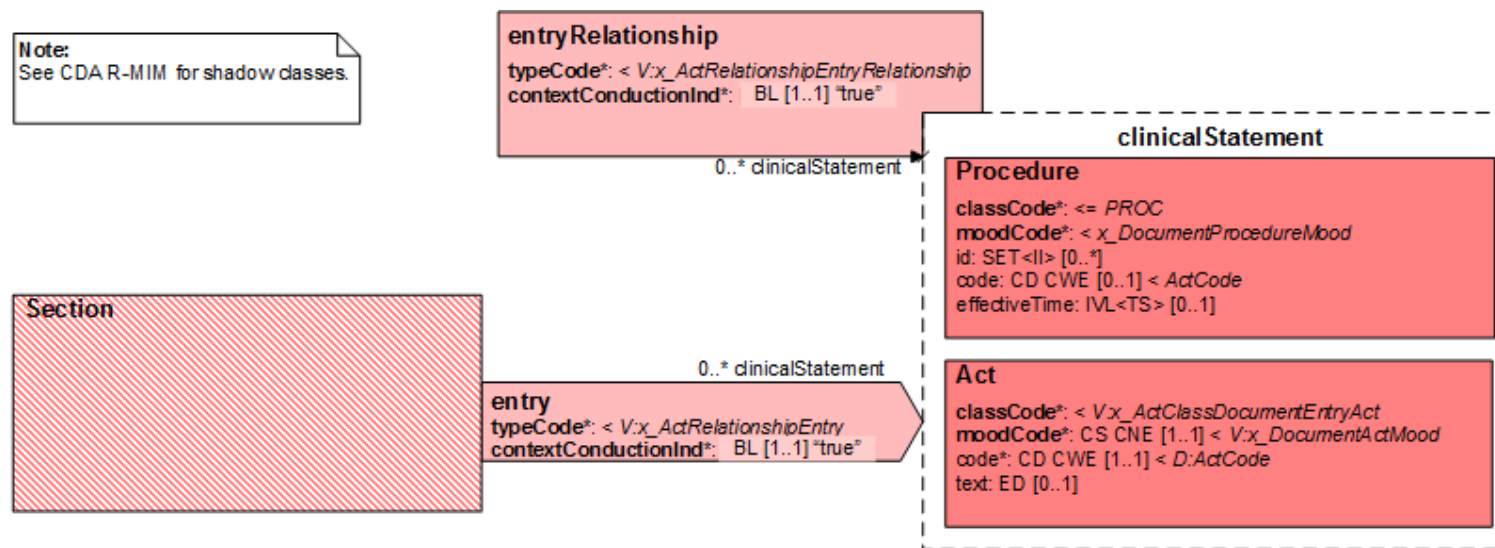
Figure 7.21. PROCEDURE

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[med_hist]/section/		
PROCEDURE	Clinical activity carried out for therapeutic, evaluative, investigative, screening or diagnostic purposes.	0..*	**entry[proc]**		
			entry[proc]/procedure		
			entry[proc]/procedure/**@classCode="PROC"**		
			entry[proc]/procedure/**@moodCode="EVN"**		
PROCEDURE > **Procedure Instance Identifier**	Globally unique identifier for each instance of a Procedure action.	0..1	entry[proc]/procedure/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
PROCEDURE > **Procedure Name**	Name of the procedure (to be) performed.	1..1	entry[proc]/procedure/**code**	SNOMED CT-AU: • 32570141000036105 |*Procedure foundation reference set*|	See <code> for available attributes. code/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".
PROCEDURE > **Procedure Comment**	Additional narrative about the procedure not captured in other fields.	0..1	entry[proc]/procedure/entryRelationship[proc_cmt]/**@typeCode="COMP"**		
			entry[proc]/procedure/entryRelationship[proc_cmt]/**act**		
			entry[proc]/procedure/entryRelationship[proc_cmt]/act/**@classCode="INFRM"**		
			entry[proc]/procedure/entryRelationship[proc_cmt]/act/**@moodCode="EVN"**		
			entry[proc]/procedure/entryRelationship[proc_cmt]/act/**code**		
			entry[proc]/procedure/entryRelationship[proc_cmt]/act/code/**@code="103.15595"**		
			entry[proc]/procedure/entryRelationship[proc_cmt]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[proc]/procedure/entryRelationship[proc_cmt]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[proc]/procedure/entryRelationship[proc_cmt]/act/code/**@displayName="Procedure Comment"**		
			entry[proc]/procedure/entryRelationship[proc_cmt]/act/**text:ST**		
PROCEDURE > **Procedure DateTime**	Date, and optionally time, of the Procedure action.	1..1	entry[proc]/procedure/**effectiveTime**		See <time> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PROCEDURE > **Detailed Clinical Model Identifier**	Globally unique identifier for this detailed clinical model.	1..1	n/a		Not mapped directly, encompassed implicitly by CDA in entry[proc]/procedure.

Example 7.20. PROCEDURE XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin Past and Current Medical History (MEDICAL HISTORY) -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- NOTE: Though no other child component sections are shown the normative constraints on the contents of this component[med_hist]/section are specified in the mapping table. -->
     <!-- Begin PROCEDURE -->
     <entry>
      <procedure classCode="PROC" moodCode="EVN">
       <!-- Procedure Instance Identifier -->
       <id root="e80565a8-aaea-42c3-ba14-b4543b65827a" />

       <!-- Procedure Name -->
       <code code="80146002"
        codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMED CT"
        displayName="Appendicectomy" />

       <!-- Begin Procedure DateTime -->
       <effectiveTime xsi:type="IVL_TS">
        <low value="20130101"/>
        <high value="20130201"/>
       </effectiveTime>
       <!-- End Procedure DateTime -->

       <!-- Begin Procedure Comment -->
       <entryRelationship typeCode="COMP">
        <act classCode="INFRM" moodCode="EVN">
         <code code="103.15595"
          codeSystem="1.2.36.1.2001.1001.101"
          codeSystemName="NCTIS Data Components"
          displayName="Procedure Comment" />
         <text xsi:type="ST">Procedure Comment goes here.</text>
        </act>
       </entryRelationship>
       <!-- End Procedure Comment -->

      </procedure>
     </entry>
     <!-- End PROCEDURE -->
     …
```

```
        </section>
      </component>
      <!-- End Past and Current Medical History (MEDICAL HISTORY) -->
      …

    </structuredBody>
  </component>
  <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.5.3 UNCATEGORISED MEDICAL HISTORY ITEM

Identification

Name	UNCATEGORISED MEDICAL HISTORY ITEM
Metadata Type	Data Group
Identifier	DG-16627

Relationships

Parent

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

CDA R-MIM Representation

Figure 7.22 UNCATEGORISED MEDICAL HISTORY ITEM shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The UNCATEGORISED MEDICAL HISTORY ITEM data group is represented by an Act class related to its containing Section class by an entry relationship. The text attribute of that Act class represents Medical History Item Description, and the effectiveTime attribute represents Medical History Item TimeInterval. Medical History Item Comment is represented by an Act class related to its containing Act (UNCATEGORISED MEDICAL HISTORY ITEM) class by an entryRelationship.
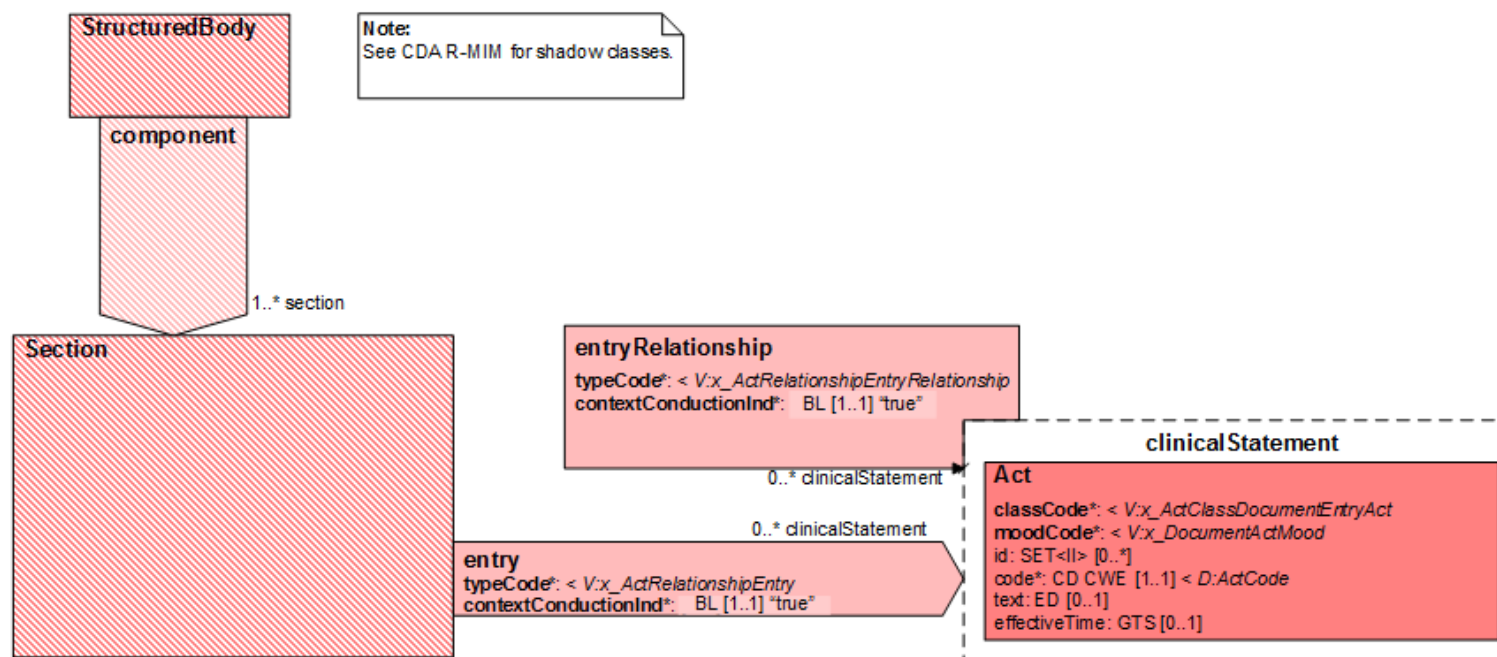
Figure 7.22. UNCATEGORISED MEDICAL HISTORY ITEM

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[med_hist]/section/		
UNCATEGORISED MEDICAL HISTORY ITEM	Medical history entry that has not been categorised as either Procedure or Problem/Diagnosis.	0..*	**entry[med_hist_item]**		
			entry[med_hist_item]/**act**		
			entry[med_hist_item]/act/**@classCode="ACT"**		
			entry[med_hist_item]/act/**@moodCode="EVN"**		
UNCATEGORISED MEDICAL HISTORY ITEM > **Uncategorised Medical History Item Instance Identifier**	Globally unique identifier for each instance of an Uncategorised Medical History Item evaluation.	0..1	entry[med_hist_item]/act/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
UNCATEGORISED MEDICAL HISTORY ITEM > **Detailed Clinical Model Identifier**	Globally unique identifier for this detailed clinical model.	1..1	entry[med_hist_item]/act/**code**		code/@nullFlavor **SHALL NOT** be present.
			entry[med_hist_item]/act/code/**@code="102.16627"**		
			entry[med_hist_item]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[med_hist_item]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[med_hist_item]/act/code/**@displayName="Uncategorised Medical History Item"**		
UNCATEGORISED MEDICAL HISTORY ITEM> **Medical History Item Description**	Full description of the problem, diagnosis or procedure as a medical history item.	1..1	entry[med_hist_item]/act/**text:ST**		text/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".
UNCATEGORISED MEDICAL HISTORY ITEM > **Medical History Item TimeInterval**	Date range during which the problem or diagnosis applied or the procedure occurred.	0..1	entry[med_hist_item]/act/**effectiveTime**		See <time> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
UNCATEGORISED MEDICAL HISTORY ITEM > **Medical History Item Comment**	Additional narrative about the problem, diagnosis or procedure.	0..1	entry[med_hist_item]/act/entryRelationship[cmt]/**@typeCode="COMP"**		
			entry[med_hist_item]/act/entryRelationship[cmt]/**act**		
			entry[med_hist_item]/act/entryRelationship[cmt]/act/**@classCode="INFRM"**		
			entry[med_hist_item]/act/entryRelationship[cmt]/act/**@moodCode="EVN"**		
			entry[med_hist_item]/act/entryRelationship[cmt]/act/**code**		
			entry[med_hist_item]/act/entryRelationship[cmt]/act/code/**@code="103.16630"**		
			entry[med_hist_item]/act/entryRelationship[cmt]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[med_hist_item]/act/entryRelationship[cmt]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[med_hist_item]/act/entryRelationship[cmt]/act/code/**@displayName="Medical History Item Comment"**		
			entry[med_hist_item]/act/entryRelationship[cmt]/act/**text:ST**		

Example 7.21. UNCATEGORISED MEDICAL HISTORY ITEM XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin Past and Current Medical History (MEDICAL HISTORY) -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- NOTE: Though no other child component sections are shown the normative constraints on the contents of this component[med_hist]/section are specified in the mapping table. -->
     <!-- Begin UNCATEGORISED MEDICAL HISTORY ITEM -->
     <entry>
      <act classCode="ACT" moodCode="EVN">
       <!-- Uncategorised Medical History Item Instance Identifier -->
       <id root="0074a727-aa48-4e13-a2e9-106174a850d6" />
       <!-- Detailed Clinical Model Identifier -->
       <code code="102.16627"
        codeSystem="1.2.36.1.2001.1001.101"
        codeSystemName="NCTIS Data Components"
        displayName="Uncategorised Medical History Item" />

       <!-- Medical History Item Description -->
       <text xsi:type="ST">Other Medical History Item Description goes here.</text>

       <!-- Begin Medical History Item Time Interval -->
       <effectiveTime>
        <low value="201010131000+1000" />
        <high value="201010131030+1000" />
       </effectiveTime>
       <!-- End Medical History Item Time Interval -->

       <!-- Begin Medical History Item Comment -->
       <entryRelationship typeCode="COMP">
        <act classCode="INFRM" moodCode="EVN">
         <code code="103.16630"
          codeSystem="1.2.36.1.2001.1001.101"
          codeSystemName="NCTIS Data Components"
          displayName="Medical History Item Comment" />
         <text xsi:type="ST">Medical History Item Comment goes here.</text>
        </act>
       </entryRelationship>
       <!-- End Medical History Item Comment -->

      </act>
     </entry>
```

```
    <!-- End UNCATEGORISED MEDICAL HISTORY ITEM -->
    …

   </section>
  </component>
  <!-- End Past and Current Medical History (MEDICAL HISTORY) -->
   …

 </structuredBody>
 </component>
 <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.6 DIAGNOSTIC INVESTIGATIONS

Identification

Name	DIAGNOSTIC INVESTIGATIONS
Metadata Type	Section
Identifier	S-20117

Relationships

Parent

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

Children

Data Type	Name	Occurrence
	PATHOLOGY TEST RESULT	0..*
	IMAGING EXAMINATION RESULT	0..*
	Pending Diagnostic Investigation (REQUESTED SERVICE)	0..*

CDA R-MIM Representation

Figure 7.23 DIAGNOSTIC INVESTIGATIONS shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The DIAGNOSTIC INVESTIGATIONS section is composed of a Section class related to its context ClinicalDocument.structuredBody by a component.

Figure 7.23. DIAGNOSTIC INVESTIGATIONS

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: /ClinicalDocument/component/structuredBody/		
DIAGNOSTIC INVESTIGATIONS	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.	0..1	component[diag_inv]/**section**		The title **SHALL** be present where narrative (section/text) is present.
			component[diag_inv]/section/**title="Diagnostic Investigations"**		See Appendix A, *CDA Narratives* and the requirements for narrative sections in *Clinical Documents Common Conformance Profile [DH2017o]*.
					Each instance of this component[diag_inv] **SHALL** contain at least one instance of:
					• PATHOLOGY TEST RESULT, or
					• IMAGING EXAMINATION RESULT, or
					• Pending Diagnostic Investigation (REQUESTED SERVICE).
			component[diag_inv]/section/**text**		Required CDA element. See Appendix A, *CDA Narratives*.
DIAGNOSTIC INVESTIGATIONS > **Diagnostic Investigations Instance Identifier**	Globally unique identifier for each instance of a Diagnostic Investigations section.	0..1	component[diag_inv]/section/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
DIAGNOSTIC INVESTIGATIONS > **Section Type**	Type of section.	1..1	component[diag_inv]/section/**code**		code/@nullFlavor **SHALL NOT** be present.
			component[diag_inv]/section/code/**@code="101.20117"**		
			component[diag_inv]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[diag_inv]/section/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			component[diag_inv]/section/code/**@displayName="Diagnostic Investigations"**		
DIAGNOSTIC INVESTIGATIONS > **PATHOLOGY TEST RESULT**	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.	0..*	See: PATHOLOGY TEST RESULT		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
DIAGNOSTIC INVESTIGATIONS > **IMAGING EXAMINATION RESULT**	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.	0..*	See: IMAGING EXAMINATION RESULT		
DIAGNOSTIC INVESTIGATIONS > **Pending Diagnostic Investigation (REQUESTED SER-VICE)**	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.	0..*	See: Pending Diagnostic Investigation (REQUESTED SERVICE)		

Example 7.22. DIAGNOSTIC INVESTIGATIONS XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin DIAGNOSTIC INVESTIGATIONS -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     <!-- Diagnostic Investigations Identifier -->
     <id root="4dcea241-a293-4ae6-baad-27aff8f717ba" />
     <!-- Section Type -->
     <code code="101.20117" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Diagnostic Investigations" />
     <title>Diagnostic Investigations</title>

     <!-- narrative block -->
     <text>
      <paragraph>Dr Jeremy SPECIALIST (Cardiologist)</paragraph>
      <paragraph>Acme Hospital Group, 55 GP Street, Healthville, QLD</paragraph>
      <paragraph>Phone: 07 8888 8888</paragraph>
      <paragraph>CVS:</paragraph>
      <paragraph>Heart sounds: x2</paragraph>
      <paragraph>Murmur: 2/6 Ejection systolic murmur. No Left carotid bruit. No Right carotid bruit.</paragraph>
      <paragraph>Respiratory:</paragraph>
      <paragraph>No respiratory distress. No recession. Not using accessory muscles No wheeze. No creps. No rhonchi.</paragraph>
      <paragraph>Genito-Urinary:</paragraph>
      <paragraph>Urinalysis: Blood, Proten: 0, Glucose: 0, Ketones: 0, Leucocytes: 0, Bilirubin: 0, neg nitrate, neg catalase</paragraph>
      <paragraph>Actions:</paragraph>
      <paragraph>Pathology requested (refer pending list). If TSH is abnormal do TFTs. Bloods done today cc Dr HEART.</paragraph>
      <paragraph>Email written - re Large Atrium, sent to: Ms Pill Popper at pillpopper@lowerboat.com.au-HMR referral</paragraph>
      <paragraph>Letter created - re HMR Referral to Pill Popping Pharmacy</paragraph>
      <paragraph>Letter created - re Medications Argus to pharmacy</paragraph>
     </text>

     <!-- Begin Pending Diagnostic Investigation (REQUESTED SERVICE) -->
     <entry>
      <act>
       …
      </act>
     </entry>
     <!-- End Pending Diagnostic Investigation (REQUESTED SERVICE) -->

     <!-- Begin PATHOLOGY TEST RESULT -->
     <component>
      <section>
       …
      </section>
```

```
    </component>
    <!-- End PATHOLOGY TEST RESULT -->

    <!-- Begin IMAGING EXAMINATION RESULT -->
    <component>
     <section>
      …
     </section>
    </component>
    <!-- End IMAGING EXAMINATION RESULT -->

   </section>
  </component>
  <!-- End DIAGNOSTIC INVESTIGATIONS -->

  …

 </structuredBody>
</component>
<!-- End CDA Body -->
</ClinicalDocument>
```

7.1.6.1 PATHOLOGY TEST RESULT

Identification

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

Relationships

Parent

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

Children

Data Type	Name	Occurrence
	Test Specimen Detail (SPECIMEN)	1..*
	Result Group (PATHOLOGY TEST RESULT GROUP)	0..*

CDA R-MIM Representation

Figure 7.24 PATHOLOGY TEST RESULT shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The PATHOLOGY TEST RESULT data group is represented by a Section class that is related to its containing Section class by a component. Pathology Test Result Name is represented by an Observation class related to the Section (PATHOLOGY TEST RESULT) class by an entry. The id attribute of that Observation class represents Laboratory Test Result Identifier, and the value attribute represents Test Result Representation.

There are four Observation classes related to the containing Observation (Pathology Test Result Name) class by entryRelationships: Diagnostic Service, Overall Pathology Test Result Status, Pathological Diagnosis, and Observation DateTime. Pathology Test Conclusion is represented by a reference Observation class related to the containing Pathology Test Result Observation class by an entryRelationship.

Clinical Information Provided is represented by an Act class that is related to the containing Observation (Pathology Test Result Name) class by an entryRelationship. Test Comment is represented by an Act class that is related to the containing Pathology Test Result Observation class by an entryRelationship.

TEST REQUEST DETAILS is represented by a subject Act class that is related to the containing Observation (Pathology Test Result Name) class by an entryRelationship. Test Requested Name is represented by an Observation class that is related to its containing Act (TEST REQUEST DETAILS) class by an entryRelationship.

entryRelationship

typeCode*: < V:x_ActRelationshipEntryRelationship
inversionInd: BL [1..1]
contextConductionInd*:   BL [1..1] "true"

Clinical Statement

Act

classCode*: < V:x_ActClassDocumentEntryAct
moodCode*: CS CNE [1..1] < V:x_DocumentActMood
code*: CD CWE [1..1] < D:ActCode
text: ED [0..1]

0..* clinical Statement

component

typeCode*: <= COMP
contextConductionInd*: BL [1..1] "true"

0..* section

Section

classCode*: <= DOCSECT
moodCode*: <= EVN
id: II [0..1]
code: CE CWE [0..1] <= DocumentSectionType
title: ST [0..1]
text*: ED [0..1]

0..* clinical Statement

entry

typeCode*: <= x_ActRelationshipEntry
contextConductionInd*: BL [1..1] "true"

Observation

classCode*: <= OBS
moodCode*: <= x_ActMoodDocumentObservation
id: SET<II> [0..*]
code*: CD CWE [1..1] < ObservationType
effectiveTime: IVL<TS> [0..1]
value: ANY CWE [0..1] < ObservationValue

Figure 7.24. PATHOLOGY TEST RESULT

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/		
PATHOLOGY TEST RESULT	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.	0..*	**component[path_test]/section**		The title **SHALL** be present where narrative (section/text) is present.
			component[path_test]/section/**title="Pathology Test Result"**		
			component[path_test]/section/**text**		See Appendix A, *CDA Narratives* and the requirements for narrative sections in *Clinical Documents Common Conformance Profile [DH2017o]*.
PATHOLOGY TEST RESULT > **Pathology Test Result Instance Identifier**	Globally unique identifier for each instance of a Pathology Test Result observation.	0..1	component[path_test]/section/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
PATHOLOGY TEST RESULT > **Detailed Clinical Model Identifier**	Globally unique identifier for this detailed clinical model.	1..1	component[path_test]/section/**code**		code/@nullFlavor **SHALL NOT** be present.
			component[path_test]/section/code/**@code="102.16144"**		
			component[path_test]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[path_test]/section/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			component[path_test]/section/code/**@displayName="Pathology Test Result"**		
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/component[path_test]/section/		
PATHOLOGY TEST RESULT > **Pathology Test Result Name**	Identification of the pathology test performed, sometimes including specimen type.	1..1	**entry[path_test_res]/observation**		
			entry[path_test_res]/observation/**@classCode="OBS"**		
			entry[path_test_res]/observation/**@moodCode="EVN"**		
			entry[path_test_res]/observation/**code:CD**	The code **SHALL** be from the set of codes recommended for pathology terminology by the Royal College of Pathologists of Australasia which are available from the RCPA tab at https://www.healthterminologies.gov.au/ncts/#/access.	When a *Pathology Test Result* record contains only a single individual test, this name may be the same as the name of the individual test. See <code> for available attributes. code/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/component[path_test]/section/entry[path_test_res]/observation/		
PATHOLOGY TEST RESULT > **Diagnostic Service**	Diagnostic service that performs the examination.	0..1	**entryRelationship[diag_serv]/@typeCode="COMP"**		
			entryRelationship[diag_serv]/**observation**		
			entryRelationship[diag_serv]/observation/**@classCode="OBS"**		
			entryRelationship[diag_serv]/observation/**@moodCode="EVN"**		
			entryRelationship[diag_serv]/observation/**code**		
			entryRelationship[diag_serv]/observation/code/**@code="310074003"**		
			entryRelationship[diag_serv]/observation/code/**@codeSystem="2.16.840.1.113883.6.96"**		
			entryRelationship[diag_serv]/observation/code/**@codeSystemName**	The value **SHOULD** be "SNOMED CT". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[diag_serv]/observation/code/**@displayName="Pathology service"**		
			entryRelationship[diag_serv]/observation/**value:CD**	HL7: Diagnostic Service Section ID	See <code> for available attributes.
PATHOLOGY TEST RESULT > **Test Specimen Detail (SPECIMEN)**	Details about specimens to which this test result refers.	1..*	See: Test Specimen Detail (SPECIMEN)		
PATHOLOGY TEST RESULT > **Overall Pathology Test Result Status**	Status of the pathology test result as a whole.	1..1	**entryRelationship[res_stat]/@typeCode="COMP"**		
			entryRelationship[res_stat]/**observation**		
			entryRelationship[res_stat]/observation/**@classCode="OBS"**		
			entryRelationship[res_stat]/observation/**@moodCode="EVN"**		
			entryRelationship[res_stat]/observation/**id**		Optional CDA element. See <id> for available attributes.
			entryRelationship[res_stat]/observation/**code**		
			entryRelationship[res_stat]/observation/code/**@code="308552006"**		
			entryRelationship[res_stat]/observation/code/**@codeSystem="2.16.840.1.113883.6.96"**		
			entryRelationship[res_stat]/observation/code/**@codeSystemName**	The value **SHOULD** be "SNOMED CT". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[res_stat]/observation/code/**@displayName="Report status"**		
			entryRelationship[res_stat]/observation/**value:CD**	NCTIS: Admin Codes - Result Status HL7: Result Status	See <code> for available attributes. value/@nullFlavor **SHALL NOT** be present.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PATHOLOGY TEST RESULT > **Clinical Inform-ation Provided**	Description or summary of relevant, prior clinical inform-ation that may help in determining the test(s) to be per-formed, or interpreting the result when compiling or reading the report.	0..1	**entryRelationship[clin_info_prov]/@typeCode="COMP"**		
			entryRelationship[clin_info_prov]/**act**		
			entryRelationship[clin_info_prov]/act/**@classCode="INFRM"**		
			entryRelationship[clin_info_prov]/act/**@moodCode="EVN"**		
			entryRelationship[clin_info_prov]/act/**code**		
			entryRelationship[clin_info_prov]/act/code/**@code="55752-0"**		
			entryRelationship[clin_info_prov]/act/code/**@codeSystem="2.16.840.1.113883.6.1"**		
			entryRelationship[clin_info_prov]/act/code/**@codeSystemName**	The value **SHOULD** be "LOINC". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[clin_info_prov]/act/code/**@displayName="Clinical information"**		
			entryRelationship[clin_info_prov]/act/**text:ST**		
PATHOLOGY TEST RESULT > **Result Group (PATHOLOGY TEST RESULT GROUP)**	Group of results that form all or part of a recognisable pathology test.	0..*	See: Result Group (PATHOLOGY TEST RESULT GROUP)		
PATHOLOGY TEST RESULT > **Pathological Diagnosis**	Single word, phrase or brief description representing the diagnostic statement as asserted by the reporting patho-logist.	0..*	**entryRelationship[path_diag]/@typeCode="REFR"**		
			entryRelationship[path_diag]/**observation**		
			entryRelationship[path_diag]/observation/**@classCode="OBS"**		
			entryRelationship[path_diag]/observation/**@moodCode="EVN"**		
			entryRelationship[path_diag]/observation/**code**		
			entryRelationship[path_diag]/observation/code/**@code="88101002"**		
			entryRelationship[path_diag]/observation/code/**@codeSystem="2.16.840.1.113883.6.96"**		
			entryRelationship[path_diag]/observation/code/**@codeSystemName**	The value **SHOULD** be "SNOMED CT". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[path_diag]/observation/code/**@displayName="Pathology diagnosis"**		
			entryRelationship[path_diag]/observation/**value:CD[LIST]**	NS	The cardinality (0..*) of this component is represented by a list of value:CD.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PATHOLOGY TEST RESULT > **Conclusion (Pathology Test Conclusion)**	Concise and clinically contextualised narrative interpretation of the pathology test results.	0..1	**entryRelationship[path_conc]/@typeCode="REFR"**		
			entryRelationship[path_conc]/**observation**		
			entryRelationship[path_conc]/observation/**@classCode="OBS"**		
			entryRelationship[path_conc]/observation/**@moodCode="EVN"**		
			entryRelationship[path_conc]/observation/**id**		Optional CDA element. See <id> for available attributes.
			entryRelationship[path_conc]/observation/**code**		
			entryRelationship[path_conc]/observation/code/**@code="386344002"**		
			entryRelationship[path_conc]/observation/code/**@codeSystem="2.16.840.1.113883.6.96"**		
			entryRelationship[path_conc]/observation/code/**@codeSystemName**	The value **SHOULD** be "SNOMED CT". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[path_conc]/observation/code/**@displayName="Laboratory data interpretation"**		
			entryRelationship[path_conc]/observation/**value:ST**		
PATHOLOGY TEST RESULT > **Test Result Representation**	Rich text representation of the entire result as issued by the diagnostic service.	0..1	**value:ED**		
PATHOLOGY TEST RESULT > **Test Comment**	Additional narrative about the test that is not captured in other fields.	0..1	**entryRelationship[tst_cmt]/@typeCode="COMP"**		
			entryRelationship[tst_cmt]/act		
			entryRelationship[tst_cmt]/act/**@classCode="INFRM"**		
			entryRelationship[tst_cmt]/act/**@moodCode="EVN"**		
			entryRelationship[tst_cmt]/act/**code**		
			entryRelationship[tst_cmt]/act/code/**@code="103.16468"**		
			entryRelationship[tst_cmt]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entryRelationship[tst_cmt]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[tst_cmt]/act/code/**@displayName="Test Comment"**		
			entryRelationship[tst_cmt]/act/**text:ST**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PATHOLOGY TEST RESULT > **TEST REQUEST DETAILS**	Details concerning a single requested pathology test.	0..*	**entryRelationship[req_dets]/@typeCode="SUBJ"**		
			entryRelationship[req_dets]/**@inversionInd="true"**		
			entryRelationship[req_dets]/**act**		
			entryRelationship[req_dets]/act/**@classCode="ACT"**		
			entryRelationship[req_dets]/act/**@moodCode="EVN"**		
			entryRelationship[req_dets]/act/**code**		
			entryRelationship[req_dets]/act/code/**@code="102.16160"**		
			entryRelationship[req_dets]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entryRelationship[req_dets]/act/code/**@codeSystemName**	The value **SHOULD** be "NC-TIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[req_dets]/act/code/**@displayName="Test Request Details"**		
PATHOLOGY TEST RESULT > TEST REQUEST DETAILS > **Test Requested Name**	Identification of the pathology test that was requested.	0..*	entryRelationship[req_dets]/act/**entryRelationship[req_name]/@typeCode="COMP"**		This logical data component **SHOULD NOT** be present if its value is equal to the value of the Pathology Test Result Name (entry[path_test_res]/observation/code).
			entryRelationship[req_dets]/act/entryRelationship[req_name]/**observation**		
			entryRelationship[req_dets]/act/entryRelationship[req_name]/observation/**@classCode="OBS"**		
			entryRelationship[req_dets]/act/entryRelationship[req_name]/observation/**@moodCode="RQO"**		
			entryRelationship[req_dets]/act/entryRelationship[req_name]/observation/**code**		
			entryRelationship[req_dets]/act/entryRelationship[req_name]/observation/code/**@code="103.16404"**		
			entryRelationship[req_dets]/act/entryRelationship[req_name]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entryRelationship[req_dets]/act/entryRelationship[req_name]/observation/code/**@codeSystemName**	The value **SHOULD** be "NC-TIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[req_dets]/act/entryRelationship[req_name]/observation/code/**@displayName="Test Requested Name"**		
			entryRelationship[req_dets]/act/entryRelationship[req_name]/observation/**value:CD**	The code **SHALL** be from the set of codes recommended for pathology terminology by the Royal College of Pathologists of Australasia which are available from the RCPA tab at https://www.healthterminologies.gov.au/ncts/#/access.	
PATHOLOGY TEST RESULT > TEST REQUEST DETAILS > **Laboratory Test Result Identifier**	Identifier given to the laboratory test result of a pathology investigation.	0..1	**id**		See <id> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
PATHOLOGY TEST RESULT > **Observation DateTime**	Date, and optionally time, when an observation is clinically significant to the condition of the subject of the observation.	1..1	**entryRelationship[tst_date]/@typeCode="COMP"**		
			entryRelationship[tst_date]/**observation**		
			entryRelationship[tst_date]/observation/**@classCode="OBS"**		
			entryRelationship[tst_date]/observation/**@moodCode="EVN"**		
			entryRelationship[tst_date]/observation/**id**		Optional CDA element. See <id> for available attributes.
			entryRelationship[tst_date]/observation/**code**		Observation DateTime is mapped to Pathology Test Result DateTime and retains the original OID and displayName of that concept for backwards compatibility.
			entryRelationship[tst_date]/observation/code/**@code="103.16605"**		
			entryRelationship[tst_date]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entryRelationship[tst_date]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs. Optional CDA element.	
			entryRelationship[tst_date]/observation/code/**@displayName="Pathology Test Result DateTime"**		
			entryRelationship[tst_date]/observation/**effectiveTime**		See <time> for available attributes.

Example 7.23. PATHOLOGY TEST RESULT XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
    …

   <!-- Begin DIAGNOSTIC INVESTIGATIONS -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
      …

     <!-- Begin PATHOLOGY TEST RESULT -->
     <component>
      <section classCode="DOCSECT" moodCode="EVN">
       <!-- Pathology Test Result Instance Identifier - used for system purposes such as matching -->
       <id root="28bfe97f-ee93-47ef-8471-357c19acbdb1" />
       <!-- Detailed Clinical Model Identifier -->
       <code code="102.16144" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components"
        displayName="Pathology Test Result" />
       <title>Pathology Test Result</title>

       <!-- narrative block -->
       <text>
       <table>
        <thead>
         <tr>
          <th>Test</th>
          <th>Value</th>
          <th>Units</th>
          <th>Reference Range</th>
          <th>Interpretation</th>
          <th>DateTime</th>
         </tr>
        </thead>
        <tbody>
         <tr>
          <td>Serum Creatinine</td>
          <td>0.06</td>
          <td>mmol/L</td>
          <td>0.04-0.11</td>
          <td>N</td>
          <td>12/02/2013</td>
         </tr>
         <tr>
          <td>Serum Uric Acid</td>
          <td>0.41</td>
          <td>mmol/L</td>
```
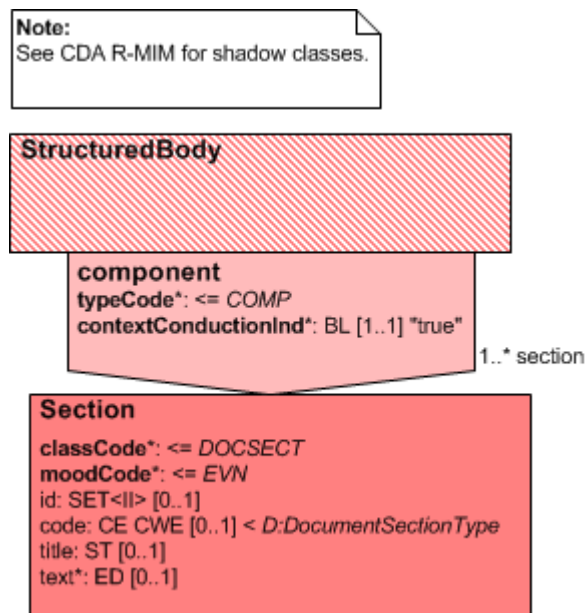
```xml
    <td>0.14-0.35</td>
    <td>HH</td>
    <td>12/02/2013</td>
   </tr>
  </tbody>
 </table>
 <paragraph>
  <linkHtml href="pathresult.pdf">downloadable PDF version</linkHtml>
 </paragraph>
</text>

<entry>
 <observation classCode="OBS" moodCode="EVN">
  <!-- Laboratory Test Result Identifier -->
  <id root="96c1acdf-0110-4522-b13b-10839c96de44" />

  <!-- Test Result Name (Pathology Test Result Name) -->
  <code code="275711006" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Serum chemistry test" xsi:type="CD" />

  <!-- Test Result Representation -->
  <value mediaType="application/pdf" xsi:type="ED">
   <reference value="pathresult.pdf" />
  </value>

  <!-- Begin Diagnostic Service -->
  <entryRelationship typeCode="COMP">
   <observation classCode="OBS" moodCode="EVN">
    <code code="310074003" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Pathology service" />
    <value code="CH" codeSystem="2.16.840.1.113883.12.74" codeSystemName="HL7 Diagnostic service section ID" displayName="Chemistry" xsi:type="CD" />
   </observation>
  </entryRelationship>
  <!-- End Diagnostic Service -->

  <!-- Begin Test Specimen Detail (SPECIMEN) -->
  <entryRelationship typeCode="SUBJ">
   <observation classCode="OBS" moodCode="EVN">

    …

   </observation>
  </entryRelationship>
  <!-- End Test Specimen Detail (SPECIMEN) -->

  <!-- Begin Overall Pathology Test Result Status -->
  <entryRelationship typeCode="COMP">
   <observation classCode="OBS" moodCode="EVN">
    <!-- id is used for system purposes such as matching -->
    <id root="1009aed3-e6a8-41a6-85b3-b7f433decba3" />
    <code code="308552006" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
     displayName="Report status" />
    <value code="3" codeSystem="1.2.36.1.2001.1001.101.104.16501"
     codeSystemName="NCTIS Result Status Values" displayName="Final" xsi:type="CD" />
   </observation>
  </entryRelationship>
  <!-- End Overall Pathology Test Result Status -->

  <!-- Begin Clinical Information Provided -->
  <entryRelationship typeCode="COMP">
   <act classCode="INFRM" moodCode="EVN">
    <code code="55752-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
     displayName="Clinical information" />
    <text>Bloods for evaluation.</text>
   </act>
  </entryRelationship>
```

```xml
<!-- End Clinical Information Provided -->

<!-- Begin Result Group (PATHOLOGY TEST RESULT GROUP) -->
<entryRelationship typeCode="COMP">
 <organizer classCode="BATTERY" moodCode="EVN">
   …

 </organizer>
</entryRelationship>
<!-- End Result Group (PATHOLOGY TEST RESULT GROUP) -->

<!-- Begin Pathological Diagnosis -->
<entryRelationship typeCode="REFR">
 <observation classCode="OBS" moodCode="EVN">
  <code code="88101002" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
   displayName="Pathology diagnosis" />
  <value code="301011002" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
   displayName="Escherichia coli urinary tract infection" xsi:type="CD" />
  <value code="197940006" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
   displayName="Microscopic haematuria" xsi:type="CD" />
 </observation>
</entryRelationship>
<!-- End Pathological Diagnosis -->

<!-- Begin Pathology Test Conclusion -->
<entryRelationship typeCode="REFR">
 <observation classCode="OBS" moodCode="EVN">
  <id root="a2f31c72-d35a-4555-9a77-351dbca72ef0" />
  <code code="386344002" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
   displayName="Laboratory data interpretation" />
  <value xsi:type="ST">Chronic problems.</value>
 </observation>
</entryRelationship>
<!-- End Pathology Test Conclusion -->

<!-- Begin Test Comment -->
<entryRelationship typeCode="COMP">
 <act classCode="INFRM" moodCode="EVN">
  <code code="103.16468" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components"
   displayName="Test Comment" />
  <text>Known PKD</text>
 </act>
</entryRelationship>
<!-- End Test Comment -->

<!-- Begin TEST REQUEST DETAILS -->
<entryRelationship inversionInd="true" typeCode="SUBJ">
 <act classCode="ACT" moodCode="EVN">
  <code code="102.16160" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components"
   displayName="Test Request Details" />

  <!-- Begin Test Requested Name -->
  <entryRelationship typeCode="COMP">
   <observation classCode="OBS" moodCode="RQO">
    <code code="103.16404" codeSystem="1.2.36.1.2001.1001.101"
     codeSystemName="NCTIS Data Components" displayName="Test Requested Name" />
    <value code="401324008" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
     displayName="Urinary microscopy, culture and sensitivities" xsi:type="CD" />
   </observation>
  </entryRelationship>
  <!-- End Test Requested Name -->

 </act>
```

```
          </entryRelationship>
          <!-- End Test TEST REQUEST DETAILS -->

          <!-- Begin Observation DateTime -->
          <entryRelationship typeCode="COMP">
           <observation classCode="OBS" moodCode="EVN">
            <!-- id is used for system purposes such as matching -->
            <id root="1a2f3f27-e812-4bf4-a922-3049adfe8d9e" />
            <code code="103.16605" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components"
             displayName="Pathology Test Result DateTime" />
            <effectiveTime value="201310201235+1000" />
           </observation>
          </entryRelationship>
          <!-- End Observation DateTime -->

         </observation>
        </entry>
       </section>
      </component>
      <!-- End PATHOLOGY TEST RESULT -->
      …

     </section>
    </component>
    <!-- End DIAGNOSTIC INVESTIGATIONS -->
    …

   </structuredBody>
  </component>
  <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.6.1.1 Test Specimen Detail (SPECIMEN)

Identification

Name	Test Specimen Detail (SPECIMEN)
Metadata Type	Data Group
Identifier	DG-16156

Relationships

Parent

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

CDA R-MIM Representation

Figure 7.25 Test Specimen Detail (SPECIMEN) shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The Test Specimen Detail (SPECIMEN) data group is represented by an Observation class that is related to its containing Observation (Pathology Test Result) class by an entryRelationship. The methodCode attribute of that Observation (SPECIMEN) class represents Collection Procedure, the effectiveTime attribute represents Collection DateTime, and targetSiteCode represents the ANATOMICAL LOCATION data elements.

Specimen Identifier is represented by the id attribute of a specimenRole which is related to its containing Observation (SPECIMEN) class by a specimen participation. PHYSICAL PROPERTIES OF AN OBJECT is represented by a specimenPlayingEntity of the containing specimenRole. The code attribute of that specimenPlayingEntity represents Specimen Tissue Type, the quantity attribute represents Weight or Volume, and the desc attribute represents Object Description. Container Identifier is represented by the Container Australian Digital Health Agency CDA extension.

Anatomical Location Image and Image are both represented by a supporting ObservationMedia class related to the containing Observation (SPECIMEN) class by an entryRelationship.

There are four component Observation classes related to the containing Observation (SPECIMEN) class by entryRelationships: Sampling Preconditions, Collection Setting, DateTime Received, and Parent Specimen Identifier.

Figure 7.25. Test Specimen Detail (SPECIMEN)

CDA Mapping

Note

NS = 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.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/component[path_test]/section/entry[path_test_res]/observation/		
Test Specimen Detail (SPECIMEN)	Details about specimens to which this test result refers.	1..*	**entryRelationship[specimen]/@typeCode="SUBJ"**		
			entryRelationship[specimen]/**observation**		
			entryRelationship[specimen]/observation/**@classCode="OBS"**		
			entryRelationship[specimen]/observation/**@moodCode="EVN"**		
			entryRelationship[specimen]/observation/**code**		
			entryRelationship[specimen]/observation/code/**@code="102.16156.231.1.1"**		
			entryRelationship[specimen]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entryRelationship[specimen]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[specimen]/observation/code/**@displayName="Specimen"**		
Test Specimen Detail (SPECIMEN) > **Specimen Tissue Type**	Type of specimen to be collected.	0..1	entryRelationship[specimen]/observation/specimen/specimenRole/specimenPlayingEntity/**code**	NS	See <code> for available attributes.
Test Specimen Detail (SPECIMEN) > **Collection Procedure**	Method of collection to be used.	0..1	entryRelationship[specimen]/observation/**methodCode**	NS	See <code> for available attributes.
Test Specimen Detail (SPECIMEN) > **Anatomical Site (ANATOMICAL LOCATION)**	Details about the anatomical locations to which this examination result refers.	0..*	n/a	Each instance of this logical data component **SHALL** contain either one instance of SPECIFIC LOCATION or one instance of Anatomical Location Description.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.

---

[9] http://www.hl7.org/oid/index.cfm?ref=footer

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Test Specimen Detail (SPECIMEN) > Anatomical Site (ANATOMICAL LOCATION) > **SPECIFIC LOCATION**	Specific and identified anatomical location.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
Test Specimen Detail (SPECIMEN) > Anatomical Site (ANATOMICAL LOCATION) > SPECIFIC LOCATION > **Anatomical Location Name**	Name of the anatomical location.	0..1	entryRelationship[specimen]/observation/**targetSiteCode**	SNOMED CT-AU: • 32570061000036105 |*Body structure foundation reference set*|	See <code> for available attributes.
Test Specimen Detail (SPECIMEN) > Anatomical Site (ANATOMICAL LOCATION) > SPECIFIC LOCATION > **Side**	Laterality of the anatomical location.	0..1	entryRelationship[specimen]/observation/targetSiteCode/**qualifier**		
			entryRelationship[specimen]/observation/targetSiteCode/qualifier/**name**		
			entryRelationship[specimen]/observation/targetSiteCode/qualifier/name/**@code="272741003"**		
			entryRelationship[specimen]/observation/targetSiteCode/qualifier/name/**@codeSystem="2.16.840.1.113883.6.96"**		
			entryRelationship[specimen]/observation/targetSiteCode/qualifier/name/**@codeSystemName**	The value **SHOULD** be "SNOMED CT". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[specimen]/observation/targetSiteCode/qualifier/name/**@displayName="Laterality"**		
			entryRelationship[specimen]/observation/targetSiteCode/qualifier/**value:CD**	SNOMED CT-AU: • 32570611000036103 |*Laterality reference set*|	See <code> for available attributes. value/@nullFlavor **SHALL NOT** be present.
Test Specimen Detail (SPECIMEN) > Anatomical Site (ANATOMICAL LOCATION) > **Anatomical Location Description**	Description of the anatomical location.	0..1	entryRelationship[specimen]/observation/targetSiteCode/**originalText**		Anatomical Location Description is an instance of targetSiteCode with only an originalText element.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Test Specimen Detail (SPECIMEN) > Anatomical Site (ANATOMICAL LOCATION) > **Anatomical Location Image**	Image used to identify a location.	0..*	entryRelationship[specimen]/observation/**entryRelationship[ana_im]/@typeCode="SPRT"**		The image may or may not be attested to and is therefore mapped to observationMedia.
			entryRelationship[specimen]/observation/entryRelationship[ana_im]/**observationMedia**		
			entryRelationship[specimen]/observation/entryRelationship[ana_im]/observationMedia/**@classCode="OBS"**		
			entryRelationship[specimen]/observation/entryRelationship[ana_im]/observationMedia/**@moodCode="EVN"**		
			entryRelationship[specimen]/observation/entryRelationship[ana_im]/observationMedia/**id**		Optional CDA element. See <id> for available attributes.
			entryRelationship[specimen]/observation/entryRelationship[ana_im]/observationMedia/**value**		
Test Specimen Detail (SPECIMEN) > **Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)**	Record of physical details, such as weight and dimensions, of a body part, device, lesion or specimen.	0..*	entryRelationship[specimen]/observation/**specimen/specimenRole/specimenPlayingEntity**		
Test Specimen Detail (SPECIMEN) > Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) > **Weight**	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.	0..1	entryRelationship[specimen]/observation/specimen/specimenRole/specimenPlayingEntity/**quantity:PQ**		Either Weight or Volume **SHALL** be present. Weight and Volume **SHALL** be mutually exclusive.
Test Specimen Detail (SPECIMEN) > Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) > **DIMENSIONS**	Dimensions of the object.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
Test Specimen Detail (SPECIMEN) > Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) > DIMENSIONS > **Volume**	Size, measure or amount of anything in three dimensions; space occupied by a body or substance measured in cubic units.	0..1	entryRelationship[specimen]/observation/specimen/specimenRole/specimenPlayingEntity/**quantity:PQ**		Either Weight or Volume **SHALL** be present. Weight and Volume **SHALL** be mutually exclusive.
Test Specimen Detail (SPECIMEN) > Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) > **Description (Object Description)**	Description of other physical characteristics of the object.	0..1	entryRelationship[specimen]/observation/specimen/specimenRole/specimenPlayingEntity/**desc:ST**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Test Specimen Detail (SPECIMEN) > Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) > **Image**	Picture of the object.	0..1	entryRelationship[specimen]/observation/**entryRelationship[spec_im]/@typeCode="SPRT"**		The image may or may not be attested to and is therefore mapped to observationMedia.
			entryRelationship[specimen]/observation/entryRelationship[spec_im]/**observationMedia**		
			entryRelationship[specimen]/observation/entryRelationship[spec_im]/observationMedia/**@classCode="OBS"**		
			entryRelationship[specimen]/observation/entryRelationship[spec_im]/observationMedia/**@moodCode="EVN"**		
			entryRelationship[specimen]/observation/entryRelationship[spec_im]/observationMedia/**id**		Optional CDA element. See <id> for available attributes.
			entryRelationship[specimen]/observation/entryRelationship[spec_im]/observationMedia/**value**		
Test Specimen Detail (SPECIMEN) > **COLLECTION AND HANDLING**	Collection and handling requirements.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
Test Specimen Detail (SPECIMEN) > COLLECTION AND HANDLING > **Sampling Preconditions**	Conditions to be met before the sample should be taken.	0..1	entryRelationship[specimen]/observation/**entryRelationship[smp_pre]/@typeCode="COMP"**		
			entryRelationship[specimen]/observation/entryRelationship[smp_pre]/**observation**		
			entryRelationship[specimen]/observation/entryRelationship[smp_pre]/observation/**@classCode="OBS"**		
			entryRelationship[specimen]/observation/entryRelationship[smp_pre]/observation/**@moodCode="EVN"**		
			entryRelationship[specimen]/observation/entryRelationship[smp_pre]/observation/**code**		
			entryRelationship[specimen]/observation/entryRelationship[smp_pre]/observation/code/**@code="103.16171"**		
			entryRelationship[specimen]/observation/entryRelationship[smp_pre]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entryRelationship[specimen]/observation/entryRelationship[smp_pre]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[specimen]/observation/entryRelationship[smp_pre]/observation/code/**@displayName="Sampling Preconditions"**		
			entryRelationship[specimen]/observation/entryRelationship[smp_pre]/observation/**value:CD**	NS	See <code> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Test Specimen Detail (SPECIMEN) > **HAND-LING AND PROCESSING**	Workflow of specimen processing or handling.	1..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
Test Specimen Detail (SPECIMEN) > HAND-LING AND PROCESSING > **Collection Date-Time**	Date, and optionally time, of collection.	1..1	entryRelationship[specimen]/observation/**effectiveTime**		See <time> for available attributes.
Test Specimen Detail (SPECIMEN) > HAND-LING AND PROCESSING > **Collection Setting**	Identification of the setting at which the specimen was collected from a subject of care.	0..1	entryRelationship[specimen]/observation/**entryRelationship[coll_set]/@typeCode="COMP"**		
			entryRelationship[specimen]/observation/entryRelationship[coll_set]/**observation**		
			entryRelationship[specimen]/observation/entryRelationship[coll_set]/observation/**@classCode="OBS"**		
			entryRelationship[specimen]/observation/entryRelationship[coll_set]/observation/**@moodCode="EVN"**		
			entryRelationship[specimen]/observation/entryRelationship[coll_set]/observation/**code**		
			entryRelationship[specimen]/observation/entryRelationship[coll_set]/observation/code/**@code="103.16529"**		
			entryRelationship[specimen]/observation/entryRelationship[coll_set]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entryRelationship[specimen]/observation/entryRelationship[coll_set]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[specimen]/observation/entryRelationship[coll_set]/observation/code/**@displayName="Collection Setting"**		
			entryRelationship[specimen]/observation/entryRelationship[coll_set]/observation/**value:ST**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Test Specimen Detail (SPECIMEN) > HANDLING AND PROCESSING > **Date and Time of Receipt (DateTime Received)**	Date and time that the sample was received at the laboratory.	0..1	entryRelationship[specimen]/observation/entryRelationship[date_rec]/**@typeCode="COMP"**		
			entryRelationship[specimen]/observation/entryRelationship[date_rec]/**observation**		
			entryRelationship[specimen]/observation/entryRelationship[date_rec]/observation/**@classCode="OBS"**		
			entryRelationship[specimen]/observation/entryRelationship[date_rec]/observation/**@moodCode="EVN"**		
			entryRelationship[specimen]/observation/entryRelationship[date_rec]/observation/**code**		
			entryRelationship[specimen]/observation/entryRelationship[date_rec]/observation/code/**@code="103.11014"**		
			entryRelationship[specimen]/observation/entryRelationship[date_rec]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entryRelationship[specimen]/observation/entryRelationship[date_rec]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[specimen]/observation/entryRelationship[date_rec]/observation/code/**@displayName="DateTime Received"**		
			entryRelationship[specimen]/observation/entryRelationship[date_rec]/observation/**value:TS**		See <time> for available attributes.
Test Specimen Detail (SPECIMEN) > **IDENTIFIERS**	Sample identifications.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
Test Specimen Detail (SPECIMEN) > IDENTIFIERS > **Specimen Identifier**	Unique identifier of the specimen, normally assigned by the laboratory.	0..1	entryRelationship[specimen]/observation/specimen/specimenRole/**id**		See <id> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Test Specimen Detail (SPECIMEN) > IDENTI-FIERS > **Parent Specimen Identifier**	Unique identifier of the parent specimen where the specimen is split into sub-samples.	0..1	entryRelationship[specimen]/observation/entryRelationship[prnt_id]/**@typeCode="COMP"**		
			entryRelationship[specimen]/observation/entryRelationship[prnt_id]/**observation**		
			entryRelationship[specimen]/observation/entryRelationship[prnt_id]/observation/**@classCode="OBS"**		
			entryRelationship[specimen]/observation/entryRelationship[prnt_id]/observation/**@moodCode="EVN"**		
			entryRelationship[specimen]/observation/entryRelationship[prnt_id]/observation/**code**		
			entryRelationship[specimen]/observation/entryRelationship[prnt_id]/observation/code/**@code="103.16187"**		
			entryRelationship[specimen]/observation/entryRelationship[prnt_id]/observation/code/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			entryRelationship[specimen]/observation/entryRelationship[prnt_id]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Compon-ents". See CodeSystem OIDs.	Optional CDA ele-ment.
			entryRelationship[specimen]/observation/entryRelationship[prnt_id]/observation/code/**@displayName="Parent Specimen Identifier"**		
			entryRelationship[specimen]/observation/entryRelationship[prnt_id]/observation/**specimen/specimenRole/id**		See <id> for available attributes.
Test Specimen Detail (SPECIMEN) > IDENTI-FIERS > **Container Identifier**	Unique identifier given to the container in which the specimen is transported or processed.	0..1	entryRelationship[specimen]/observation/specimen/specimenRole/ specimenPlayingEntity/**ext:asSpecimenInContainer**		See Australian Digital Health Agency CDA extension: Container
			entryRelationship[specimen]/observation/specimen/specimenRole/specimenPlayingEntity/ ext:asSpecimenInContainer/**@classCode="CONT"**		
			entryRelationship[specimen]/observation/specimen/specimenRole/specimenPlayingEntity/ ext:asSpecimenInContainer/**ext:container**		
			entryRelationship[specimen]/observation/specimen/specimenRole/specimenPlayingEntity/ ext:asSpecimenInContainer/ext:container/**ext:id**		See <id> for available attributes.

Example 7.24. Test Specimen Detail (SPECIMEN) XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin DIAGNOSTIC INVESTIGATIONS -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin PATHOLOGY TEST RESULT -->
     <component>
      <section classCode="DOCSECT" moodCode="EVN">
       …
       <!-- narrative block -->
       <text>
        <renderMultiMedia referencedObject="IMG01"></renderMultiMedia>
        <renderMultiMedia referencedObject="SPEC01"></renderMultiMedia>
       </text>

       <entry>
        <observation classCode="OBS" moodCode="EVN">
         …

         <!-- Begin Test Specimen Detail (SPECIMEN) -->
         <entryRelationship typeCode="SUBJ">
          <observation classCode="OBS" moodCode="EVN">
           <!-- id is used for system purposes such as matching -->
           <id root="13bfe35a-133b-4410-8a0d-9390bfc0b93c" />
           <code code="102.16156.231.1.1" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Specimen" />
           <!-- Collection DateTime -->
           <effectiveTime value="201310201235+1000" />

           <!-- Collection Procedure -->
           <methodCode code="48635004" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
            displayName="Fine needle biopsy" />

           <!-- Anatomical Site (ANATOMICAL LOCATION) :: Examples provided of all three allowed variants. These variants are mutually exclusive -->
           <!-- Begin Example with complete SPECIFIC LOCATION -->
           <!-- Name of Location (Anatomical Location Name) -->
           <targetSiteCode code="51185008" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Thoracic structure">

            <!-- Begin Side -->
            <qualifier>
             <name code="272741003" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Laterality" />
             <value code="7771000" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Left" xsi:type="CD" />
```

```xml
  </qualifier>
  <!-- End Side -->

</targetSiteCode>
<!-- End Example with complete SPECIFIC LOCATION -->

<!-- Begin Example with partial SPECIFIC LOCATION -->
<!-- Name of Location (Anatomical Location Name) -->
<targetSiteCode code="51185008" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Thoracic structure" />
<!-- End Example with partial SPECIFIC LOCATION -->

<!-- Begin Example with Description -->
<targetSiteCode>
 <!-- Description (Anatomical Location Description) -->
 <originalText>Chest/Thoracic structure</originalText>
</targetSiteCode>
<!-- End Example with Description -->

<!-- Begin Physical Details -->
<specimen>
 <specimenRole>
  <!-- Specimen Identifier -->
  <id root="1538103e-845b-4f86-95ed-33b62e7589d0" />

  <!-- Begin Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) -->
  <specimenPlayingEntity>
   <!-- Specimen Tissue Type -->
   <code code="258442002" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Fluid sample" />

   <!-- Begin Weight/Volume -->
   <quantity unit="mL" value="5" />
   <!-- End Weight/Volume -->

   <!-- Begin Description (Object Description) -->
   <desc xsi:type="ST">5 mL</desc>
   <!-- End Description (Object Description) -->

   <!-- Begin Container Identifier -->
   <ext:asSpecimenInContainer classCode="CONT">
    <ext:container>
     <ext:id extension="CNH45218964" root="48cdb501-66c4-452b-b30f-b6bf3f02aa5e" />
    </ext:container>
   </ext:asSpecimenInContainer>
   <!-- End Container Identifier -->

  </specimenPlayingEntity>
  <!-- End Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) -->
 </specimenRole>
</specimen>
<!-- End Physical Details -->

<!-- Begin Anatomical Location Image -->
<entryRelationship typeCode="SPRT">
 <observationMedia ID="IMG01" classCode="OBS" moodCode="EVN">
  <id root="4d80d1a1-9dbd-479c-a5b2-06db1e502934" />
  <value mediaType="image/jpeg" >
   <reference value="location.jpeg" />
  </value>
 </observationMedia>
</entryRelationship>
<!-- End Anatomical Location Image -->

<!-- Begin Image -->
```

```xml
<entryRelationship typeCode="SPRT">
 <observationMedia ID="SPEC01" classCode="OBS" moodCode="EVN">
  <id root="1d64bb51-c5b3-4048-9a9f-e753f4e3c203" />
  <value mediaType="image/jpeg" >
   <reference value="specimen.jpeg" />
  </value>
 </observationMedia>
</entryRelationship>
<!-- End Image -->

<!-- Begin Sampling Preconditions -->
<entryRelationship typeCode="COMP">
 <observation classCode="OBS" moodCode="EVN">
  <code code="103.16171" codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components" displayName="Sampling Preconditions" />
  <value code="16985007" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
   displayName="Fasting" xsi:type="CD" />
 </observation>
</entryRelationship>
<!-- End Sampling Preconditions -->

<!-- Begin Collection Setting -->
<entryRelationship typeCode="COMP">
 <observation classCode="OBS" moodCode="EVN">
  <code code="103.16529" codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components" displayName="Collection Setting" />
  <value xsi:type="ST">Pathology Clinic</value>
 </observation>
</entryRelationship>
<!-- End Collection Setting -->

<!-- Begin Date and Time of Receipt (DateTime Received) -->
<entryRelationship typeCode="COMP">
 <observation classCode="OBS" moodCode="EVN">
  <code code="103.11014" codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components" displayName="DateTime Received" />
  <value value="201112141120+1000" xsi:type="TS" />
 </observation>
</entryRelationship>
<!-- End Date and Time of Receipt (DateTime Received) -->

<!-- Begin Parent Specimen Identifier -->
<entryRelationship typeCode="COMP">
 <observation classCode="OBS" moodCode="EVN">
  <code code="103.16187" codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components" displayName="Parent Specimen Identifier" />
  <specimen>
   <specimenRole>
    <id root="7013b12a-f9d0-4197-9726-88a6803d4d13" />
   </specimenRole>
  </specimen>
 </observation>
</entryRelationship>
<!-- End Parent Specimen Identifier -->

</observation>
</entryRelationship>
<!-- End Test Specimen Detail (SPECIMEN) -->
…

<!-- Begin Result Group (PATHOLOGY TEST RESULT GROUP) -->
<entryRelationship typeCode="COMP">
 <organizer classCode="BATTERY" moodCode="EVN">
```
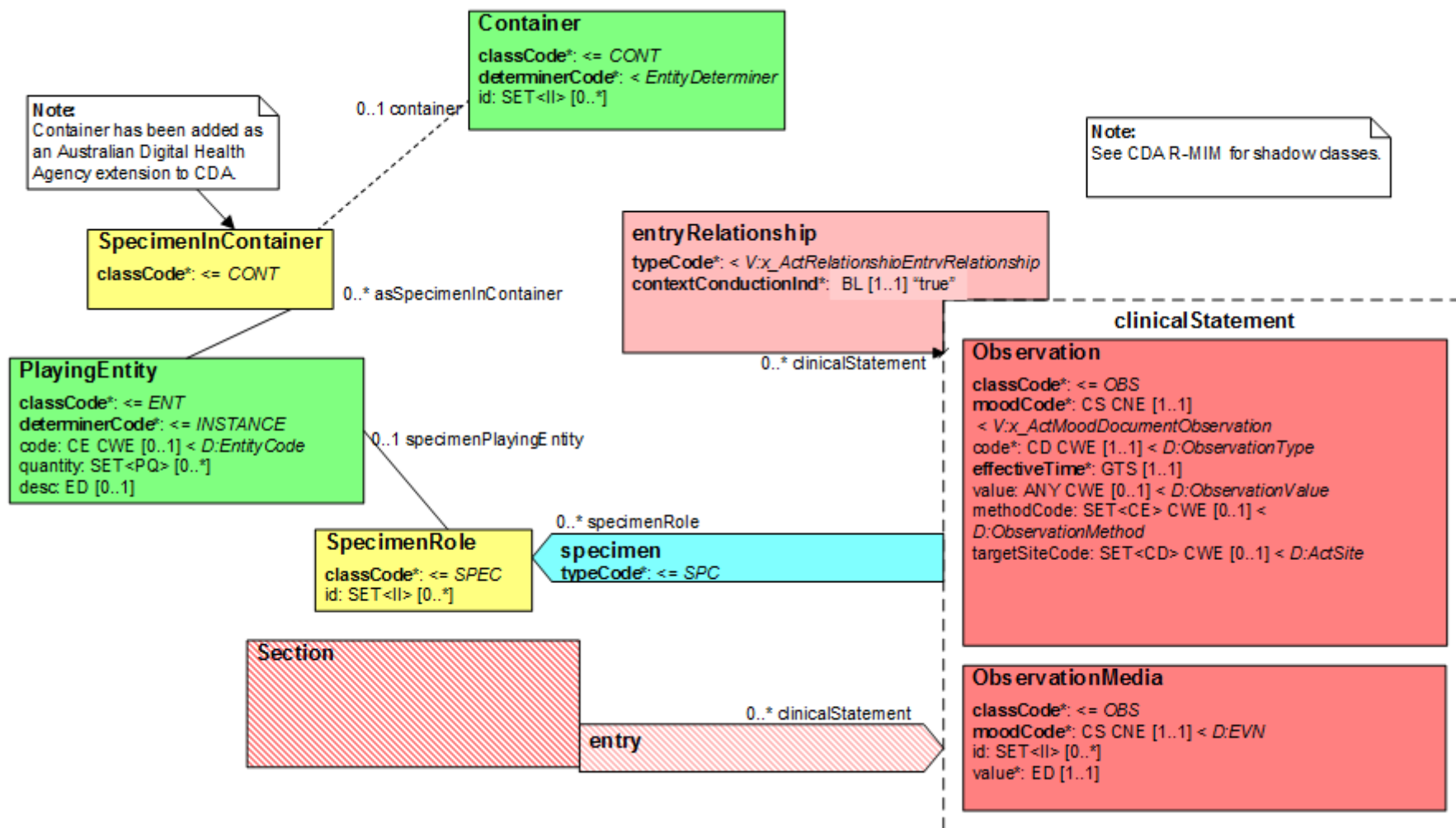
```
          …
        </organizer>
      </entryRelationship>
      <!-- End Result Group (PATHOLOGY TEST RESULT GROUP) -->
        …

      <!-- Begin TEST REQUEST DETAILS -->
      <entryRelationship inversionInd="true" typeCode="SUBJ">
       <act classCode="ACT" moodCode="EVN">
         …

       </act>
      </entryRelationship>
      <!-- End Test TEST REQUEST DETAILS -->
        …

      </observation>
     </entry>
    </section>
   </component>
   <!-- End PATHOLOGY TEST RESULT -->
     …

   </section>
  </component>
  <!-- End DIAGNOSTIC INVESTIGATIONS -->
   …

  </structuredBody>
 </component>
 <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.6.1.2 Result Group (PATHOLOGY TEST RESULT GROUP)

Identification

Name	Result Group (PATHOLOGY TEST RESULT GROUP)
Metadata Type	Data Group
Identifier	DG-16469

Relationships

Parent

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

Children

Data Type	Name	Occurrence
	Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS)	0..1
	Result Group Specimen Detail (SPECIMEN)	0..1

CDA R-MIM Representation

Figure 7.26 Result Group (PATHOLOGY TEST RESULT GROUP) shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

Result Group (PATHOLOGY TEST RESULT GROUP) is represented by an Organizer class related to its containing Observation class by an entryRelationship. The code attribute of that Organizer class represents Pathology Test Result Group Name.

Each INDIVIDUAL PATHOLOGY TEST RESULT data group is represented by an Observation class related to the containing Organizer class by a component. The code attribute of that Observation (INDIVIDUAL PATHOLOGY TEST RESULT) class represents Individual Pathology Test Result Name and the value attribute represents Individual Pathology Test Result Value.

There are two Act classes related to the containing Observation (INDIVIDUAL PATHOLOGY TEST RESULT) class by an entryRelationship: Individual Pathology Test Result Comment and Individual Pathology Test Result Reference Range Guidance. Individual Pathology Test Result Status is represented by an Observation class related to the containing Observation (INDIVIDUAL PATHOLOGY TEST RESULT) class by an entryRelationship.
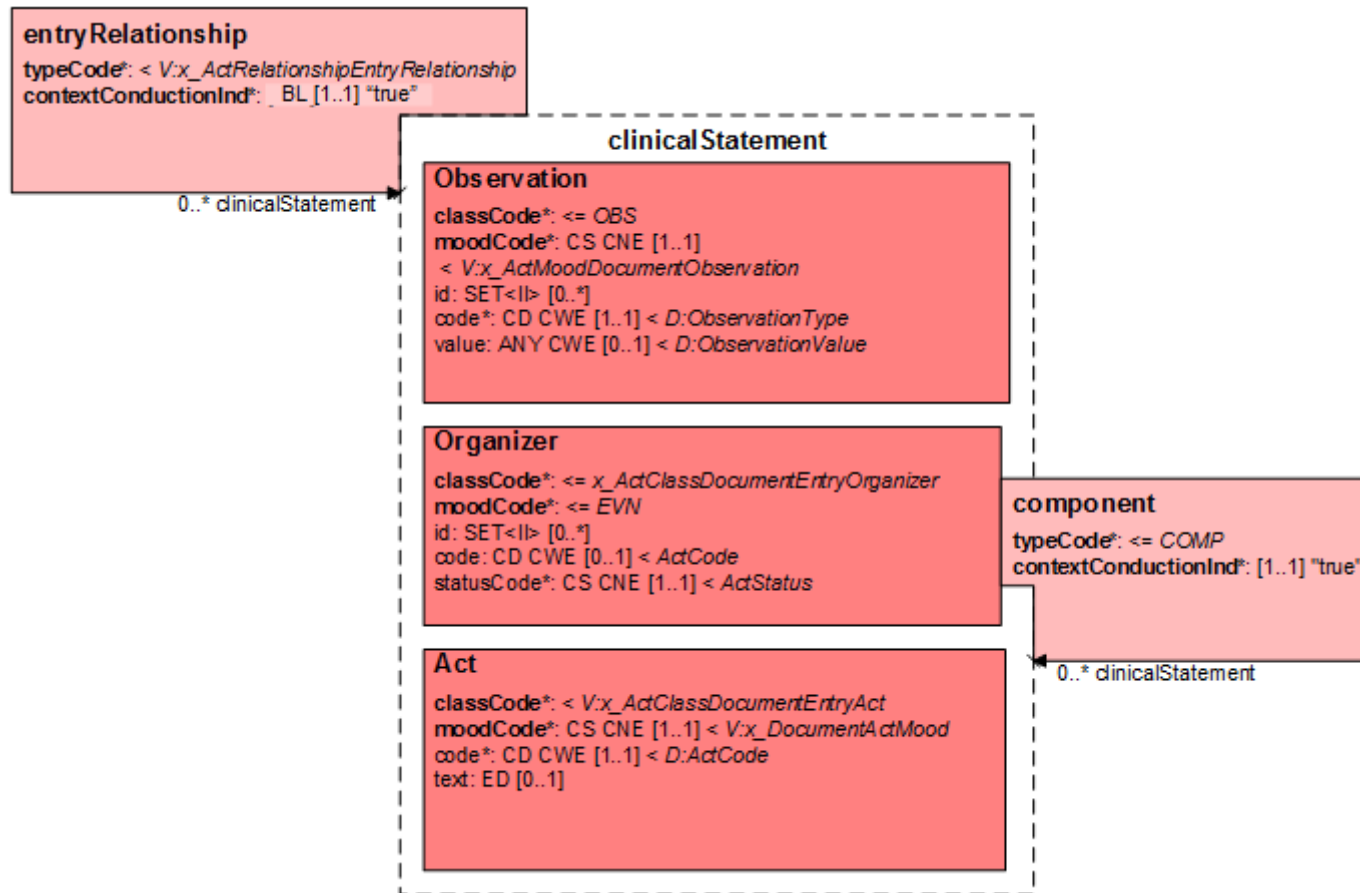
Figure 7.26. Result Group (PATHOLOGY TEST RESULT GROUP)

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/component[path_test]/section/entry[path_test_res]/observation/		
Result Group (PATHOLOGY TEST RESULT GROUP)	Group of results that form all or part of a recognisable pathology test.	0..*	**entryRelationship[res_gp]/@typeCode="COMP"**		
			entryRelationship[res_gp]/**organizer**		
			entryRelationship[res_gp]/organizer/**@classCode="BATTERY"**		
			entryRelationship[res_gp]/organizer/**@moodCode="EVN"**		
			entryRelationship[res_gp]/organizer/**id**		Optional CDA element. See <id> for available attributes.
			entryRelationship[res_gp]/organizer/**statusCode/@code="completed"**		Required CDA element.
Result Group (PATHOLOGY TEST RESULT GROUP) > **Pathology Test Result Group Name**	Name of a group of pathology test results.	1..1	entryRelationship[res_gp]/organizer/**code**	The code **SHALL** be from the set of codes recommended for pathology terminology by the Royal College of Pathologists of Australasia which are available from the RCPA tab at https://www.healthterminologies.gov.au/ncts/#/access.	See <code> for available attributes.
Result Group (PATHOLOGY TEST RESULT GROUP) > **Result (INDIVIDUAL PATHOLOGY TEST RESULT)**	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.	1..*	entryRelationship[res_gp]/organizer/**component[ind_res]**		
			entryRelationship[res_gp]/organizer/component[ind_res]/**observation**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/**@classCode="OBS"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/**@moodCode="EVN"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/**id**		Optional CDA element. See <id> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Result Group (PATHOLOGY TEST RESULT GROUP) > Result (INDIVIDUAL PATHOLOGY TEST RESULT) > **Individual Pathology Test Result Name**	Name of an individual pathology test result.	1..1	entryRelationship[res_gp]/organizer/component[ind_res]/observation/**code**	The code **SHALL** be from the set of codes recommended for pathology terminology by the Royal College of Pathologists of Australasia which are available from the RCPA tab at ht-tps://www.healthter-minolo-gies.gov.au/ncts/#/ac-cess.	See <code> for available attributes.
Result Group (PATHOLOGY TEST RESULT GROUP) > Result (INDIVIDUAL PATHOLOGY TEST RESULT) > **Result Value (INDIVIDUAL PATHOLOGY TEST RESULT VALUE)**	Value of the result, with reference range information.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
Result Group (PATHOLOGY TEST RESULT GROUP) > Result (INDIVIDUAL PATHOLOGY TEST RESULT) > Result Value (INDIVIDUAL PATHOLOGY TEST RESULT VALUE) > **Individual Pathology Test Result Value**	Actual value of the result.	1..1	entryRelationship[res_gp]/organizer/component[ind_res]/observation/**value**		Although **value** is of datatype ANY only CD, CE, CV, PQ, BL, ST, SC, TS, IVL_TS, CO, ED, SLIST_PQ, INT, RTO, or IVL_PQ **SHALL** be used.
Result Group (PATHOLOGY TEST RESULT GROUP) > Result (INDIVIDUAL PATHOLOGY TEST RESULT) > Result Value (INDIVIDUAL PATHOLOGY TEST RESULT VALUE) > **Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS)**	Reference ranges applicable to the Individual Pathology Test Result Value.	0..1	See: Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS)		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Result Group (PATHOLOGY TEST RESULT GROUP) > Result (INDIVIDUAL PATHOLOGY TEST RESULT) > **Individual Pathology Test Result Comment**	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.	0..*	entryRelationship[res_gp]/organizer/component[ind_res]/observation/**entryRelationship[res_cmt]/@typeCode= "COMP"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_cmt]/**act**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_cmt]/act/**@classCode= "INFRM"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_cmt]/ act/**@moodCode="EVN"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_cmt]/act/**code**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_cmt]/act/ code/**@code="281296001"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_cmt]/act/ code/**@codeSystem="2.16.840.1.113883.6.96"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_cmt]/act/ code/**@codeSystemName**	The value **SHOULD** be "SNOMED CT". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_cmt]/act/ code/**@displayName="Result comments"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_cmt]/act/**text:ST**		
Result Group (PATHOLOGY TEST RESULT GROUP) > Result (INDIVIDUAL PATHOLOGY TEST RESULT) > **Individual Pathology Test Result Reference Range Guidance**	Additional advice on the applicability of the reference range.	0..1	entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[ref_guide]/**@typeCode= "COMP"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[ref_guide]/**act**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[ref_guide]/ act/**@classCode="INFRM"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[ref_guide]/ act/**@moodCode="EVN"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[ref_guide]/act/**code**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[ref_guide]/act/ code/**@code="281298000"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[ref_guide]/act/ code/**@codeSystem="2.16.840.1.113883.6.96"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[ref_guide]/act/ code/**@codeSystemName**	The value **SHOULD** be "SNOMED CT". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[ref_guide]/act/ code/**@displayName="Reference range comments"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[ref_guide]/act/**text:ST**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Result Group (PATHOLOGY TEST RESULT GROUP) > Result (INDIVIDUAL PATHOLOGY TEST RESULT) > **Individual Pathology Test Result Status**	Status of an individual pathology test result.	1..1	entryRelationship[res_gp]/organizer/component[ind_res]/observation/**entryRelationship[res_stat]/@typeCode= "COMP"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_stat]/**observation**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_stat]/ observation/**@classCode="OBS"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_stat]/ observation/**@moodCode="EVN"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_stat]/ observation/**code**		See <code> for available attributes.
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_stat]/observation/ code/**@code="308552006"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_stat]/observation/ code/**@codeSystem="2.16.840.1.113883.6.96"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_stat]/observation/ code/**@codeSystemName**	The value **SHOULD** be "SNOMED CT". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_stat]/observation/ code/**@displayName="Report status"**		
			entryRelationship[res_gp]/organizer/component[ind_res]/observation/entryRelationship[res_stat]/ observation/**value:CD**	NCTIS: Admin Codes - Result Status HL7: Result Status	See <code> for available attributes. value/@nullFlavor **SHALL NOT** be present.
Result Group (PATHOLOGY TEST RESULT GROUP) > **Result Group Specimen Detail (SPECIMEN)**	Details about the individual specimen to which these result group test results refer, where testing of multiple specimens is required.	0..1	See: Result Group Specimen Detail (SPECIMEN)		

Example 7.25. Result Group (PATHOLOGY TEST RESULT GROUP) XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin DIAGNOSTIC INVESTIGATIONS -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin PATHOLOGY TEST RESULT -->
     <component>
      <section classCode="DOCSECT" moodCode="EVN">
       …

       <entry>
        <observation classCode="OBS" moodCode="EVN">
         …

         <!-- Begin Test Specimen Detail (SPECIMEN) -->
         <entryRelationship typeCode="SUBJ">
          <observation classCode="OBS" moodCode="EVN">
           …

          </observation>
         </entryRelationship>
         <!-- End Test Specimen Detail (SPECIMEN) -->
         …

         <!-- Begin Result Group (PATHOLOGY TEST RESULT GROUP) -->
         <entryRelationship typeCode="COMP">
          <organizer classCode="BATTERY" moodCode="EVN">
           <id root="5c74e8c3-4e13-4361-862f-f90818b17b39" />

           <!-- Pathology Test Result Group Name -->
           <code code="18719-5" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
            displayName="Chemistry studies (set)" />
           <statusCode code="completed" />

           <!-- Begin Result (INDIVIDUAL PATHOLOGY TEST RESULT) -->
           <component>
            <observation classCode="OBS" moodCode="EVN">
             <id root="7272eaa0-557d-4055-ba96-553d735b828a" />
             <!-- Individual Pathology Test Result Name -->
             <code code="14682-9" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Serum Creatinine" />
             <!-- Individual Pathology Test Result Value -->
```

```xml
<value unit="mmol/L" value="0.06" xsi:type="PQ" />

…

<!-- Begin Individual Pathology Test Result Comment -->
<entryRelationship typeCode="COMP">
 <act classCode="INFRM" moodCode="EVN">
  <code code="281296001" codeSystem="2.16.840.1.113883.6.96"
   codeSystemName="SNOMED CT"
   displayName="Result comments" />
  <text>Within normal range.</text>
 </act>
</entryRelationship>
<!-- End Individual Pathology Test Result Comment -->

<!-- Begin Individual Pathology Test Result Reference Range Guidance -->
<entryRelationship typeCode="COMP">
 <act classCode="INFRM" moodCode="EVN">
  <code code="281298000" codeSystem="2.16.840.1.113883.6.96"
   codeSystemName="SNOMED CT"
   displayName="Reference range comments" />
  <text xsi:type="ST">Within normal range +/- 5%.</text>
 </act>
</entryRelationship>
<!-- End Individual Pathology Test Result Reference Range Guidance -->

<!-- Begin Individual Pathology Test Result Status -->
<entryRelationship typeCode="COMP">
 <observation classCode="OBS" moodCode="EVN">
  <code code="308552006" codeSystem="2.16.840.1.113883.6.96"
   codeSystemName="SNOMED CT"
   displayName="Report status" />
  <value code="3" codeSystem="1.2.36.1.2001.1001.101.104.16501"
   codeSystemName="NCTIS Result Status Values" displayName="Final" xsi:type="CD" />
 </observation>
</entryRelationship>
<!-- End Individual Pathology Test Result Status -->

<!-- Begin Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS) -->
<referenceRange typeCode="REFV">
 <!-- Begin REFERENCE RANGE -->
 <observationRange classCode="OBS" moodCode="EVN.CRT">

  …

 </observationRange>
 <!-- End REFERENCE RANGE -->
</referenceRange>
<!-- End Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS) -->

</observation>
</component>
<!-- End Result (INDIVIDUAL PATHOLOGY TEST RESULT) -->

<!-- Begin Result Group Specimen Detail (SPECIMEN) -->
<component>
 <observation classCode="OBS" moodCode="EVN">

  …

 </observation>
</component>
<!-- End Result Group Specimen Detail (SPECIMEN) -->

</organizer>
```

```
            </entryRelationship>
            <!-- End Result Group (PATHOLOGY TEST RESULT GROUP) -->
            …

            <!-- Begin TEST REQUEST DETAILS -->
            <entryRelationship inversionInd="true" typeCode="SUBJ">
             <act classCode="ACT" moodCode="EVN">
               …

             </act>
            </entryRelationship>
            <!-- End Test TEST REQUEST DETAILS -->
            …

          </observation>
         </entry>
        </section>
       </component>
       <!-- End PATHOLOGY TEST RESULT -->
       …

      </section>
     </component>
     <!-- End DIAGNOSTIC INVESTIGATIONS -->
     …

    </structuredBody>
   </component>
   <!-- End CDA Body -->
  </ClinicalDocument>
```

7.1.6.1.2.1 Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS)

Identification

Name	Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS)
Metadata Type	Data Group
Identifier	DG-16325

Relationships

Parent

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

CDA R-MIM Representation

Figure 7.27 Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS) shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The REFERENCE RANGE DETAILS data group is represented by an ObservationRange class that is related to its containing Observation class by a referenceRange relationship. Normal Status is represented by the interpretationCode attribute of the containing Observation class. The code attribute of the ObservationRange class represents Reference Range Meaning, and the value attribute represents Reference Range.

Figure 7.27. Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS)

CDA Mapping

Note

NS = In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the [HL7 code set registration procedure](#)[10] with an appropriate object identifier (OID), and **SHALL** be publicly available.

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

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/component[path_test]/section/entry[path_test_res]/observation/entryRelationship[res_gp]/organizer/component[ind_res]/observation/		
Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS)	Reference ranges applicable to the Individual Pathology Test Result Value.	0..1	n/a		This logical data component has no mapping to CDA. See Known Issues.
Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS) > **Normal Status**	Indication of the degree of diagnostically significant abnormality of the value, based on available clinical information.	0..1	**interpretationCode**	HL7 V3: ObservationInterpretationNormality	See <code> for available attributes.
Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS) > **REFERENCE RANGE**	Named range to be associated with any quantity datum.	0..*	**referenceRange/@typeCode="REFV"**		
			referenceRange/**observationRange**		
			referenceRange/observationRange/**@classCode="OBS"**		
			referenceRange/observationRange/**@moodCode="EVN.CRT"**		
Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS) > REFERENCE RANGE > **Reference Range Meaning**	Term whose value indicates the meaning of this range.	1..1	referenceRange/observationRange/**code**	NS	See <code> for available attributes. code/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".
Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS) > REFERENCE RANGE > **Reference Range**	Data range for the associated Reference Range Meaning data element.	1..1	referenceRange/observationRange/**value:IVL_PQ**		

---

[10] http://www.hl7.org/oid/index.cfm?ref=footer

Example 7.26. Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS) XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
  …
  >
  …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin DIAGNOSTIC INVESTIGATIONS -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin PATHOLOGY TEST RESULT -->
     <component>
      <section classCode="DOCSECT" moodCode="EVN">
       …

       <entry>
        <observation classCode="OBS" moodCode="EVN">
         …

         <!-- Begin Result Group (PATHOLOGY TEST RESULT GROUP) -->
         <entryRelationship typeCode="COMP">
          <organizer classCode="BATTERY" moodCode="EVN">
           …

           <!-- Begin Result (INDIVIDUAL PATHOLOGY TEST RESULT) -->
           <component>
            <observation classCode="OBS" moodCode="EVN">
             …

             <!-- Normal Status -->
             <interpretationCode code="N" codeSystemName="HL7 ObservationInterpretationNormality"
              codeSystem="2.16.840.1.113883.5.83" displayName="Normal" />
             …

             <!-- Begin Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS) -->
             <referenceRange typeCode="REFV">
              <!-- Begin REFERENCE RANGE -->
              <observationRange classCode="OBS" moodCode="EVN.CRT">
               <!-- Reference Range Meaning -->
               <code code="260395002" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
                displayName="Normal range" />
               <!-- Reference Range -->
               <value xsi:type="IVL_PQ">
                <low value="0.04" />
                <high value="0.11" />
               </value>
```

```
            </observationRange>
            <!-- End REFERENCE RANGE -->
          </referenceRange>
          <!-- End Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS) -->

        </observation>
      </component>
      <!-- End Result (INDIVIDUAL PATHOLOGY TEST RESULT) -->
       …

      </organizer>
    </entryRelationship>
    <!-- End Result Group (PATHOLOGY TEST RESULT GROUP) -->
     …

    </observation>
   </entry>
  </section>
 </component>
 <!-- End PATHOLOGY TEST RESULT -->
  …

 </section>
</component>
<!-- End DIAGNOSTIC INVESTIGATIONS -->
 …

 </structuredBody>
</component>
<!-- End CDA Body -->
</ClinicalDocument>
```

7.1.6.1.2.2 Result Group Specimen Detail (SPECIMEN)

Identification

Name	Result Group Specimen Detail (SPECIMEN)
Metadata Type	Data Group
Identifier	DG-16156

Relationships

Parent

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

CDA R-MIM Representation

Figure 7.28 Result Group Specimen Detail (SPECIMEN) shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The Result Group Specimen Detail (SPECIMEN) data group is represented by an Observation class that is related to its containing Section class by a component. The methodCode attribute of that Observation (SPECIMEN) class represents Collection Procedure, the effectiveTime attribute represents Collection DateTime, and targetSiteCode represents the ANATOMICAL LOCATION data elements.

Specimen Identifier is represented by the id attribute of a specimenRole which is related to its containing Observation (Pathology Test Result Name) class by a specimen participation. PHYSICAL PROPERTIES OF AN OBJECT is represented by a specimenPlayingEntity of the containing specimenRole. The code attribute of that specimenPlayingEntity represents Specimen Tissue Type, the quantity attribute represents Weight or Volume, and the desc attribute represents Object Description. Container Identifier is represented by the Container Australian Digital Health Agency CDA extension.

Anatomical Location Image and Image are both represented by a supporting ObservationMedia class related to the containing Observation (SPECIMEN) class by an entryRelationship.

There are four component Observation classes related to the containing Observation (SPECIMEN) class by entryRelationships: Sampling Preconditions, Collection Setting, DateTime Received, and Parent Specimen Identifier.

Note:
Container has been added as an Australian Digital Health Agency extension to CDA.

Container
classCode*: <= *CONT*
determinerCode*: < *EntityDeterminer*
id: SET<II> [0..*]

0..1 container

SpecimenInContainer
classCode*: <= *CONT*

0..* asSpecimenInContainer

entryRelationship
typeCode*: < *V:x_ActRelationshipEntryRelationship*
contextConductionInd*:   BL [1..1] "true"

0..* clinicalStatement

clinicalStatement

Observation
classCode*: <= *OBS*
moodCode*: CS CNE [1..1] < *V:x_ActMoodDocumentObservation*
code*: CD CWE [1..1] < *D:ObservationType*
effectiveTime*: GTS [1..1]
value: ANY CWE [0..1] < *D:ObservationValue*
methodCode: SET<CE> CWE [0..1] < *D:ObservationMethod*
targetSiteCode: SET<CD> CWE [0..1] < *D:ActSite*

PlayingEntity
classCode*: <= *ENT*
determinerCode*: <= *INSTANCE*
code: CE CWE [0..1] < *D:EntityCode*
quantity: SET<PQ> [0..*]
desc: ED [0..1]

0..1 specimenPlayingEntity

SpecimenRole
classCode*: <= *SPEC*
id: SET<II> [0..*]

0..* specimenRole

specimen
typeCode*: <= *SPC*

ObservationMedia
classCode*: <= *OBS*
moodCode*: CS CNE [1..1] < *D:EVN*
id: SET<II> [0..1]
value: ANY CWE [0..1] < *D:ObservationValue*

Section
classCode*: <= *DOCSECT*
moodCode*: <= *EVN*
id: II [0..1]
code: CE CWE [0..1] < *DocumentSectionType*
title: ST [0..1]
text*: ED [0..1]

entry
typeCode*: <= *x_ActRelationshipEntry*
contextConductionInd*: BL [1..1] "true"

0..* clinicalStatement

Organizer
classCode*: <= *x_ActClassDocumentEntryOrganizer*
moodCode*: <= *EVN*
id: SET<II> [0..*]
code: CD CWE [0..1] < *ActCode*
statusCode*: CS CNE [1..1] < *ActStatus*
effectiveTime: IVL<TS> [0..1]

component
typeCode*: <= *COMP*
contextConductionInd*:   BL [1..1] "true"

0..* clinicalStatement

Figure 7.28. Result Group Specimen Detail (SPECIMEN)

CDA Mapping

Note

NS = In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the [HL7 code set registration procedure](#)[11] with an appropriate object identifier (OID), and **SHALL** be publicly available.

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

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/component[path_test]/section/entry[path_test_res]/observation/entryRe-lationship[res_gp]/organizer/		
Result Group Specimen Detail (SPECIMEN)	Details about the individual specimen to which these result group test results refer, where testing of multiple specimens is required.	0..1	**component[gp_specimen]**		
			component[gp_specimen]/**observation**		
			component[gp_specimen]/observation/**@classCode="OBS"**		
			component[gp_specimen]/observation/**@moodCode="EVN"**		
			component[gp_specimen]/observation/**code**		
			component[gp_specimen]/observation/code/**@code="102.16156.231.1.2"**		
			component[gp_specimen]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[gp_specimen]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See [CodeSystem OIDs](#).	Optional CDA element.
			component[gp_specimen]/observation/code/**@displayName="Specimen"**		
Result Group Specimen Detail (SPECIMEN) > **Specimen Tissue Type**	Type of specimen to be collected.	0..1	component[gp_specimen]/observation/specimen/specimenRole/specimenPlayingEntity/**code**	NS	See <code> for available attributes.
Result Group Specimen Detail (SPECIMEN) > **Collection Procedure**	Method of collection to be used.	0..1	component[gp_specimen]/observation/**methodCode**	NS	See <code> for available attributes.
Result Group Specimen Detail (SPECIMEN) > **Anatomical Site (ANATOMICAL LOCA-TION)**	Details about the anatomical locations to which this examination result refers.	0..*	n/a	Each instance of this logical data component **SHALL** contain either one instance of SPECIFIC LOCATION or one instance of Anatomical Location Description.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.

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[11] http://www.hl7.org/oid/index.cfm?ref=footer

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Result Group Specimen Detail (SPECIMEN) > Anatomical Site (ANATOMICAL LOCATION) > **SPECIFIC LOCATION**	Specific and identified anatomical location.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
Result Group Specimen Detail (SPECIMEN) > Anatomical Site (ANATOMICAL LOCATION) > SPECIFIC LOCATION > **Anatomical Location Name**	Name of the anatomical location.	0..1	component[gp_specimen]/observation/**targetSiteCode**	SNOMED CT-AU: • 32570061000036105 |*Body structure foundation reference set*|	See <code> for available attributes.
Result Group Specimen Detail (SPECIMEN) > Anatomical Site (ANATOMICAL LOCATION) > SPECIFIC LOCATION > **Side**	Laterality of the anatomical location.	0..1	component[gp_specimen]/observation/targetSiteCode/**qualifier**		
			component[gp_specimen]/observation/targetSiteCode/qualifier/**name**		
			component[gp_specimen]/observation/targetSiteCode/qualifier/name/**@code="272741003"**		
			component[gp_specimen]/observation/targetSiteCode/qualifier/name/**@codeSystem="2.16.840.1.113883.6.96"**		
			component[gp_specimen]/observation/targetSiteCode/qualifier/name/**@codeSystemName**	The value **SHOULD** be "SNOMED CT". See CodeSystem OIDs.	Optional CDA element.
			component[gp_specimen]/observation/targetSiteCode/qualifier/name/**@displayName="Laterality"**		
			component[gp_specimen]/observation/targetSiteCode/qualifier/**value:CD**	SNOMED CT-AU: • 32570611000036103 |*Laterality reference set*|	See <code> for available attributes.
Result Group Specimen Detail (SPECIMEN) > Anatomical Site (ANATOMICAL LOCATION) > **Anatomical Location Description**	Description of the anatomical location.	0..1	component[gp_specimen]/observation/targetSiteCode/**originalText**		Anatomical Location Description is an instance of targetSiteCode with only an originalText element.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Result Group Specimen Detail (SPECIMEN) > Anatomical Site (ANATOMICAL LOCATION) > **Anatomical Location Image**	Image used to identify a location.	0..*	component[gp_specimen]/observation/**entryRelationship[ana_im]/@typeCode="SPRT"**		The image may or may not be attested to and is therefore mapped to observationMedia.
			component[gp_specimen]/observation/entryRelationship[ana_im]/**observationMedia**		
			component[gp_specimen]/observation/entryRelationship[ana_im]/observationMedia/**@classCode="OBS"**		
			component[gp_specimen]/observation/entryRelationship[ana_im]/observationMedia/**@moodCode="EVN"**		
			component[gp_specimen]/observation/entryRelationship[ana_im]/observationMedia/**id**		Optional CDA element. See <id> for available attributes.
			component[gp_specimen]/observation/entryRelationship[ana_im]/observationMedia/**value**		
Result Group Specimen Detail (SPECIMEN) > **Physical Details (PHYSICAL PROPERTIES OF AN OBJECT)**	Record of physical details, such as weight and dimensions, of a body part, device, lesion or specimen.	0..*	component[gp_specimen]/observation/**specimen/specimenRole/specimenPlayingEntity**		
Result Group Specimen Detail (SPECIMEN) > Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) > **Weight**	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.	0..1	component[gp_specimen]/observation/specimen/specimenRole/specimenPlayingEntity/**quantity:PQ**		Either Weight or Volume **SHALL** be present. Weight and Volume **SHALL** be mutually exclusive.
Result Group Specimen Detail (SPECIMEN) > Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) > **DIMENSIONS**	Dimensions of the object.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
Result Group Specimen Detail (SPECIMEN) > Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) > DIMENSIONS > **Volume**	Size, measure or amount of anything in three dimensions; space occupied by a body or substance measured in cubic units.	0..1	component[gp_specimen]/observation/specimen/specimenRole/specimenPlayingEntity/**quantity:PQ**		Either Weight or Volume **SHALL** be present. Weight and Volume **SHALL** be mutually exclusive.
Result Group Specimen Detail (SPECIMEN) > Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) > **Description (Object Description)**	Description of other physical characteristics of the object.	0..1	component[gp_specimen]/observation/specimen/specimenRole/specimenPlayingEntity/**desc:ST**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Result Group Specimen Detail (SPECIMEN) > Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) > **Image**	Picture of the object.	0..1	component[gp_specimen]/observation/**entryRelationship[spec_im]/@typeCode="SPRT"**		The image may or may not be attested to and is therefore mapped to observationMedia.
			component[gp_specimen]/observation/entryRelationship[spec_im]/**observationMedia**		
			component[gp_specimen]/observation/entryRelationship[spec_im]/observationMedia/**@classCode="OBS"**		
			component[gp_specimen]/observation/entryRelationship[spec_im]/observationMedia/**@moodCode="EVN"**		
			component[gp_specimen]/observation/entryRelationship[spec_im]/observationMedia/**id**		Optional CDA element. See <id> for available attributes.
			component[gp_specimen]/observation/entryRelationship[spec_im]/observationMedia/**value**		
Result Group Specimen Detail (SPECIMEN) > **COLLECTION AND HANDLING**	Collection and handling requirements.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
Result Group Specimen Detail (SPECIMEN) > COLLECTION AND HANDLING > **Sampling Preconditions**	Conditions to be met before the sample should be taken.	0..1	component[gp_specimen]/observation/**entryRelationship[smp_pre]/@typeCode="COMP"**		
			component[gp_specimen]/observation/entryRelationship[smp_pre]/**observation**		
			component[gp_specimen]/observation/entryRelationship[smp_pre]/observation/**@classCode="OBS"**		
			component[gp_specimen]/observation/entryRelationship[smp_pre]/observation/**@moodCode="EVN"**		
			component[gp_specimen]/observation/entryRelationship[smp_pre]/observation/**code**		
			component[gp_specimen]/observation/entryRelationship[smp_pre]/observation/code/**@code="103.16171"**		
			component[gp_specimen]/observation/entryRelationship[smp_pre]/observation/code/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			component[gp_specimen]/observation/entryRelationship[smp_pre]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			component[gp_specimen]/observation/entryRelationship[smp_pre]/observation/code/**@displayName="Sampling Preconditions"**		
			component[gp_specimen]/observation/entryRelationship[smp_pre]/observation/**value:CD**	NS	See <code> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Result Group Specimen Detail (SPECIMEN) > **HANDLING AND PROCESSING**	Workflow of specimen processing or handling.	1..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
Result Group Specimen Detail (SPECIMEN) > HANDLING AND PROCESSING > **Collection DateTime**	Date, and optionally time, of collection.	1..1	component[gp_specimen]/observation/**effectiveTime**		See <time> for available attributes.
Result Group Specimen Detail (SPECIMEN) > HANDLING AND PROCESSING > **Collection Setting**	Identification of the setting at which the specimen was collected from a subject of care.	0..1	component[gp_specimen]/observation/**entryRelationship[coll_set]/@typeCode="COMP"**		
			component[gp_specimen]/observation/entryRelationship[coll_set]/**observation**		
			component[gp_specimen]/observation/entryRelationship[coll_set]/observation/**@classCode="OBS"**		
			component[gp_specimen]/observation/entryRelationship[coll_set]/observation/**@moodCode="EVN"**		
			component[gp_specimen]/observation/entryRelationship[coll_set]/observation/**code**		
			component[gp_specimen]/observation/entryRelationship[coll_set]/observation/code/**@code="103.16529"**		
			component[gp_specimen]/observation/entryRelationship[coll_set]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[gp_specimen]/observation/entryRelationship[coll_set]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			component[gp_specimen]/observation/entryRelationship[coll_set]/observation/code/**@displayName="Collection Setting"**		
			component[gp_specimen]/observation/entryRelationship[coll_set]/observation/**value:ST**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Result Group Specimen Detail (SPECIMEN) > HANDLING AND PROCESSING > **Date and Time of Receipt (DateTime Received)**	Date and time that the sample was received at the laboratory.	0..1	component[gp_specimen]/observation/entryRelationship[date_rec]/**@typeCode="COMP"**		
			component[gp_specimen]/observation/entryRelationship[date_rec]/**observation**		
			component[gp_specimen]/observation/entryRelationship[date_rec]/observation/**@classCode="OBS"**		
			component[gp_specimen]/observation/entryRelationship[date_rec]/observation/**@moodCode="EVN"**		
			component[gp_specimen]/observation/entryRelationship[date_rec]/observation/**code**		
			component[gp_specimen]/observation/entryRelationship[date_rec]/observation/code/**@code="103.11014"**		
			component[gp_specimen]/observation/entryRelationship[date_rec]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[gp_specimen]/observation/entryRelationship[date_rec]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			component[gp_specimen]/observation/entryRelationship[date_rec]/observation/code/**@displayName="DateTime Received"**		
			component[gp_specimen]/observation/entryRelationship[date_rec]/observation/**value:TS**		See <time> for available attributes.
Result Group Specimen Detail (SPECIMEN) > **IDENTIFIERS**	Sample identifications.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
Result Group Specimen Detail (SPECIMEN) > IDENTIFIERS > **Specimen Identifier**	Unique identifier of the specimen, normally assigned by the laboratory.	0..1	component[gp_specimen]/observation/specimen/specimenRole/**id**		See <id> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Result Group Specimen Detail (SPECIMEN) > IDENTIFIERS > **Parent Specimen Identifier**	Unique identifier of the parent specimen where the specimen is split into sub-samples.	0..1	component[gp_specimen]/observation/entryRelationship[prnt_id]/**@typeCode="COMP"**		
			component[gp_specimen]/observation/entryRelationship[prnt_id]/**observation**		
			component[gp_specimen]/observation/entryRelationship[prnt_id]/observation/**@classCode="OBS"**		
			component[gp_specimen]/observation/entryRelationship[prnt_id]/observation/**@moodCode="EVN"**		
			component[gp_specimen]/observation/entryRelationship[prnt_id]/observation/**code**		
			component[gp_specimen]/observation/entryRelationship[prnt_id]/observation/code/**@code="103.16187"**		
			component[gp_specimen]/observation/entryRelationship[prnt_id]/observation/code/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			component[gp_specimen]/observation/entryRelationship[prnt_id]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			component[gp_specimen]/observation/entryRelationship[prnt_id]/observation/code/**@displayName="Parent Specimen Identifier"**		
			component[gp_specimen]/observation/entryRelationship[prnt_id]/observation/**specimen/specimenRole/id**		See <id> for available attributes.
Result Group Specimen Detail (SPECIMEN) > IDENTIFIERS > **Container Identifier**	Unique identifier given to the container in which the specimen is transported or processed.	0..1	component[gp_specimen]/observation/specimen/specimenRole/specimenPlayingEntity/**ext:asSpecimenInContainer**		See Australian Digital Health Agency CDA extension: Container
			component[gp_specimen]/observation/specimen/specimenRole/specimenPlayingEntity/ ext:asSpecimenInContainer/**@classCode="CONT"**		
			component[gp_specimen]/observation/specimen/specimenRole/specimenPlayingEntity/ ext:asSpecimenInContainer/**ext:container**		
			component[gp_specimen]/observation/specimen/specimenRole/specimenPlayingEntity/ ext:asSpecimenInContainer/ext:container/**ext:id**		See <id> for available attributes.

Example 7.27. Result Group Specimen Detail (SPECIMEN) XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin DIAGNOSTIC INVESTIGATIONS -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin PATHOLOGY TEST RESULT -->
     <component>
      <section classCode="DOCSECT" moodCode="EVN">
       …

       <!-- narrative block -->
       <text>
        <renderMultiMedia referencedObject="IMG02"></renderMultiMedia>
        <renderMultiMedia referencedObject="SPEC02"></renderMultiMedia>
       </text>

       <entry>
        <observation classCode="OBS" moodCode="EVN">
         …

         <!-- Begin Result Group (PATHOLOGY TEST RESULT GROUP) -->
         <entryRelationship typeCode="COMP">
          <organizer classCode="BATTERY" moodCode="EVN">
           …

           <!-- Begin Result (INDIVIDUAL PATHOLOGY TEST RESULT) -->
           <component>
            <observation classCode="OBS" moodCode="EVN">
             …

            </observation>
           </component>
           <!-- End Result (INDIVIDUAL PATHOLOGY TEST RESULT) -->

           <!-- Begin Result Group Specimen Detail (SPECIMEN) -->
           <component>
            <observation classCode="OBS" moodCode="EVN">
             <!-- id is used for system purposes such as matching -->
             <id root="1cbb4098-a5e0-4d02-82d7-63f2dfbccc00" />
             <code code="102.16156.231.1.2" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Specimen" />
             <!-- Collection DateTime -->
```
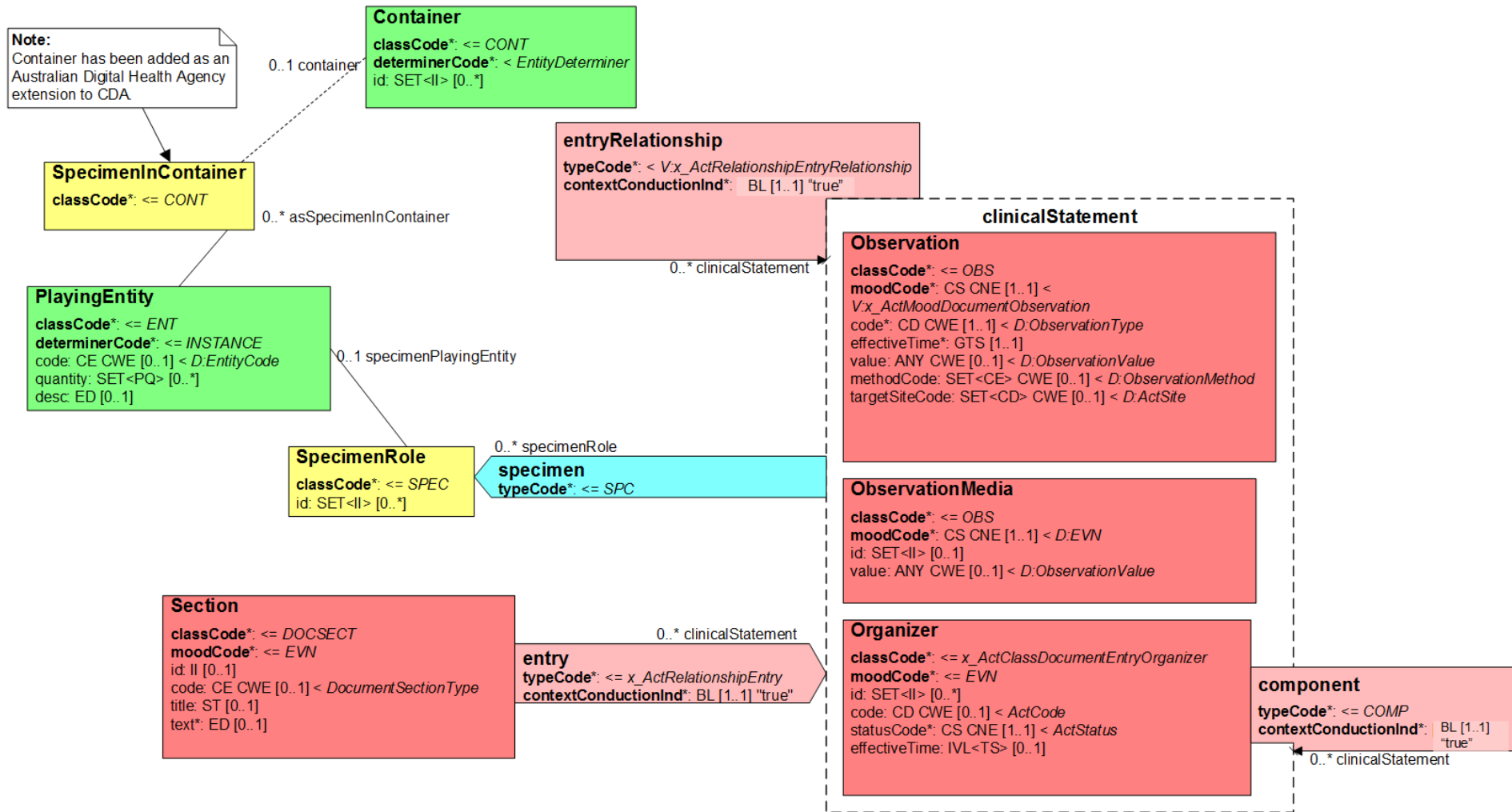
```xml
<effectiveTime value="201310201235+1000" />

<!-- Collection Procedure -->
<methodCode code="48635004" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
 displayName="Fine needle biopsy" />

<!-- Anatomical Site (ANATOMICAL LOCATION) :: Examples provided of all three allowed variants. These variants are mutually exclusive -->
<!-- Begin Example with complete SPECIFIC LOCATION -->
<!-- Name of Location (Anatomical Location Name) -->
<targetSiteCode code="51185008" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Thoracic structure">

 <!-- Begin Side -->
 <qualifier>
  <name code="272741003" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Laterality" />
  <value code="7771000" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Left" xsi:type="CD" />
 </qualifier>
 <!-- End Side -->

</targetSiteCode>
<!-- End Example with complete SPECIFIC LOCATION -->

<!-- Begin Example with partial SPECIFIC LOCATION -->
<!-- Name of Location (Anatomical Location Name) -->
<targetSiteCode code="51185008" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Thoracic structure" />
<!-- End Example with partial SPECIFIC LOCATION -->

<!-- Begin Example with Description -->
<targetSiteCode>
 <!-- Description (Anatomical Location Description) -->
 <originalText>Chest/Thoracic structure</originalText>
</targetSiteCode>
<!-- End Example with Description -->

<!-- Begin Physical Details -->
<specimen>
 <specimenRole>
  <!-- Specimen Identifier -->
  <id root="1538103e-845b-4f86-95ed-33b62e7589d0" />

  <!-- Begin Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) -->
  <specimenPlayingEntity>
   <!-- Specimen Tissue Type -->
   <code code="258442002" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Fluid sample" />

   <!-- Begin Weight/Volume -->
   <quantity unit="mL" value="5" />
   <!-- End Weight/Volume -->

   <!-- Begin Description (Object Description) -->
   <desc xsi:type="ST">5 mL</desc>
   <!-- End Description (Object Description) -->

   <!-- Begin Container Identifier -->
   <ext:asSpecimenInContainer classCode="CONT">
    <ext:container>
     <ext:id extension="CNH45218964" root="cfbcce23-f3a5-4738-ab6a-017805a84e1a" />
    </ext:container>
   </ext:asSpecimenInContainer>
   <!-- End Container Identifier -->

  </specimenPlayingEntity>
  <!-- End Physical Details (PHYSICAL PROPERTIES OF AN OBJECT) -->
 </specimenRole>
```

```xml
    </specimen>
    <!-- End Physical Details -->

    <!-- Begin Anatomical Location Image -->
    <entryRelationship typeCode="SPRT">
     <observationMedia ID="IMG02" classCode="OBS" moodCode="EVN">
      <id root="6799369a-f831-4ca9-9082-ef0bacef05f2" />
      <value mediaType="image/jpeg" >
       <reference value="location.jpeg" />
      </value>
     </observationMedia>
    </entryRelationship>
    <!-- End Anatomical Location Image -->

    <!-- Begin Image -->
    <entryRelationship typeCode="SPRT">
     <observationMedia ID="SPEC02" classCode="OBS" moodCode="EVN">
      <id root="1d64bb51-c5b3-4048-9a9f-e753f4e3c203" />
      <value mediaType="image/jpeg" >
       <reference value="specimen.jpeg" />
      </value>
     </observationMedia>
    </entryRelationship>
    <!-- End Image -->

    <!-- Begin Sampling Preconditions -->
    <entryRelationship typeCode="COMP">
     <observation classCode="OBS" moodCode="EVN">
      <code code="103.16171" codeSystem="1.2.36.1.2001.1001.101"
       codeSystemName="NCTIS Data Components" displayName="Sampling Preconditions" />
      <value code="16985007" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
       displayName="Fasting" xsi:type="CD" />
     </observation>
    </entryRelationship>
    <!-- End Sampling Preconditions -->

    <!-- Begin Collection Setting -->
    <entryRelationship typeCode="COMP">
     <observation classCode="OBS" moodCode="EVN">
      <code code="103.16529" codeSystem="1.2.36.1.2001.1001.101"
       codeSystemName="NCTIS Data Components" displayName="Collection Setting" />
      <value xsi:type="ST">Pathology Clinic</value>
     </observation>
    </entryRelationship>
    <!-- End Collection Setting -->

    <!-- Begin Date and Time of Receipt (DateTime Received) -->
    <entryRelationship typeCode="COMP">
     <observation classCode="OBS" moodCode="EVN">
      <code code="103.11014" codeSystem="1.2.36.1.2001.1001.101"
       codeSystemName="NCTIS Data Components" displayName="DateTime Received" />
      <value value="201112141120+1000" xsi:type="TS" />
     </observation>
    </entryRelationship>
    <!-- End Date and Time of Receipt (DateTime Received) -->

    <!-- Begin Parent Specimen Identifier -->
    <entryRelationship typeCode="COMP">
     <observation classCode="OBS" moodCode="EVN">
      <code code="103.16187" codeSystem="1.2.36.1.2001.1001.101"
       codeSystemName="NCTIS Data Components" displayName="Parent Specimen Identifier" />
      <specimen>
       <specimenRole>
```

```xml
                <id root="7013b12a-f9d0-4197-9726-88a6803d4d13" />
              </specimenRole>
            </specimen>
          </observation>
        </entryRelationship>
        <!-- End Parent Specimen Identifier -->

        </observation>
      </component>
      <!-- End Result Group Specimen Detail (SPECIMEN) -->

      </organizer>
    </entryRelationship>
    <!-- End Result Group (PATHOLOGY TEST RESULT GROUP) -->
    …

    </observation>
  </entry>
  </section>
  </component>
  <!-- End PATHOLOGY TEST RESULT -->
  …

  </section>
  </component>
  <!-- End DIAGNOSTIC INVESTIGATIONS -->
  …

 </structuredBody>
</component>
<!-- End CDA Body -->
</ClinicalDocument>
```

7.1.6.2 IMAGING EXAMINATION RESULT

Identification

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

Relationships

Parent

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

Children

Data Type	Name	Occurrence
	Result Group (IMAGING EXAMINATION RESULT GROUP)	0..*
	EXAMINATION REQUEST DETAILS	0..*

CDA R-MIM Representation

Figure 7.29 IMAGING EXAMINATION RESULT shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The IMAGING EXAMINATION RESULT data group is represented by a Section class that is related to its containing Section class by a component. Imaging Examination Result Name is represented by an Observation class related to the Section (IMAGING EXAMINATION RESULT) class by an entry. The methodCode attribute of that Observation class represents Imaging Modality, the text attribute represents Examination Result Representation, and targetSiteCode represents the ANATOMICAL LOCATION data elements.

Anatomical Location Image and Image are both represented by a supporting ObservationMedia class related to the containing Observation (Imaging Examination Result Name) class by an entryRelationship.

There are three Observation classes related to the containing Observation (Imaging Examination Result Name) class: Observation DateTime, Findings, and Imaging Examination Result Status. Clinical Information Provided is represented by an Act class that is related to the containing Observation (Imaging Examination Result Name) class by an entryRelationship.
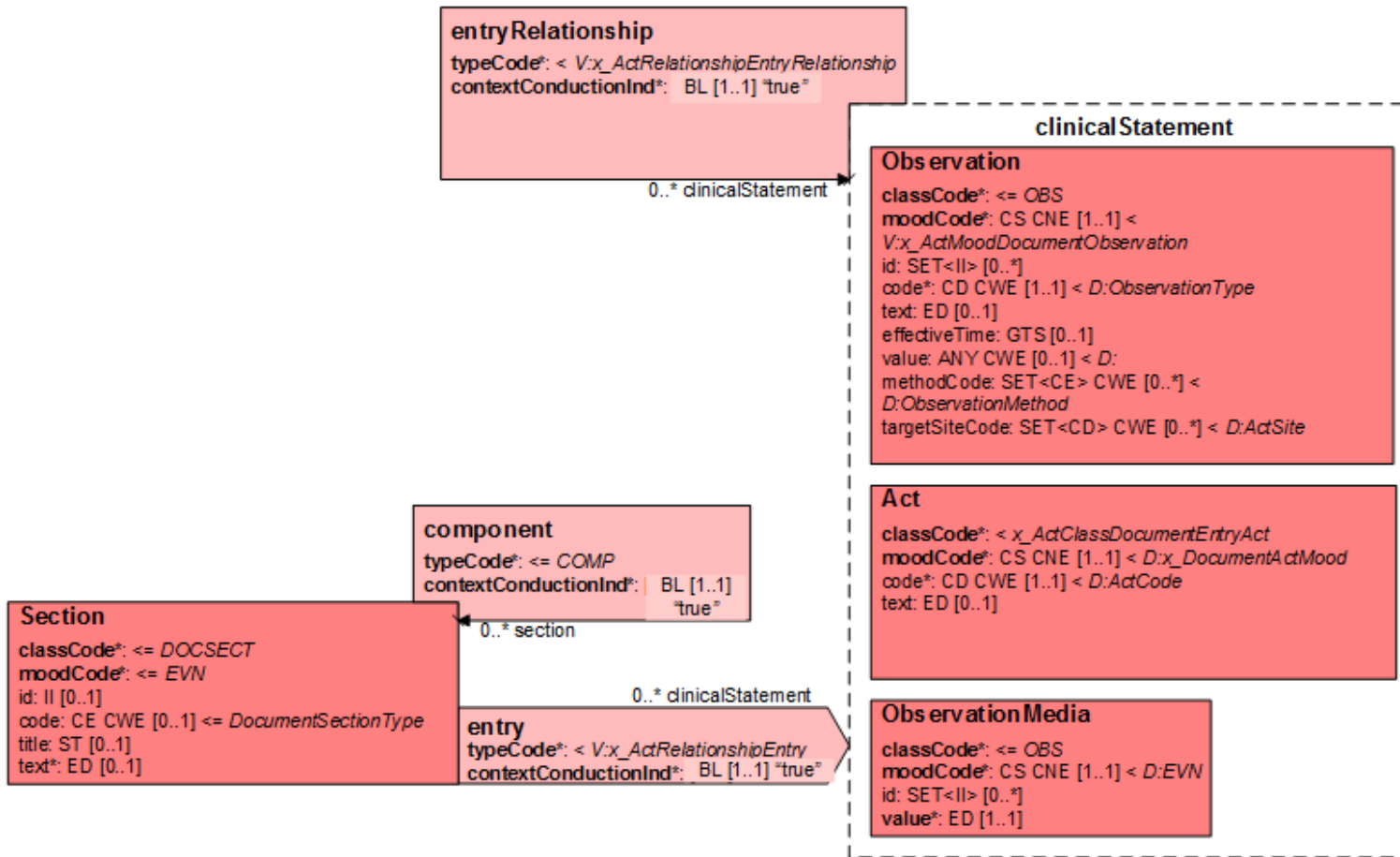
Figure 7.29. IMAGING EXAMINATION RESULT

CDA Mapping

Note

NS = In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the HL7 code set registration procedure[12] with an appropriate object identifier (OID), and **SHALL** be publicly available.

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

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/		
IMAGING EXAMINATION RESULT	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.	0..*	**component[img_exam]/section**		The title **SHALL** be present where narrative (section/text) is present. See Appendix A, *CDA Narratives* and the requirements for narrative sections in *Clinical Documents Common Conformance Profile [DH2017o]*.
			component[img_exam]/section/**title="Imaging Examination Result"**		
			component[img_exam]/section/**text**		Required CDA element. See Appendix A, *CDA Narratives*.
IMAGING EXAMINATION RESULT > **Imaging Examination Result Instance Identifier**	Globally unique identifier for each instance of an Imaging Examination Result observation.	0..1	component[img_exam]/section/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
IMAGING EXAMINATION RESULT > **Detailed Clinical Model Identifier**	Globally unique identifier for this detailed clinical model.	1..1	component[img_exam]/section/**code**		code/@nullFlavor **SHALL NOT** be present.
			component[img_exam]/section/code/**@code="102.16145"**		
			component[img_exam]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[img_exam]/section/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			component[img_exam]/section/code/**@displayName="Imaging Examination Result"**		
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/component[img_exam]/section/		
IMAGING EXAMINATION RESULT > **Examination Result Name (Imaging Examination Result Name)**	Identification of the imaging examination or procedure performed, typically including modality and anatomical location (including laterality).	1..1	entry[img_exam_res]/**observation**		
			entry[img_exam_res]/observation/**@classCode="OBS"**		
			entry[img_exam_res]/observation/**@moodCode="EVN"**		
			entry[img_exam_res]/observation/**id**		Optional CDA element. See <id> for available attributes.
			entry[img_exam_res]/observation/**code**	NS	See <code> for available attributes. code/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/component[img_exam]/section/entry[img_exam_res]/observation/		
IMAGING EXAMINATION RESULT > **Imaging Modality**	Imaging method used to perform the examination.	0..1	**methodCode**	NS	See <code> for available attributes.
IMAGING EXAMINATION RESULT > **Anatomical Site (ANATOMICAL LOCATION)**	Details about the anatomical locations to which this examination result refers.	0..*	n/a	Each instance of this logical data component **SHALL** contain exactly one instance of SPECIFIC LOCATION or exactly one instance of Anatomical Location Description.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
IMAGING EXAMINATION RESULT > Anatomical Site (ANATOMICAL LOCATION) > **SPECIFIC LOCATION**	Specific and identified anatomical location.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
IMAGING EXAMINATION RESULT > Anatomical Site (ANATOMICAL LOCATION) > SPECIFIC LOCATION > **Anatomical Location Name**	Name of the anatomical location.	0..1	**targetSiteCode**	SNOMED CT-AU: • 32570061000036105 |*Body structure foundation reference set*|	See <code> for available attributes.
IMAGING EXAMINATION RESULT > Anatomical Site (ANATOMICAL LOCATION) > SPECIFIC LOCATION > **Side**	Laterality of the anatomical location.	0..1	targetSiteCode/**qualifier**		
			targetSiteCode/qualifier/**name**		
			targetSiteCode/qualifier/name/**@code="272741003"**		
			targetSiteCode/qualifier/name/**@codeSystem="2.16.840.1.113883.6.96"**		
			targetSiteCode/qualifier/name/**@codeSystemName**	The value **SHOULD** be "SNOMED CT". See CodeSystem OIDs.	Optional CDA element.
			targetSiteCode/qualifier/name/**@displayName="Laterality"**		
			targetSiteCode/qualifier/**value:CD**	SNOMED CT-AU: • 32570611000036103 |*Laterality reference set*|	See <code> for available attributes. value/@nullFlavor **SHALL NOT** be present.
IMAGING EXAMINATION RESULT > Anatomical Site (ANATOMICAL LOCATION) > **Anatomical Location Description**	Description of the anatomical location.	0..1	targetSiteCode/**originalText**		Anatomical Location Description is an instance of targetSiteCode with only an originalText element.
IMAGING EXAMINATION RESULT > Anatomical Site (ANATOMICAL LOCATION) > **Anatomical Location Image**	Image or images used to identify a location.	0..*	entryRelationship[img]/**@typeCode="REFR"**		The image may or may not be attested to and is therefore mapped to observationMedia.
			entryRelationship[img]/**observationMedia**		
			entryRelationship[img]/observationMedia/**@classCode="OBS"**		
			entryRelationship[img]/observationMedia/**@moodCode="EVN"**		
			entryRelationship[img]/observationMedia/**id**		Optional CDA element. See <id> for available attributes.
			entryRelationship[img]/observationMedia/**value**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
IMAGING EXAMINATION RESULT > **Imaging Examination Result Status**	Status of the examination result as a whole.	1..1	**entryRelationship[res_stat]/@typeCode="COMP"**		
			entryRelationship[res_stat]/**observation**		
			entryRelationship[res_stat]/observation/**@classCode="OBS"**		
			entryRelationship[res_stat]/observation/**@moodCode="EVN"**		
			entryRelationship[res_stat]/observation/**id**		Optional CDA element. See <id> for available attributes.
			entryRelationship[res_stat]/observation/**code**		
			entryRelationship[res_stat]/observation/code/**@code="308552006"**		
			entryRelationship[res_stat]/observation/code/**@codeSystem="2.16.840.1.113883.6.96"**		
			entryRelationship[res_stat]/observation/code/**@codeSystemName**	The value **SHOULD** be "SNOMED CT". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[res_stat]/observation/code/**@displayName="Report status"**		
			entryRelationship[res_stat]/observation/**value:CD**	NCTIS: Admin Codes - Result Status HL7: Result Status	See <code> for available attributes. value/@nullFlavor **SHALL NOT** be present.
IMAGING EXAMINATION RESULT > **Clinical Information Provided**	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.	0..1	**entryRelationship[clin_inf]/@typeCode="COMP"**		
			entryRelationship[clin_inf]/**act**		
			entryRelationship[clin_inf]/act/**@classCode="INFRM"**		
			entryRelationship[clin_inf]/act/**@moodCode="EVN"**		
			entryRelationship[clin_inf]/act/**code**		
			entryRelationship[clin_inf]/act/code/**@code="55752-0"**		
			entryRelationship[clin_inf]/act/code/**@codeSystem="2.16.840.1.113883.6.1"**		
			entryRelationship[clin_inf]/act/code/**@codeSystemName**	The value **SHOULD** be "LOINC". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[clin_inf]/act/code/**@displayName="Clinical information"**		
			entryRelationship[clin_inf]/act/**text:ST**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
IMAGING EXAMINATION RESULT > **Findings**	Clinical assessment and opinion based on one or more observations and examinations.	0..1	**entryRelationship[find]/@typeCode="REFR"**		
			entryRelationship[find]/**observation**		
			entryRelationship[find]/observation/**@classCode="OBS"**		
			entryRelationship[find]/observation/**@moodCode="EVN"**		
			entryRelationship[find]/observation/**id**		Optional CDA element. See <id> for available attributes.
			entryRelationship[find]/observation/**code**		
			entryRelationship[find]/observation/code/**@code="103.16503"**		
			entryRelationship[find]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entryRelationship[find]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[find]/observation/code/**@displayName="Findings"**		
			entryRelationship[find]/observation/**text:ST**		
IMAGING EXAMINATION RESULT > **Result Group (IMAGING EXAMINATION RESULT GROUP)**	Group of structured results.	0..*	See: Result Group (IMAGING EXAMINATION RESULT GROUP).		
IMAGING EXAMINATION RESULT > **Examination Result Representation**	Rich text representation of the entire result as issued by the diagnostic service.	0..1	**text**		Used for results unable to be sent and/or received as structured information. Multiple formats are allowed but they **SHALL** be semantically equivalent.
IMAGING EXAMINATION RESULT > **EXAMINATION REQUEST DETAILS**	Details concerning a single requested examination.	0..*	See: EXAMINATION REQUEST DETAILS		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
IMAGING EXAMINATION RESULT > **Observation DateTime**	Date, and optionally time, when an observation is clinically significant to the condition of the subject of the observation.	1..1	**entryRelationship[res_date]/@typeCode="COMP"**		Observation DateTime is mapped to Imaging Examination Result DateTime and retains the original OID and displayName of that concept for backwards compatibility.
			entryRelationship[res_date]/**observation**		
			entryRelationship[res_date]/observation/**@classCode="OBS"**		
			entryRelationship[res_date]/observation/**@moodCode="EVN"**		
			entryRelationship[res_date]/observation/**code**		
			entryRelationship[res_date]/observation/code/**@code="103.16589"**		
			entryRelationship[res_date]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entryRelationship[res_date]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[res_date]/observation/code/**@displayName="Imaging Examination Result DateTime"**		
			entryRelationship[res_date]/observation/**effectiveTime**		See <time> for available attributes.

Example 7.28. IMAGING EXAMINATION RESULT XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin DIAGNOSTIC INVESTIGATIONS -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin IMAGING EXAMINATION RESULT -->
     <component>
      <section classCode="DOCSECT" moodCode="EVN">
       <!-- Imaging Examination Result Instance Identifier -->
       <id root="3b54f35c-c521-4353-8513-0e16c126cd45" />
       <!-- Detailed Clinical Model Identifier -->
       <code code="102.16145" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Imaging Examination Result" />
       <title>Imaging Examination Result</title>

       <!-- narrative block -->
       <text>
        <table>
         <thead>
          <tr>
           <th>Imaging Examination</th>
           <th>Modality</th>
           <th>Status</th>
           <th>Anatomical Location</th>
           <th>Examination Procedure</th>
           <th>Date of Image</th>
          </tr>
         </thead>
         <tbody>
          <tr>
           <td>Chest X-ray</td>
           <td>x-ray</td>
           <td>Left, Chest</td>
           <td>Final results; results stored and verified. Can only be changed with a corrected result.</td>
           <td>The examination was carried out using the particular procedure.</td>
           <td>20th October 2013</td>
          </tr>
         </tbody>
        </table>
        <paragraph>
         <linkHtml href="imagingexam.pdf">downloadable PDF version</linkHtml>
        </paragraph>
```

```xml
 <renderMultiMedia referencedObject="LOC01"></renderMultiMedia>
</text>

<entry>
 <observation classCode="OBS" moodCode="EVN">
  <!-- id is used for system purposes such as matching -->
  <id root="058236ba-6cf2-4ab7-9c16-23d29658b7ca" />

  <!-- Examination Result Name (Imaging Examination Result Name) -->
  <code code="399208008" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Plain chest x-ray" />

  <!-- Examination Result Representation -->
  <text mediaType="application/pdf">
   <reference value="imagingexam.pdf" />
  </text>

  <!-- Imaging Modality -->
  <methodCode code="363680008" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="X-ray" />

  <!-- NOTE: The instance of Anatomical Site (ANATOMICAL LOCATION) has been duplicated at the Examination Group level for illustrative purposes only. -->
  <!-- Anatomical Site (ANATOMICAL LOCATION) :: Examples provided of all three allowed variants. These variants are mutually exclusive -->
  <!--  Begin Example with complete SPECIFIC LOCATION -->
  <!-- Name of Location (Anatomical Location Name) -->
  <targetSiteCode code="51185008" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Thoracic structure">

   <!-- Begin Side -->
   <qualifier>
    <name code="272741003" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Laterality" />
    <value code="7771000" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Left" xsi:type="CD" />
   </qualifier>
   <!-- End Side -->

  </targetSiteCode>
  <!-- End Example with complete SPECIFIC LOCATION -->

  <!-- Begin Example with partial SPECIFIC LOCATION -->
  <!-- Name of Location (Anatomical Location Name) -->
  <targetSiteCode code="51185008" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Thoracic structure" />
  <!-- End Example with partial SPECIFIC LOCATION -->

  <!-- Begin Example with Description -->
  <targetSiteCode>
   <!-- Description (Anatomical Location Description) -->
   <originalText>Chest/Thoracic structure</originalText>
  </targetSiteCode>
  <!-- End Example with Description -->

  <!-- Begin Anatomical Location Image -->
  <entryRelationship typeCode="REFR">
   <observationMedia ID="LOC01" classCode="OBS" moodCode="EVN">
    <id root="e66fef7e-0d84-45d7-bb38-f12adb16d9cb" />
    <value mediaType="image/jpeg" xsi:type="ED">
     <reference value="location.jpeg" />
    </value>
   </observationMedia>
  </entryRelationship>
  <!-- End Anatomical Location Image -->

  <!-- Begin Imaging Examination Result Status -->
  <entryRelationship typeCode="COMP">
   <observation classCode="OBS" moodCode="EVN">
    <!-- id is used for system purposes such as matching -->
    <id root="e4691ff9-acee-4d6a-9db6-0318a400bd72" />
```

```xml
      <code code="308552006" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Report status" />
      <value code="F" codeSystem="2.16.840.1.113883.12.123" codeSystemName="HL7 Result Status" displayName="Final results; results stored and verified. Can only be changed with a corrected result." xsi:type="CD" />
     </observation>
    </entryRelationship>
    <!-- End Imaging Examination Result Status -->

    <!-- Begin Clinical Information Provided -->
    <entryRelationship typeCode="COMP">
     <act classCode="INFRM" moodCode="EVN">
      <code code="55752-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
       displayName="Clinical information" />
      <text xsi:type="ST">Fluid Retention.</text>
     </act>
    </entryRelationship>
    <!-- End Clinical Information Provided -->

    <!-- Begin Findings -->
    <entryRelationship typeCode="REFR">
     <observation classCode="OBS" moodCode="EVN">
      <id root="e37b60ba-f847-49ec-b296-72fa0eb03699" />
      <code code="103.16503" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components"
       displayName="Findings" />
      <text xsi:type="ST">The lungs and pleura appear clear. Cardiac and mediastinal contours are within normal
       limits.</text>
     </observation>
    </entryRelationship>
    <!-- End Findings -->

    <!-- Begin Result Group (IMAGING EXAMINATION RESULT GROUP) -->
    <entryRelationship typeCode="COMP">
     <organizer classCode="BATTERY" moodCode="EVN">
       …

     </organizer>
    </entryRelationship>
    <!-- End Result Group (IMAGING EXAMINATION RESULT GROUP) -->

    <!-- Begin EXAMINATION REQUEST DETAILS -->
    <entryRelationship inversionInd="true" typeCode="SUBJ">
     <act classCode="ACT" moodCode="EVN">
       …

     </act>
    </entryRelationship>
    <!-- End EXAMINATION REQUEST DETAILS -->

    <!-- Begin Observation DateTime -->
    <entryRelationship typeCode="COMP">
     <observation classCode="OBS" moodCode="EVN">
      <code code="103.16589" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Imaging Examination Result DateTime" />
      <effectiveTime value="201310201235+1000" />
     </observation>
    </entryRelationship>
    <!-- End Observation DateTime -->

   </observation>
  </entry>

 </section>
</component>
<!-- End IMAGING EXAMINATION RESULT -->
…
```

```
        </section>
      </component>
      <!-- End DIAGNOSTIC INVESTIGATIONS -->
      …

    </structuredBody>
  </component>
  <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.6.2.1 Result Group (IMAGING EXAMINATION RESULT GROUP)

Identification

Name	Result Group (IMAGING EXAMINATION RESULT GROUP)
Metadata Type	Data Group
Identifier	DG-16504

Relationships

Parent

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..*

Children

Data Type	Name	Occurrence
	Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS)	0..1

CDA R-MIM Representation

Figure 7.30 Result Group (IMAGING EXAMINATION RESULT GROUP) shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The Result Group (IMAGING EXAMINATION RESULT GROUP) is represented by an Organizer class related to its containing Observation class by an entryRelationship. The code attribute of that Organizer class represents Imaging Examination Result Group Name.

Each INDIVIDUAL IMAGING EXAMINATION RESULT data group is represented by an Observation class related to the containing Organizer class by a component. The code attribute of that Observation (INDIVIDUAL IMAGING EXAMINATION RESULT) class represents Individual Imaging Examination Result Name, the value attribute represents Individual Imaging Examination Result Value, and targetSiteCode represents the ANATOMICAL LOCATION data elements. Result Comment is represented by an Act class that is related to the containing Observation (Imaging Examination Result Name) class by an entryRelationship.

Anatomical Location Image and Image are both represented by a supporting ObservationMedia class related to the containing Observation (Imaging Examination Result Name) class by an entryRelationship.

entryRelationship

typeCode*: < V:x_ActRelationshipEntry Relationship
contextConductionInd*: BL [1..1] "true"

0..* clinicalStatement

clinicalStatement

Observation

classCode*: <= OBS
moodCode*: CS CNE [1..1]
 < V:x_ActMoodDocumentObservation
id: SET<II> [0..*]
code*: CD CWE [1..1] < D:ObservationType
value: ANY CWE [0..1] < D:ObservationValue
targetSiteCode: SET<CD> CWE [0..*] < D:ActSite

Organizer

classCode*: <= x_ActClassDocumentEntryOrganizer
moodCode*: <= EVN
id: SET<II> [0..*]
code: CD CWE [0..1] < ActCode
statusCode*: CS CNE [1..1] < ActStatus

ObservationMedia

classCode*: <= OBS
moodCode*: CS CNE [1..1] < D:EVN
id: SET<II> [0..*]
value*: ED [1..1]

Act

classCode*: <= ACT
moodCode*: CS CNE [1..1] < D:EVN
code*: CD CWE [1..1] < D:ActCode
text: ED [0..1]

component

typeCode*: <= COMP
contextConductionInd*: BL [1..1]
"true"

0..* clinicalStatement

Figure 7.30. Result Group (IMAGING EXAMINATION RESULT GROUP)

CDA Mapping

Note

NS = In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the HL7 code set registration procedure[13] with an appropriate object identifier (OID), and **SHALL** be publicly available.

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

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/component[img_exam]/section/entry[img_exam_res]/observation/		
Result Group (IMAGING EXAMINATION RESULT GROUP)	Group of structured results.	0..*	**entryRelationship[im_res_gp]/@typeCode="COMP"**		
			entryRelationship[im_res_gp]/**organizer**		
			entryRelationship[im_res_gp]/organizer/**@classCode="BATTERY"**		
			entryRelationship[im_res_gp]/organizer/**@moodCode="EVN"**		
			entryRelationship[im_res_gp]/organizer/**id**		Optional CDA element. See <id> for available attributes.
			entryRelationship[im_res_gp]/organizer/**statusCode**		Required CDA element.
			entryRelationship[im_res_gp]/organizer/statusCode/**@code="completed"**		
Result Group (IMAGING EXAMINATION RESULT GROUP) > **Imaging Examination Result Group Name**	Name of a group of structured results.	1..1	entryRelationship[im_res_gp]/organizer/**code**	NS	See <code> for available attributes.
Result Group (IMAGING EXAMINATION RESULT GROUP) > **Result (INDIVIDUAL IMAGING EXAMINATION RESULT)**	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.	1..*	entryRelationship[im_res_gp]/organizer/**component[ind_im_res]**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/**observation**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/**@classCode="OBS"**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/**@moodCode="EVN"**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/**id**		Optional CDA element. See <id> for available attributes.

---

[13] http://www.hl7.org/oid/index.cfm?ref=footer

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Result Group (IMAGING EXAMINATION RESULT GROUP) > Result (INDIVIDUAL IMAGING EXAMINATION RESULT) > **Individual Imaging Examination Result Name**	Name of a specific detailed result.	1..1	entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/**code**	NS	See <code> for available attributes.
Result Group (IMAGING EXAMINATION RESULT GROUP) > Result (INDIVIDUAL IMAGING EXAMINATION RESULT) > **Result Value (IMAGING EXAMINATION RESULT VALUE)**	Value of the result, with reference range information.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
Result Group (IMAGING EXAMINATION RESULT GROUP) > Result (INDIVIDUAL IMAGING EXAMINATION RESULT) > Result Value (IMAGING EXAMINATION RESULT VALUE) > **Result Value (Imaging Examination Result Value)**	Actual value of the result.	1..1	entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/**value**		Although **value** is of datatype ANY only CD or PQ **SHALL** be used.
Result Group (IMAGING EXAMINATION RESULT GROUP) > Result (INDIVIDUAL IMAGING EXAMINATION RESULT) > Result Value (IMAGING EXAMINATION RESULT VALUE) > **Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS)**	Reference ranges applicable to the Imaging Examination Result Value.	0..1	See: Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS)		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Result Group (IMAGING EXAMINATION RESULT GROUP) > Result (INDIVIDUAL IMAGING EXAMINATION RESULT) > **Result Comment**	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.	0..*	entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/ entryRelationship[res_cmt]/**@typeCode="COMP"**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/entryRelationship[res_cmt]/**act**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/entryRelationship[res_cmt]/ act/**@classCode="INFRM"**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/entryRelationship[res_cmt]/ act/**@moodCode="EVN"**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/entryRelationship[res_cmt]/ act/**code**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/entryRelationship[res_cmt]/act/ code/**@code="281296001"**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/entryRelationship[res_cmt]/act/ code/**@codeSystem="2.16.840.1.113883.6.96"**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/entryRelationship[res_cmt]/act/ code/**@codeSystemName**	The value **SHOULD** be "SNOMED CT". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/entryRelationship[res_cmt]/act/ code/**@displayName="Result comments"**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/entryRelationship[res_cmt]/ act/**text:ST**		
Result Group (IMAGING EXAMINATION RESULT GROUP) > **Anatomical Site (ANATOMICAL LOCATION)**	Details about the individual anatomical location to which these result group examination results refer, where finer-grained representation of Anatomical Location is required.	0..1	n/a	Each instance of Anatomical Site (ANATOMICAL LOCATION) **SHALL** contain exactly one instance of SPECIFIC LOCATION or exactly one instance of Anatomical Location Description.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
Result Group (IMAGING EXAMINATION RESULT GROUP) > Anatomical Site (ANATOMICAL LOCATION) > **SPECIFIC LOCATION**	Specific and identified anatomical location.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
Result Group (IMAGING EXAMINATION RESULT GROUP) > Anatomical Site (ANATOMICAL LOCATION) > SPECIFIC LOCATION > **Anatomical Location Name**	Name of the anatomical location.	0..1	entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/**targetSiteCode**	SNOMED CT-AU: • 32570061000036105 |*Body structure foundation reference set*|	See <code> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Result Group (IMAGING EXAMINATION RESULT GROUP) > Anatomical Site (ANATOMICAL LOCATION) > SPECIFIC LOCATION > **Side**	Laterality of the anatomical location.	0..1	entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/targetSiteCode/**qualifier**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/targetSiteCode/qualifier/**name**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/targetSiteCode/qualifier/name/**@code="272741003"**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/targetSiteCode/qualifier/name/**@codeSystem="2.16.840.1.113883.6.96"**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/targetSiteCode/qualifier/name/**@codeSystemName**	The value **SHOULD** be "SNOMED CT". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/targetSiteCode/qualifier/name/**@displayName="Laterality"**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/targetSiteCode/qualifier/**value:CD**	SNOMED CT-AU: • 32570611000036103 |*Laterality reference set*|	See <code> for available attributes. value/@nullFlavor **SHALL NOT** be present.
Result Group (IMAGING EXAMINATION RESULT GROUP) > Anatomical Site (ANATOMICAL LOCATION) > **Anatomical Location Description**	Description of the anatomical location.	0..1	entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/targetSiteCode/**originalText**		Anatomical Location Description is an instance of targetSiteCode with only an originalText element.
Result Group (IMAGING EXAMINATION RESULT GROUP) > Anatomical Site (ANATOMICAL LOCATION) > **Anatomical Location Image**	Image or images used to identify a location.	0..*	entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/entryRelationship[img]/**@typeCode="REFR"**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/entryRelationship[img]/**observationMedia**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/entryRelationship[img]/observationMedia/**@classCode="OBS"**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/entryRelationship[img]/observationMedia/**@moodCode="EVN"**		
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/entryRelationship[img]/observationMedia/**id**		Optional CDA element. See <id> for available attributes.
			entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/entryRelationship[img]/observationMedia/**value**		

Example 7.29. Result Group (IMAGING EXAMINATION RESULT GROUP) XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin DIAGNOSTIC INVESTIGATIONS -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin IMAGING EXAMINATION RESULT -->
     <component>
      <section classCode="DOCSECT" moodCode="EVN">
       …
       <!-- narrative block -->
       <text>
        <renderMultiMedia referencedObject="LOC02"></renderMultiMedia>
       </text>

       <entry>
        <observation classCode="OBS" moodCode="EVN">
         …

         <!-- Begin Result Group (IMAGING EXAMINATION RESULT GROUP) -->
         <entryRelationship typeCode="COMP">
          <organizer classCode="BATTERY" moodCode="EVN">
           <id root="6cda8321-28c0-48ad-95c8-cbfa5d2425b1" />
           <!-- Imaging Examination Result Group Name -->
           <code code="399208008" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
            displayName="Plain chest x-ray" />
           <statusCode code="completed" />

           <!-- Begin Result (INDIVIDUAL IMAGING EXAMINATION RESULT) -->
           <component>
            <observation classCode="OBS" moodCode="EVN">
             <id root="1cff8509-b746-42d3-9f5f-758ed3ed77c9" />
             <!-- Individual Imaging Examination Result Name -->
             <code nullFlavor="UNK">
              <originalText>Cardiothoracic Ratio</originalText>
             </code>
             <!-- Result Value (Imaging Examination Result Value))-->
             <value value="0.45" xsi:type="PQ" />

             …

             <!-- Anatomical Site (ANATOMICAL LOCATION) :: Examples provided of all three allowed variants. These variants are mutually exclusive -->
```

```xml
<!-- Begin Example with complete SPECIFIC LOCATION -->
<!-- Name of Location (Anatomical Location Name) -->
<targetSiteCode code="51185008" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Thoracic structure">

 <!-- Begin Side -->
 <qualifier>
  <name code="272741003" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Laterality" />
  <value code="7771000" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Left" xsi:type="CD" />
 </qualifier>
 <!-- End Side -->

</targetSiteCode>
<!-- End Example with complete SPECIFIC LOCATION -->

<!-- Begin Example with partial SPECIFIC LOCATION -->
<!-- Name of Location (Anatomical Location Name) -->
<targetSiteCode code="51185008" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Thoracic structure" />
<!-- End Example with partial SPECIFIC LOCATION -->

<!-- Begin Example with Description -->
<targetSiteCode>
 <!-- Description (Anatomical Location Description) -->
 <originalText>Chest/Thoracic structure</originalText>
</targetSiteCode>
<!-- End Example with Description -->

<!-- Begin Anatomical Location Image -->
<entryRelationship typeCode="REFR">
 <observationMedia ID="LOC02" classCode="OBS" moodCode="EVN">
  <id root="c71b7ee3-5ec2-488a-ba5c-bc241f8395dc" />
  <value mediaType="image/jpeg" xsi:type="ED">
   <reference value="location.jpeg" />
  </value>
 </observationMedia>
</entryRelationship>
<!-- End Anatomical Location Image -->

<!-- Begin Result Comment -->
<entryRelationship typeCode="COMP">
 <act classCode="INFRM" moodCode="EVN">
  <code code="281296001" codeSystem="2.16.840.1.113883.6.96"
   codeSystemName="SNOMED CT"
   displayName="Result comments" />
  <text>CTR within normal limits.</text>
 </act>
</entryRelationship>
<!-- End Result Comment -->

<!-- Begin Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS) -->
<referenceRange typeCode="REFV">
 <!-- Begin REFERENCE RANGE -->
 <observationRange classCode="OBS" moodCode="EVN.CRT">

  …

 </observationRange>
 <!-- End REFERENCE RANGE -->
</referenceRange>
<!-- End Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS) -->

 </observation>
</component>
<!-- End Result (INDIVIDUAL IMAGING EXAMINATION RESULT) -->
```

```
          </organizer>
        </entryRelationship>
        <!-- End Result Group (IMAGING EXAMINATION RESULT GROUP) -->

        <!-- Begin EXAMINATION REQUEST DETAILS -->
        <entryRelationship inversionInd="true" typeCode="SUBJ">
         <act classCode="ACT" moodCode="EVN">
           …

         </act>
        </entryRelationship>
        <!-- End EXAMINATION REQUEST DETAILS -->
        …

      </observation>
     </entry>

    </section>
   </component>
   <!-- End IMAGING EXAMINATION RESULT -->
   …

   </section>
  </component>
  <!-- End DIAGNOSTIC INVESTIGATIONS -->
  …

 </structuredBody>
</component>
<!-- End CDA Body -->
</ClinicalDocument>
```
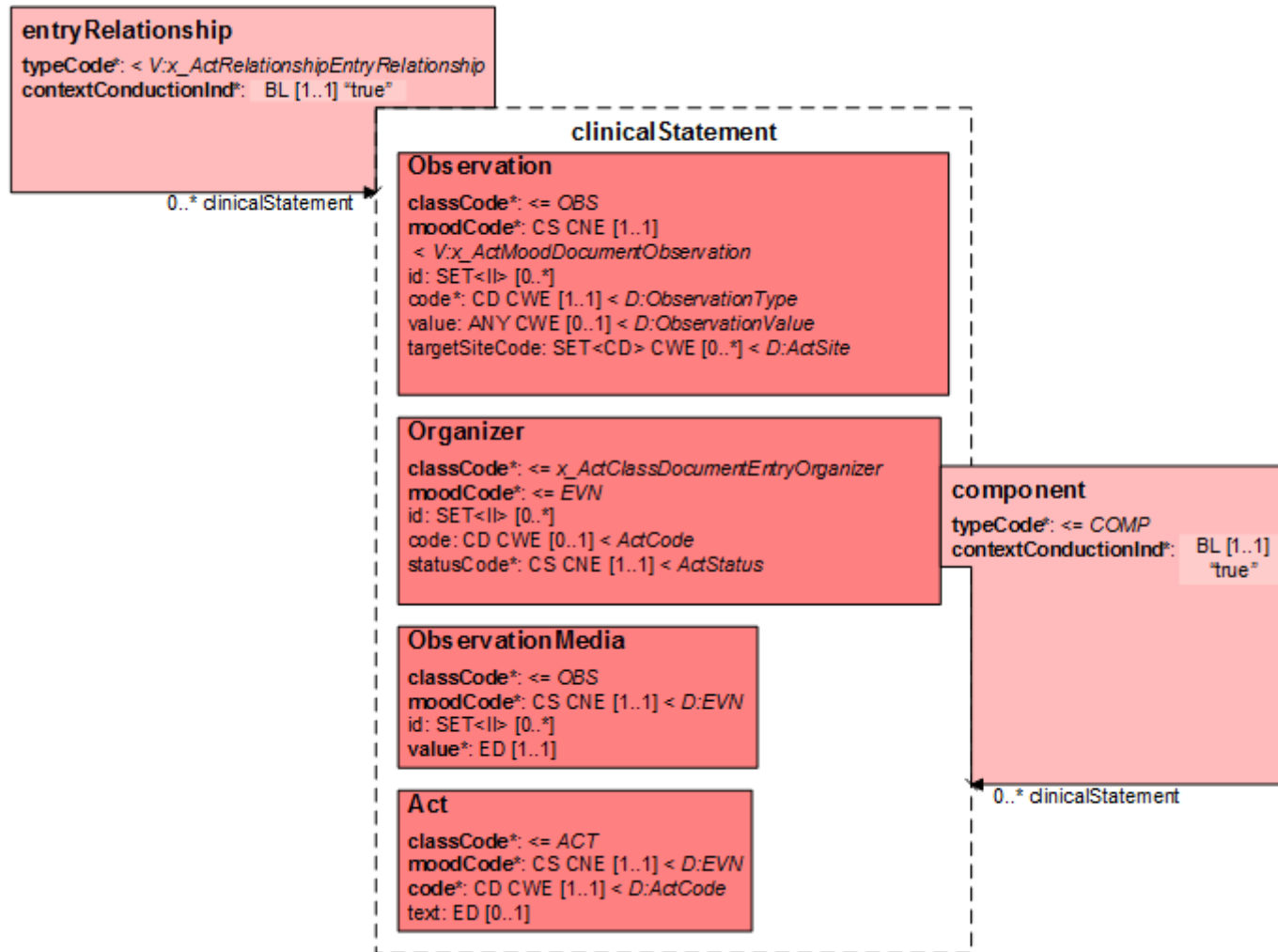
7.1.6.2.1.1 Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS)

Identification

Name	Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS)
Metadata Type	Data Group
Identifier	DG-16325

Relationships

Parent

Data Type	Name	Occurrences (child within parent)
	Result Group (IMAGING EXAMINATION RESULT GROUP)	0..1

CDA R-MIM Representation

Figure 7.31 Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS) shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The REFERENCE RANGE DETAILS data group is represented by an ObservationRange class that is related to its containing Observation class by a referenceRange relationship. Normal Status is represented by the interpretationCode attribute of the containing Observation class. The code attribute of the ObservationRange class represents Reference Range Meaning, and the value attribute represents Reference Range.

Figure 7.31. Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS)

CDA Mapping

Note

NS = In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the <u>HL7 code set registration procedure</u>[14] with an appropriate object identifier (OID), and **SHALL** be publicly available.

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

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/component[img_exam]/section/entry[img_exam_res]/observation/entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/		
Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS)	Reference ranges applicable to the Imaging Examination Result Value.	0..1	n/a		This logical data component has no mapping to CDA. See Known Issues.
Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS) > **Normal Status**	Indication of the degree of diagnostically significant abnormality of the value, based on available clinical information.	0..1	**interpretationCode**	HL7 V3: ObservationInterpretationNormality	See <code> for available attributes.
Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS) > **REFERENCE RANGE**	Named range to be associated with any quantity datum.	0..*	**referenceRange/@typeCode="REFV"**		
			referenceRange/**observationRange**		
			referenceRange/observationRange/**@classCode="OBS"**		
			referenceRange/observationRange/**@moodCode="EVN.CRT"**		
Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS) > **REFERENCE RANGE** > **Reference Range Meaning**	Term whose value indicates the meaning of this range.	1..1	referenceRange/observationRange/**code**	NS	See <code> for available attributes. code/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".
Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS) > **REFERENCE RANGE** > **Reference Range**	Data range for the associated Reference Range Meaning data element.	1..1	referenceRange/observationRange/**value:IVL_PQ**		

---

[14] http://www.hl7.org/oid/index.cfm?ref=footer

Example 7.30. Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS) XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin DIAGNOSTIC INVESTIGATIONS -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin IMAGING EXAMINATION RESULT -->
     <component>
      <section classCode="DOCSECT" moodCode="EVN">
       …

       <entry>
        <observation classCode="OBS" moodCode="EVN">
         …

         <!-- Begin Result Group (IMAGING EXAMINATION RESULT GROUP) -->
         <entryRelationship typeCode="COMP">
          <organizer classCode="BATTERY" moodCode="EVN">
           …

           <!-- Begin Result (INDIVIDUAL IMAGING EXAMINATION RESULT) -->
           <component>
            <observation classCode="OBS" moodCode="EVN">
             …

             <!-- Normal Status -->
             <interpretationCode code="N" codeSystemName="HL7 ObservationInterpretationNormality"
              codeSystem="2.16.840.1.113883.5.83"
              displayName="Normal" />

             …

             <!-- Begin Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS) -->
             <referenceRange typeCode="REFV">
              <!-- Begin REFERENCE RANGE -->
              <observationRange classCode="OBS" moodCode="EVN.CRT">

               <!-- Reference Range Meaning -->
               <code code="260395002" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
                displayName="Normal range" />
               <!-- Reference Range -->
               <value xsi:type="IVL_PQ">
```

```
              <low value="0.25" />
              <high value="0.50" />
            </value>

          </observationRange>
          <!-- End REFERENCE RANGE -->
        </referenceRange>
        <!-- End Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS) -->

      </observation>
    </component>
    <!-- End Result (INDIVIDUAL IMAGING EXAMINATION RESULT) -->

    </organizer>
    </entryRelationship>
    <!-- End Result Group (IMAGING EXAMINATION RESULT GROUP) -->

      …

      </observation>
    </entry>

    </section>
  </component>
  <!-- End IMAGING EXAMINATION RESULT -->

  …

  </section>
  </component>
  <!-- End DIAGNOSTIC INVESTIGATIONS -->
  …

  </structuredBody>
  </component>
  <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.6.2.2 EXAMINATION REQUEST DETAILS

Identification

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

Relationships

Parent

Data Type	Name	Occurrences (child within parent)
	IMAGING EXAMINATION RESULT	0..*

CDA R-MIM Representation

Figure 7.32 EXAMINATION REQUEST DETAILS shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The EXAMINATION REQUEST DETAILS data group is represented by an Act class related to its containing Observation class by an entryRelationship. Examination Requested Name is represented by a reference Observation class related to the containing Act class by an entryRelationship. DICOM Study Identifier is represented by a subject Act class related to the containing Act class by an entryRelationship. Report Identifier is represented by a component Observation class related to the containing Act class by an entryRelationship.

IMAGE DETAILS is represented by an Observation class related to its containing Act (DICOM Study Identifier) class by an entryRelationship. The id attribute of that Observation (IMAGE DETAILS) class represents Image Identifier, the value attribute represents Image View Name and the effectiveTime attribute represents Image DateTime. DICOM Series Identifier is represented by a reference Act class that is related to its containing Observation (IMAGE DETAILS) class by an entryRelationship. Subject Position is represented by a reference Act class that is related to its containing Observation (IMAGE DETAILS) class by an entryRelationship. Image is represented by an ObservationMedia class related to its containing Observation (IMAGE DETAILS) class by an entryRelationship.
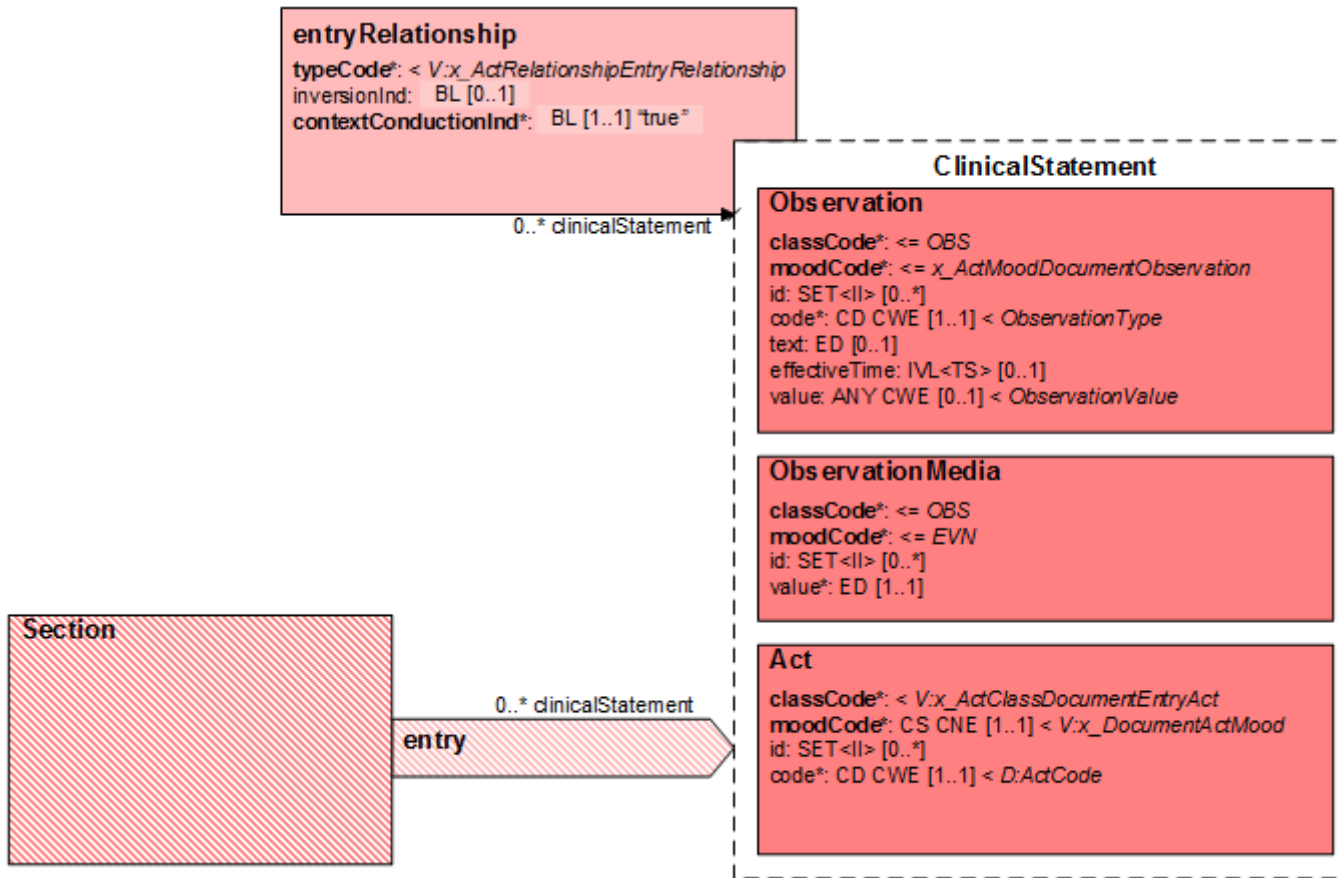
Figure 7.32. EXAMINATION REQUEST DETAILS

CDA Mapping

Note

NS = In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the [HL7 code set registration procedure](#)[15] with an appropriate object identifier (OID), and **SHALL** be publicly available.

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

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/component[img_exam]/section/entry[img_exam_res]/observation/		
EXAMINATION REQUEST DETAILS	Details concerning a single requested examination.	0..*	**entryRelationship[exam_req]/@typeCode="SUBJ"**		
			entryRelationship[exam_req]/**@inversionInd="true"**		
			entryRelationship[exam_req]/**act**		
			entryRelationship[exam_req]/act/**@classCode="ACT"**		
			entryRelationship[exam_req]/act/**@moodCode="EVN"**		
			entryRelationship[exam_req]/act/**code**		
			entryRelationship[exam_req]/act/code/**@code="102.16511"**		
			entryRelationship[exam_req]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entryRelationship[exam_req]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See [CodeSystem OIDs](#).	Optional CDA element.
			entryRelationship[exam_req]/act/code/**@displayName="Examination Request Details"**		

---

[15] http://www.hl7.org/oid/index.cfm?ref=footer

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
EXAMINATION REQUEST DETAILS > **Examination Requested Name**	Identification of the imaging examination which was requested.	0..*	entryRelationship[exam_req]/act/**entryRelationship[im_req_exam_nm]/@typeCode="REFR"**		This logical data component **SHOULD NOT** be present if its value is equal to the value of the Imaging Examination Result Name (entry[img_exam_res]/observation/code).
			entryRelationship[exam_req]/act/entryRelationship[im_req_exam_nm]/**observation**		
			entryRelationship[exam_req]/act/entryRelationship[im_req_exam_nm]/observation/**@classCode="OBS"**		
			entryRelationship[exam_req]/act/entryRelationship[im_req_exam_nm]/observation/**@moodCode="EVN"**		
			entryRelationship[exam_req]/act/entryRelationship[im_req_exam_nm]/observation/**code**		
			entryRelationship[exam_req]/act/entryRelationship[im_req_exam_nm]/observation/code/**@code="103.16512"**		
			entryRelationship[exam_req]/act/entryRelationship[im_req_exam_nm]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entryRelationship[exam_req]/act/entryRelationship[im_req_exam_nm]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[exam_req]/act/entryRelationship[im_req_exam_nm]/observation/code/**@displayName="Examination Requested Name"**		
			entryRelationship[exam_req]/act/entryRelationship[im_req_exam_nm]/observation/**text:ST**		
EXAMINATION REQUEST DETAILS > **DICOM Study Identifier**	Unique identifier of this study allocated by the imaging service.	0..1	entryRelationship[exam_req]/act/**entryRelationship[exam_perf]/@typeCode="SUBJ"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/**act**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/**act/@classCode="ACT"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/**act/@moodCode="EVN"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/**code**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/code/**@code="103.16513"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/code/**@displayName="DICOM Study Identifier"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/**id**		See <id> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
EXAMINATION REQUEST DETAILS > **Report Identifier**	Local identifier given to the imaging examination report.	0..1	entryRelationship[exam_req]/act/**entryRelationship[im_rep_id]/@typeCode="COMP"**		
			entryRelationship[exam_req]/act/entryRelationship[im_rep_id]/**observation**		
			entryRelationship[exam_req]/act/entryRelationship[im_rep_id]/observation/**@classCode="OBS"**		
			entryRelationship[exam_req]/act/entryRelationship[im_rep_id]/observation/**@moodCode="EVN"**		
			entryRelationship[exam_req]/act/entryRelationship[im_rep_id]/observation/**id**		See <id> for available attributes.
			entryRelationship[exam_req]/act/entryRelationship[im_rep_id]/observation/**code**		
			entryRelationship[exam_req]/act/entryRelationship[im_rep_id]/observation/code/**@code="103.16514"**		
			entryRelationship[exam_req]/act/entryRelationship[im_rep_id]/observation/code/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			entryRelationship[exam_req]/act/entryRelationship[im_rep_id]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[exam_req]/act/entryRelationship[im_rep_id]/observation/code/**@displayName="Report Identifier"**		
EXAMINATION REQUEST DETAILS > **IMAGE DETAILS**	Images referenced or provided to assist clinical understanding of the examination.	0..*	entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/**entryRelationship[img_det]/@typeCode= "COMP"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/**observation**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/**@classCode="OBS"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/**@moodCode="EVN"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/**code**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/code/**@code="102.16515"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/code/**@displayName="Image Details"**		
EXAMINATION REQUEST DETAILS > IMAGE DETAILS > **Image Identifier**	Unique identifier of this image allocated by the imaging service.	0..1	entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/**id**		See <id> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
EXAMINATION REQUEST DETAILS > IMAGE DETAILS > **DICOM Series Identifier**	Unique identifier of this series allocated by the imaging service.	0..1	entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/ observation/**entryRelationship[dicom_ser]/@typeCode="REFR"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/ entryRelationship[dicom_ser]/**act**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/ entryRelationship[dicom_ser]/act/**@classCode="ACT"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/ entryRelationship[dicom_ser]/act/**@moodCode="EVN"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/ entryRelationship[dicom_ser]/act/**id**		See <id> for available attributes. NB. The DICOM Series Identifier is placed in the root attribute.
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/ entryRelationship[dicom_ser]/act/**code**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/ entryRelationship[dicom_ser]/act/code/**@code="103.16517"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/ entryRelationship[dicom_ser]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/ entryRelationship[dicom_ser]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/ entryRelationship[dicom_ser]/act/code/**@displayName="DICOM Series Identifier"**		
EXAMINATION REQUEST DETAILS > IMAGE DETAILS > **Image View Name**	Name of the imaging view.	0..1	entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/ observation/**value:CD**	NS	See <code> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
EXAMINATION REQUEST DETAILS > IMAGE DETAILS > **Subject Position**	Description of the subject's position when the imaging examination was performed.	0..1	entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/**entryRelationship[sub_pos]/@typeCode="REFR"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/entryRelationship[sub_pos]/**observation**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/entryRelationship[sub_pos]/observation/**@classCode="OBS"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/entryRelationship[sub_pos]/observation/**@moodCode="EVN"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/entryRelationship[sub_pos]/observation/**code**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/entryRelationship[sub_pos]/observation/code/**@code="103.16519"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/entryRelationship[sub_pos]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/entryRelationship[sub_pos]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/entryRelationship[sub_pos]/observation/code/**@displayName="Subject Position"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/entryRelationship[sub_pos]/observation/**value:ST**		
EXAMINATION REQUEST DETAILS > IMAGE DETAILS > **Image DateTime**	Date, and optionally time, the imaging examination was performed.	0..1	entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/**effectiveTime**		See <time> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
EXAMINATION REQUEST DETAILS > IMAGE DETAILS > **Image**	Attached or referenced image of a current view.	0..1	entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/ entryRelationship[img]/**@typeCode="SPRT"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/ entryRelationship[img]/**observationMedia**		The image may or may not be attested to and is therefore mapped to observationMedia.
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/ entryRelationship[img]/**observationMedia/@classCode="OBS"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/ entryRelationship[img]/**observationMedia/@moodCode="EVN"**		
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/ entryRelationship[img]/**observationMedia/id**		Optional CDA element. See <id> for available attributes.
			entryRelationship[exam_req]/act/entryRelationship[exam_perf]/act/entryRelationship[img_det]/observation/ entryRelationship[img]/**observationMedia/value:ED**		

Example 7.31. EXAMINATION REQUEST DETAILS XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

<!-- Begin CDA Body -->
<component>
 <structuredBody>
   …

   <!-- Begin DIAGNOSTIC INVESTIGATIONS -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
      …

     <!-- Begin IMAGING EXAMINATION RESULT -->
     <component>
      <section classCode="DOCSECT" moodCode="EVN">
        …

       <entry>
        <observation classCode="OBS" moodCode="EVN">
         …

         <!-- Begin Result Group (IMAGING EXAMINATION RESULT GROUP) -->
         <entryRelationship typeCode="COMP">
          <organizer classCode="BATTERY" moodCode="EVN">
            …

          </organizer>
         </entryRelationship>
         <!-- End Result Group (IMAGING EXAMINATION RESULT GROUP) -->

         <!-- Begin EXAMINATION REQUEST DETAILS -->
         <entryRelationship inversionInd="true" typeCode="SUBJ">
          <act classCode="ACT" moodCode="EVN">
           <code code="102.16511" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Examination Request Details" />

           <!-- Begin Examination Requested Name -->
           <entryRelationship typeCode="REFR">
            <observation classCode="OBS" moodCode="EVN">
             <code code="103.16512" codeSystem="1.2.36.1.2001.1001.101"
              codeSystemName="NCTIS Data Components" displayName="Examination Requested Name" />
             <text xsi:type="ST">Chest X-ray</text>
            </observation>
           </entryRelationship>
           <!-- End Examination Requested Name -->

           <entryRelationship typeCode="SUBJ">
            <act classCode="ACT" moodCode="EVN">
             <!-- DICOM Study Identifier -->
```

```xml
<id root="1.2.312.1264.124654654.12456456301" />
<code code="103.16513" codeSystem="1.2.36.1.2001.1001.101"
 codeSystemName="NCTIS Data Components" displayName="DICOM Study Identifier" />

<!-- Begin IMAGE DETAILS -->
<entryRelationship typeCode="COMP">
 <observation classCode="OBS" moodCode="EVN">
  <!-- Image Identifier -->
  <id root="1.2.3.4.5.123654789654" />
  <code code="102.16515" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Image Details" />

  <!-- Image DateTime -->
  <effectiveTime value="201012141120+1000" />

  <!-- Image View Name -->
  <value code="67632007" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
   displayName="Diagnostic radiography of chest, PA" xsi:type="CD" />

  <!-- Begin DICOM Series Identifier -->
  <entryRelationship typeCode="REFR">
   <act classCode="ACT" moodCode="EVN">
    <id root="1.2.3.1.2.2654654654654564" />
    <code code="103.16517" codeSystem="1.2.36.1.2001.1001.101"
     codeSystemName="NCTIS Data Components" displayName="DICOM Series Identifier" />
   </act>
  </entryRelationship>
  <!-- End DICOM Series Identifier -->

  <!-- Begin Subject Position -->
  <entryRelationship typeCode="REFR">
   <observation classCode="OBS" moodCode="EVN">
    <code code="103.16519" codeSystem="1.2.36.1.2001.1001.101"
     codeSystemName="NCTIS Data Components" displayName="Subject Position" />
    <value xsi:type="ST">PA Erect</value>
   </observation>
  </entryRelationship>
  <!-- End Subject Position -->

  <!-- Begin Image -->
  <entryRelationship typeCode="SPRT">
   <observationMedia classCode="OBS" moodCode="EVN">
    <id root="c0b8ea87-ac6f-4c77-a3cf-7335a3e8cc40" />
    <value mediaType="image/jpeg" xsi:type="ED">
     <reference value="xray.jpeg" />
    </value>
   </observationMedia>
  </entryRelationship>
  <!-- End Image -->
 </observation>
</entryRelationship>
<!-- End IMAGE DETAILS -->

</act>
</entryRelationship>

<!-- Begin Report Identifier -->
<entryRelationship typeCode="COMP">
 <observation classCode="OBS" moodCode="EVN">
  <id root="2c224515-d0cb-4193-9e96-7c955246a498" />
  <code code="103.16514" codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components" displayName="Report Identifier" />
 </observation>
</entryRelationship>
```

```
          <!-- End Report Identifier -->

        </act>
      </entryRelationship>
      <!-- End EXAMINATION REQUEST DETAILS -->
      …

    </observation>
   </entry>

  </section>
 </component>
 <!-- End IMAGING EXAMINATION RESULT -->
  …

 </section>
</component>
<!-- End DIAGNOSTIC INVESTIGATIONS -->
  …

</structuredBody>
</component>
<!-- End CDA Body -->
</ClinicalDocument>
```

7.1.6.3 Pending Diagnostic Investigation (REQUESTED SERVICE)

Identification

Name	Pending Diagnostic Investigation (REQUESTED SERVICE)
Metadata Type	Data Group
Identifier	DG-20158

Relationships

Parent

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

Children

Data Type	Name	Occurrence
	SERVICE PROVIDER	0..1

CDA R-MIM Representation

Figure 7.33 Pending Diagnostic Investigation (REQUESTED SERVICE) shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The Pending Diagnostic Investigation (REQUESTED SERVICE) data group is represented by an Act class that is related to its containing Section class by an entry. The moodCode of that Act class represents the Service Booking Status, the code attribute represents Service Category, and the effectiveTime attribute represents Service Commencement Window.

There are three Act classes related to the containing Act (REQUESTED SERVICE) class by entryRelationships: Reason for Service, Subject of Care Instruction Description, and Requested Service DateTime. Reason for Service Description is represented by the text attribute of its containing Act (Reason for Service) class.

Service Description is represented by an Observation class that is related to its containing Act (REQUESTED SERVICE) class by an entry.
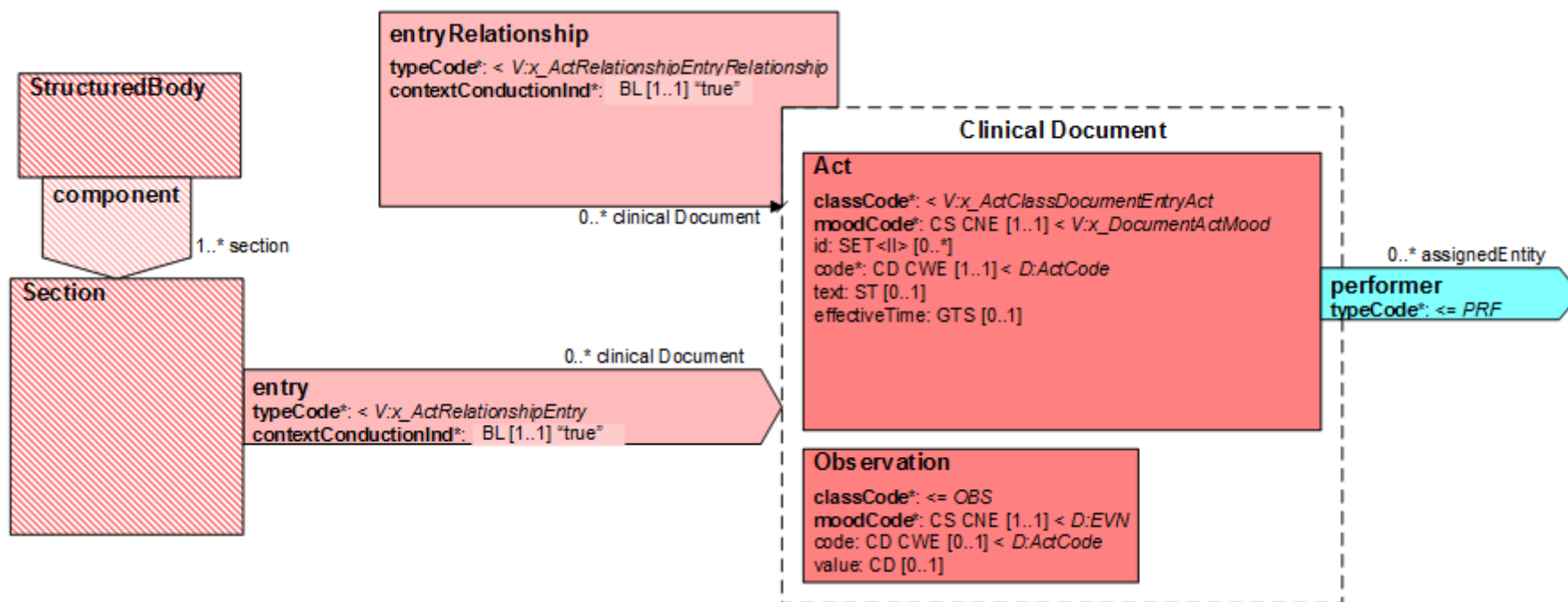
Figure 7.33. Pending Diagnostic Investigation (REQUESTED SERVICE)

CDA Mapping

Note

NS = In the absence of national standard code sets, the code sets used **SHALL** be registered code sets, i.e. registered through the [HL7 code set registration procedure](#)[16] with an appropriate object identifier (OID), and **SHALL** be publicly available.

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

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/		
Pending Diagnostic Investigation (REQUESTED SERVICE)	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.	0..*	**entry[pend_service]**		
			entry[pend_service]/**act**		
			entry[pend_service]/act/**@classCode="ACT"**		
Pending Diagnostic Investigation (REQUESTED SERVICE) > **Reason for Service**	Reason for the services being requested or provided.	0..1	entry[pend_service]/act/**entryRelationship[rsn_svc]**		
			entry[pend_service]/act/entryRelationship[rsn_svc]/**@typeCode="COMP"**		
			entry[pend_service]/act/entryRelationship[rsn_svc]/**act**		
			entry[pend_service]/act/entryRelationship[rsn_svc]/act/**@classCode="ACT"**		
			entry[pend_service]/act/entryRelationship[rsn_svc]/act/**@moodCode="EVN"**		
			entry[pend_service]/act/entryRelationship[rsn_svc]/act/**code**	NS	See <code> for available attributes.
Pending Diagnostic Investigation (REQUESTED SERVICE) > **Reason for Service Description**	Narrative about the reason for the services being requested or provided.	0..1	entry[pend_service]/act/entryRelationship[rsn_svc]/act/**text:ST**		

---

[16] http://www.hl7.org/oid/index.cfm?ref=footer

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Pending Diagnostic Investigation (REQUES-TED SERVICE) > **Service Description**	Description of the services requested or provided.	1..1	entry[pend_service]/act/**entryRelationship[svc_desc]**		
			entry[pend_service]/act/entryRelationship[svc_desc]/**@typeCode="COMP"**		
			entry[pend_service]/act/entryRelationship[svc_desc]/**observation**		
			entry[pend_service]/act/entryRelationship[svc_desc]/observation/**@classCode="OBS"**		
			entry[pend_service]/act/entryRelationship[svc_desc]/observation/**@moodCode="EVN"**		
			entry[pend_service]/act/entryRelationship[svc_desc]/observation/**code**		
			entry[pend_service]/act/entryRelationship[svc_desc]/observation/code/**@code="103.20117"**		
			entry[pend_service]/act/entryRelationship[svc_desc]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[pend_service]/act/entryRelationship[svc_desc]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[pend_service]/act/entryRelationship[svc_desc]/observation/code/**@displayName="Service Description"**		
			entry[pend_service]/act/entryRelationship[svc_desc]/observation/**value:CD**	NS	See <code> for available attributes. value/@nullFlavor **SHALL NOT** equal "NI", "UNK", "ASKU", "NAV", "NASK", "MSK", or "NA".
Pending Diagnostic Investigation (REQUES-TED SERVICE) > **DateTime Service Scheduled**	Date, and optionally time, at which the arranged services are scheduled to be provided.	0..1	entry[pend_service]/act/**effectiveTime:TS**		See <time> for available attributes. DateTime Service Scheduled **SHALL NOT** be present if Service Commencement Window is present. DateTime Service Scheduled is used when the booking has occurred, i.e. Service Booking Status(moodCode)="EVN".
Pending Diagnostic Investigation (REQUES-TED SERVICE) > **Service Commencement Window**	Period of time during which it would be ideal for the subject to be seen, in the opinion of the requester.	0..1	entry[pend_service]/act/**effectiveTime:IVL_TS**		See <time> for available attributes. Service Commencement Window **SHALL NOT** be present if DateTime Service Scheduled is present. Service Commencement Window is used before the booking has occurred, i.e. Service Booking Status(moodCode)="INT".

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Pending Diagnostic Investigation (REQUESTED SERVICE) > **Service Booking Status**	Indication of the status of the requested or provided services.	1..1	entry[pend_service]/act/**@moodCode**	Service Booking Status Value **SHALL** equal "APT", "ARQ", "EVN", or "RQO". See HL7 v3 CDA: Act.moodCode for definitions.	The value "EVN" would only be used in exceptional circumstances, for example a test has been carried out but the report is still not available.
Pending Diagnostic Investigation (REQUESTED SERVICE) > **Service Comment**	Additional narrative about the services that is not captured in other fields.	0..1	entry[pend_service]/act/**entryRelationship[svc_cmnt]**		
			entry[pend_service]/act/entryRelationship[svc_cmnt]/**@typeCode="COMP"**		
			entry[pend_service]/act/entryRelationship[svc_cmnt]/**act**		
			entry[pend_service]/act/entryRelationship[svc_cmnt]/act/**@classCode="INFRM"**		
			entry[pend_service]/act/entryRelationship[svc_cmnt]/act/**@moodCode="EVN"**		
			entry[pend_service]/act/entryRelationship[svc_cmnt]/act/**code**		
			entry[pend_service]/act/entryRelationship[svc_cmnt]/act/code/**@code="103.17035"**		
			entry[pend_service]/act/entryRelationship[svc_cmnt]/act/code/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			entry[pend_service]/act/entryRelationship[svc_cmnt]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[pend_service]/act/entryRelationship[svc_cmnt]/act/code/**@displayName="Service Comment"**		
			entry[pend_service]/act/entryRelationship[svc_cmnt]/act/**text:ST**		
Pending Diagnostic Investigation (REQUESTED SERVICE) > **Subject of Care Instruction Description**	Instructions, advice or information that has been given to the subject from a care provider in relation to the requested services.	0..*	entry[pend_service]/act/**entryRelationship[instruct]**		
			entry[pend_service]/act/entryRelationship[instruct]/**@typeCode="COMP"**		
			entry[pend_service]/act/entryRelationship[instruct]/**act**		
			entry[pend_service]/act/entryRelationship[instruct]/act/**@classCode="INFRM"**		
			entry[pend_service]/act/entryRelationship[instruct]/act/**@moodCode="EVN"**		
			entry[pend_service]/act/entryRelationship[instruct]/act/**code**		
			entry[pend_service]/act/entryRelationship[instruct]/act/code/**@code="103.10146"**		
			entry[pend_service]/act/entryRelationship[instruct]/act/code/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			entry[pend_service]/act/entryRelationship[instruct]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[pend_service]/act/entryRelationship[instruct]/act/code/**@displayName="Subject of Care Instruction Description"**		
			entry[pend_service]/act/entryRelationship[instruct]/act/**text**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Pending Diagnostic Investigation (REQUESTED SERVICE) > **SERVICE PROVIDER**	Provider (individual or organisation) to whom the subject of care is being referred.	0..1	See: SERVICE PROVIDER		
Pending Diagnostic Investigation (REQUESTED SERVICE) > **Requested Service Date-Time**	Period or date (and optionally time) of completion of the Requested Service action.	1..1	entry[pend_service]/act/**entryRelationship[serv_date]**		
			entry[pend_service]/act/entryRelationship[serv_date]/**@typeCode="COMP"**		
			entry[pend_service]/act/entryRelationship[serv_date]/**act**		
			entry[pend_service]/act/entryRelationship[serv_date]/act/**@classCode="ACT"**		
			entry[pend_service]/act/entryRelationship[serv_date]/act/**@moodCode="EVN"**		
			entry[pend_service]/act/entryRelationship[serv_date]/act/**code**		
			entry[pend_service]/act/entryRelationship[serv_date]/act/code/**@code="103.16635"**		
			entry[pend_service]/act/entryRelationship[serv_date]/act/code/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			entry[pend_service]/act/entryRelationship[serv_date]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[pend_service]/act/entryRelationship[serv_date]/act/code/**@displayName="Requested Service DateTime"**		
			entry[pend_service]/act/entryRelationship[serv_date]/act/**effectiveTime**		See <time> for available attributes.
Pending Diagnostic Investigation (REQUESTED SERVICE) > **Requested Service Instance Identifier**	Globally unique identifier for each instance of a Requested Service action.	0..1	entry[pend_service]/act/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
Pending Diagnostic Investigation (REQUESTED SERVICE) > **Detailed Clinical Model Identifier**	Globally unique identifier for this detailed clinical model.	1..1	entry[pend_service]/act/**code**		code/@nullFlavor **SHALL NOT** be present. The semantics of the Pending Diagnostic Investigation (REQUESTED SERVICE) is represented by a combination of entry [pend_service]/act/@moodCode and entry [pend_service]/act/@code.
			entry[pend_service]/act/code/**@code="102.20158"**		
			entry[pend_service]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[pend_service]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[pend_service]/act/code/**@displayName="Requested Service"**		

Example 7.32. Pending Diagnostic Investigation (REQUESTED SERVICE) XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
  …
  >
  …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin DIAGNOSTIC INVESTIGATIONS -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     …

     <!-- Begin Pending Diagnostic Investigation (REQUESTED SERVICE) -->
     <entry>
      <!-- Service Booking Status (moodCode) -->
      <act classCode="ACT" moodCode="RQO">
       <!-- Requested Service Instance Identifier - used for system purposes such as matching -->
       <id root="40dd5b94-9b84-4389-aad5-0bded41b12c2" />
       <!-- Detailed Clinical Model Identifier -->
       <code code="101.20158" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components"
        displayName="Requested Service" />

       <!-- Begin DateTime Service Scheduled / Service Commencement Window -->
       <effectiveTime>
        <center value="201612301000+1000" />
        <width unit="wk" value="2" />
       </effectiveTime>
       <!-- End DateTime Service Scheduled / Service Commencement Window -->

       <!-- SERVICE PROVIDER -->
       <performer typeCode="PRF">
        …
       </performer>

       <!-- Begin Reason for Service -->
       <entryRelationship typeCode="COMP">
        <act classCode="ACT" moodCode="EVN">
         <code code="399208008" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
          displayName="Plain chest X-ray" />
         <!-- End Reason for Service -->

         <!-- Reason for Service Description -->
         <text>Thank you for seeing this 14-year-old schoolboy who fell whilst playing football at school yesterday. I suspect he has a fracture.</text>
        </act>
       </entryRelationship>

       <!-- Begin Service Description -->
       <entryRelationship typeCode="COMP">
```

```xml
        <observation classCode="OBS" moodCode="EVN">
         <code code="103.20117" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components"
          displayName="Service Description" />
         <value xsi:type="CD" code="241646009" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="MRI of cervical spine"/>
        </observation>
       </entryRelationship>
       <!-- End Service Description -->

       <!-- Begin Service Comment -->
       <entryRelationship typeCode="COMP">
        <act classCode="INFRM" moodCode="EVN">
         <code code="103.17035" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components"
          displayName="Service Comment" />
         <text>comments</text>
        </act>
       </entryRelationship>
       <!-- End Service Comment -->

       <!-- Begin Subject of Care Instruction Description -->
       <entryRelationship typeCode="COMP">
        <act classCode="INFRM" moodCode="EVN">
         <code code="103.10146" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components"
          displayName="Subject of Care Instruction Description" />
         <text>Drip dry.</text>
        </act>
       </entryRelationship>
       <!-- End Subject of Care Instruction Description -->

       <!-- Begin Requested Service DateTime -->
       <entryRelationship typeCode="COMP">
        <act classCode="ACT" moodCode="EVN">
         <code code="103.16635" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components"
          displayName="Requested Service DateTime" />
         <effectiveTime value="201612301000+1000" />
        </act>
       </entryRelationship>
       <!-- End Requested Service DateTime -->

      </act>
     </entry>
     <!-- End Pending Diagnostic Investigation (REQUESTED SERVICE) -->

    </section>
   </component>
   <!-- End DIAGNOSTIC INVESTIGATIONS -->

 </structuredBody>
</component>
<!-- End CDA Body -->
</ClinicalDocument>
```

7.1.6.3.1 SERVICE PROVIDER

Identification

Name	SERVICE PROVIDER
Metadata Type	Data Group
Identifier	DG-10296

Relationships

Parent

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

Choices

Note

Mentioned below are the possible mutually exclusive 'SERVICE PROVIDER' instantiation choices.

Data Type	Name
	SERVICE PROVIDER as a PERSON
	SERVICE PROVIDER as an ORGANISATION

7.1.6.3.1.1 SERVICE PROVIDER as a PERSON

CDA R-MIM Representation

Figure 7.34 SERVICE PROVIDER as a PERSON shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The SERVICE PROVIDER data group instantiated as 'PERSON' is related to its containing Act class by the performer participation class. A performer is a person in the role of assignedEntity (AssignedEntity class). The entity playing the role is assignedPerson (Person class). The entity identifier of the participant is mapped to the EntityIdentifier class (Australian Digital Health Agency CDA extension) which is associated to the assignedEntity. Employment detail is mapped to the Australian Digital Health Agency CDA extension Employment.

Figure 7.34. SERVICE PROVIDER as a PERSON

Figure 7.35 SERVICE PROVIDER as a PERSON - ENTITLEMENT shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

Figure 7.35. SERVICE PROVIDER as a PERSON - ENTITLEMENT

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/entry[pend_serv]/act/		
SERVICE PROVIDER	Provider (individual or organisation) to whom the subject of care is being referred.	0..1	**performer[serv_prov]**		
SERVICE PROVIDER > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	0..0	performer[serv_prov]/**time**		
SERVICE PROVIDER > **LOCATION OF PARTI-CIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIP-ATION is not currently mapped.
SERVICE PROVIDER > **Participation Type**	The categorisation of the nature of the participant's in-volvement in the healthcare event described by this participation.	1..1	performer[serv_prov]/**@typeCode="PRF"**	Participation Type **SHALL** have an imple-mentation-specific value equivalent to "Referee".	
SERVICE PROVIDER > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	performer[serv_prov]/**assignedEntity/code**	Role **SHOULD** have a value chosen from *1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occu-pations, 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 publicly available **MAY** be used.	See <code> for avail-able attributes.
n/a	n/a	1..1	performer[serv_prov]/assignedEntity/**id**		Required CDA ele-ment. See <id> for available attributes.
SERVICE PROVIDER > **PARTICIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a health-care event/encounter/clinical interaction.	1..1	performer[serv_prov]/assignedEntity/**assignedPerson**		
SERVICE PROVIDER > PARTICIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..*	performer[serv_prov]/assignedEntity/assignedPerson/<**Entity Identifier**>		See common pattern: Entity Identifier.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SERVICE PROVIDER > PARTICIPANT > **AD-DRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	performer[serv_prov]/assignedEntity/<**Address**>	AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. Address Purpose (addr/@use) **SHALL** be set to Business (see AS 5017-2006: Health Care Client Identifier Address Purpose).	See common pattern: Address.
SERVICE PROVIDER > PARTICIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	performer[serv_prov]/assignedEntity/<**Electronic Communication Detail**>	Electronic Communication Usage Code (telecom/@use) **SHALL** be set to Workplace (see HL7: TelecommunicationAddressUse).	See common pattern: Electronic Communication Detail.
SERVICE PROVIDER > PARTICIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **PERSON**	An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient).	1..1	n/a		Not mapped directly, encompassed implicitly in performer[serv_prov]/assignedEntity/assignedPerson.
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **PERSON NAME**	The appellation by which an individual may be identified separately from any other within a social context.	1..*	performer[serv_prov]/assignedEntity/assignedPerson/<**Person Name**>		See common pattern: Person Name.
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **Relationship to Subject of Care**	The relationship of a participant to a subject of care (patient).	0..0	performer[serv_prov]/assignedEntity/assignedPerson/**ext:personalRelationship**		
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **EMPLOYMENT DETAIL**	A person's occupation and employer.	1..1	performer[serv_prov]/assignedEntity/assignedPerson/<**Employment**>		See common pattern: Employment.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **DEMOGRAPHIC DATA**	Additional characteristics of a person that may be useful for identification or other clinical purposes.	0..0	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
			performer[serv_prov]/assignedEntity/assignedPerson/**ext:administrativeGenderCode**		
			performer[serv_prov]/assignedEntity/assignedPerson/**ext:birthTime**		
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See *4 Administrative Observations*)		
SERVICE PROVIDER > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..*	**ext:coverage2[serv_prov]/@typeCode="COVBY"**		
			ext:coverage2[serv_prov]/**ext:entitlement**		
			ext:coverage2[serv_prov]/ext:entitlement/**@classCode="COV"**		
			ext:coverage2[serv_prov]/ext:entitlement/**@moodCode="EVN"**		
			ext:coverage2[serv_prov]/ext:entitlement/**ext:participant/@typeCode="HLD"**		
			ext:coverage2[serv_prov]/ext:entitlement/ext:participant/**ext:participantRole/@classCode="ASSIGNED"**		
			ext:coverage2[serv_prov]/ext:entitlement/ext:participant/ext:participantRole/**ext:id**		This **SHALL** hold the same value as performer[serv_prov]/assignedEntity/id.
SERVICE PROVIDER > PARTICIPANT > ENTITLEMENT > **Entitlement Number**	A number or code issued for the purpose of identifying the entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	1..1	ext:coverage2[serv_prov]/ext:entitlement/**ext:id**		See <id> for available attributes.
SERVICE PROVIDER > PARTICIPANT > ENTITLEMENT > **Entitlement Type**	The description of the scope of an entitlement.	1..1	ext:coverage2[serv_prov]/ext:entitlement/**ext:code**	NCTIS: Admin Codes - Entitlement Type	See <code> for available attributes.
SERVICE PROVIDER > PARTICIPANT > ENTITLEMENT > **Entitlement Validity Duration**	The time interval for which an entitlement is valid.	0..1	ext:coverage2[serv_prov]/ext:entitlement/**ext:effectiveTime**		See <time> for available attributes.
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/entry[pend_serv]/act/		
SERVICE PROVIDER > PARTICIPANT > **Qualifications**	A list of professional certifications, and certificates recognising having passed a course.	0..1	performer[serv_prov]/assignedEntity/assignedPerson/**ext:asQualifications**		See Australian Digital Health Agency CDA extension: Qualifications.
			performer[serv_prov]/assignedEntity/assignedPerson/ext:asQualifications/**@classCode="QUAL"**		
			performer[serv_prov]/assignedEntity/assignedPerson/ext:asQualifications/**ext:code/originalText**	Qualifications is a text field, so the text list is entered in the originalText field of the code element.	

Example 7.33. SERVICE PROVIDER as a PERSON XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

<!-- Begin CDA Body -->
<component>
 <structuredBody>
   …

  <!-- Begin Administrative Observations -->
  <component>
   <section>
    <code code="102.16080" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Administrative Observations"/>
    <title>Administrative Observations</title>

    <!-- narrative block -->
    <text>
     <table>
      <tbody>
         <tr>
             <th>Australian Medicare Prescriber Number</th>
             <td>049960CT</td>
         </tr>
      </tbody>
     </table>
    </text>
     …

    <!-- Begin SERVICE PROVIDER as a PERSON ENTITLEMENT -->
    <ext:coverage2 typeCode="COVBY">
     <ext:entitlement classCode="COV" moodCode="EVN">
      <ext:id assigningAuthorityName="Medicare Prescriber number" root="1.2.36.174030967.0.3" extension="049960CT" />
      <ext:code code="10" codeSystem="1.2.36.1.2001.1001.101.104.16047" codeSystemName="NCTIS Entitlement Type Values"
          displayName="Medicare Prescriber Number" />
      <ext:effectiveTime>
          <low value="200501010101+1100" />
          <high value="202501010101+1100" />
      </ext:effectiveTime>
      <ext:participant typeCode="HLD">
          <ext:participantRole classCode="ASSIGNED">
             <!-- Same as the SERVICE PROVIDER as a Person (participant) id -->
             <ext:id root="48a14a67-a494-484b-8772-2887e1d99d50" />
          </ext:participantRole>
      </ext:participant>
     </ext:entitlement>
    </ext:coverage2>
    <!-- End SERVICE PROVIDER as a PERSON ENTITLEMENT -->
     …
```

```xml
  </section>
</component>
<!-- End Administrative Observations -->
…

<!-- Begin DIAGNOSTIC INVESTIGATIONS -->
<component typeCode="COMP">
 <section classCode="DOCSECT" moodCode="EVN">
  …

  <!-- Begin Pending Diagnostic Investigation (REQUESTED SERVICE) -->
  <entry>
   <act classCode="ACT" moodCode="INT">

    <!-- Begin SERVICE PROVIDER as a PERSON -->
    <performer typeCode="PRF">
     <assignedEntity classCode="ASSIGNED">
      <!-- id is used for system purposes such as matching -->
      <id root="db7c3d78-79e9-4d06-874e-890241cfce14"/>

      <!-- Role -->
      <code code="811311" codeSystem="2.16.840.1.113883.13.62"
       codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
       displayName="Domestic Cleaner"/>

      <!-- ADDRESS -->
      <addr use="WP">
       <streetAddressLine>55 Radiology Drive</streetAddressLine>
       <city>Healthville</city>
       <state>QLD</state>
       <postalCode>5555</postalCode>
       <additionalLocator>32568931</additionalLocator>
       <country>Australia</country>
      </addr>

      <!-- ELECTRONIC COMMUNICATION DETAIL -->
      <telecom use="WP" value="tel:0722222222"/>

      <assignedPerson>
       <!-- PERSON NAME -->
       <name use="L">
        <prefix>Dr.</prefix>
        <given>Bone</given>
        <family>Doctore</family>
       </name>

       <!-- Entity Identifier -->
       <ext:asEntityIdentifier classCode="IDENT">
        <ext:id assigningAuthorityName="HPI-I"
         root="1.2.36.1.2001.1003.0.8003619900015717"/>
        <ext:assigningGeographicArea classCode="PLC">
         <ext:name>National Identifier</ext:name>
        </ext:assigningGeographicArea>
       </ext:asEntityIdentifier>

       <!-- Begin EMPLOYMENT DETAIL -->
       <ext:asEmployment classCode="EMP">
        <!-- Position In Organisation -->
        <ext:code>
         <originalText>Staff Radiologist</originalText>
        </ext:code>

        <!-- Occupation -->
```
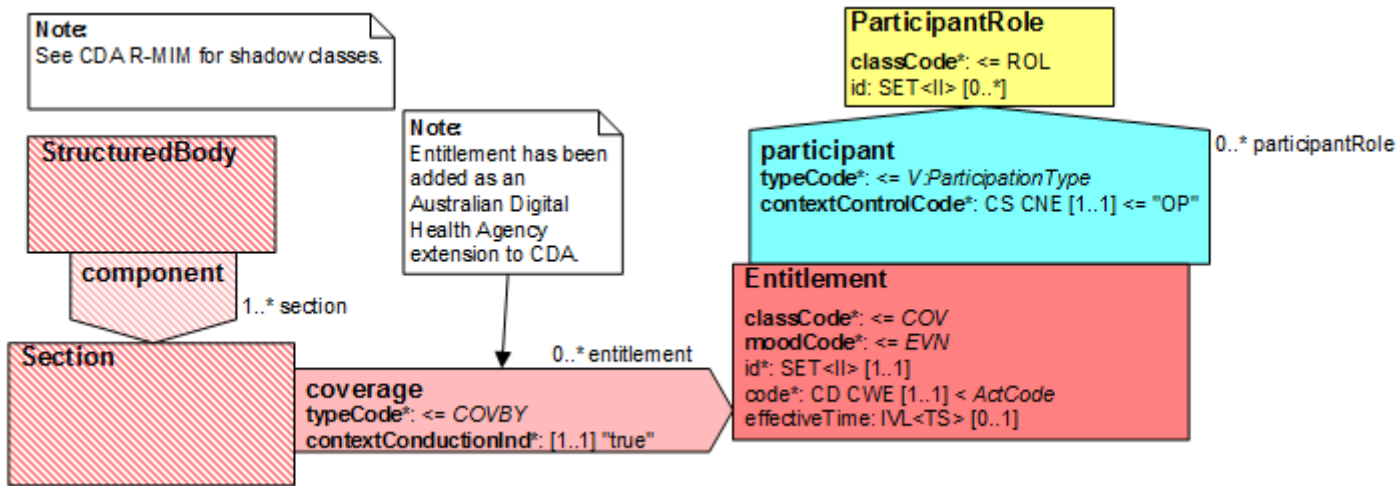
```xml
  <ext:jobCode code="253917"
   codeSystem="2.16.840.1.113883.13.62"
   codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
   displayName="Diagnostic and Interventional Radiologist"/>

  <!-- Employment Type -->
  <ext:jobClassCode code="FT"
   codeSystem="2.16.840.1.113883.5.1059"
   codeSystemName="HL7:EmployeeJobClass"
   displayName="full-time"/>

  <!-- Begin EMPLOYER ORGANISATION -->
  <ext:employerOrganization>
   <!-- Department/Unit -->
   <name>Radiology Dept</name>

   <asOrganizationPartOf>
    <wholeOrganization>
     <!-- Organisation Name -->
     <name use="ORGB">Acme Hospital Group</name>

     <!-- ELECTRONIC COMMUNICATION DETAIL -->
     <telecom value="tel:0499999999" use="WP"/>

     <!-- ADDRESS -->
     <addr use="WP">
      <houseNumber>1</houseNumber>
      <streetName>Clinician</streetName>
      <streetNameType>St</streetNameType>
      <city>Healthville</city>
      <state>QLD</state>
      <postalCode>5555</postalCode>
      <additionalLocator>32568931</additionalLocator>
     </addr>

     <!-- Entity Identifier -->
     <ext:asEntityIdentifier classCode="IDENT">
      <ext:id assigningAuthorityName="HPI-O"
       root="1.2.36.1.2001.1003.0.8003621566684455"/>
      <ext:assigningGeographicArea classCode="PLC">
       <ext:name>National Identifier</ext:name>
      </ext:assigningGeographicArea>
     </ext:asEntityIdentifier>

    </wholeOrganization>
   </asOrganizationPartOf>
  </ext:employerOrganization>
  <!-- End EMPLOYER ORGANISATION -->

 </ext:asEmployment>
 <!-- End EMPLOYMENT DETAIL -->

 <!-- Qualifications -->
 <ext:asQualifications classCode="QUAL">
  <ext:code>
   <originalText>M.B.B.S</originalText>
  </ext:code>
 </ext:asQualifications>

 </assignedPerson>
 </assignedEntity>
</performer>
<!-- End SERVICE PROVIDER as a PERSON -->
```

```
        …

      </act>
     </entry>
     <!-- End Pending Diagnostic Investigation (REQUESTED SERVICE) -->

      …

    </section>
   </component>
   <!-- End DIAGNOSTIC INVESTIGATIONS -->

      …

  </structuredBody>
 </component>
 <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.6.3.1.2 SERVICE PROVIDER as an ORGANISATION

CDA R-MIM Representation

Figure 7.36 SERVICE PROVIDER as an ORGANISATION shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The SERVICE PROVIDER data group instantiated as 'ORGANISATION' is related to its containing Act class by the participant Performer class. A participant is an organisation in the role of assignedEntity (AssignedEntity class). The entity playing the role is representedOrganization (Organization class). The department/unit name is mapped to representedOrganization.name and the organisation name is mapped to the wholeOrganization (Organization class) which represents a whole-part relationship using the OrganizationPartOf role. The organisation entity identifier is represented by the EntityIdentifier class (Australian Digital Health Agency CDA extension) which is associated to the wholeOrganization.

Figure 7.36. SERVICE PROVIDER as an ORGANISATION

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/entry[pend_serv]/act/		
SERVICE PROVIDER	Provider (individual or organisation) to whom the subject of care is being referred.	0..1	**performer[serv_prov_org]**		
SERVICE PROVIDER > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	0..0	performer[serv_prov_org]/**time**		See common pattern: time.
SERVICE PROVIDER > **LOCATION OF PARTICIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues		LOCATION OF PARTICIPATION is not currently mapped.
SERVICE PROVIDER > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	performer[serv_prov_org]/**@typeCode="PRF"**	Participation Type **SHALL** have an implementation-specific value equivalent to "Referee".	
SERVICE PROVIDER > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	performer[serv_prov_org]/**assignedEntity/code**	Role **SHOULD** have a value representing the type of Facility e.g. Hospital, Clinic, Community Service Centre, Home care/housekeeping assistance.	See <code> for available attributes.
n/a	n/a	1..1	performer[serv_prov_org]/assignedEntity/**id**		Required CDA element. See <id> for available attributes.
SERVICE PROVIDER > **PARTICIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	performer[serv_prov_org]/assignedEntity/**representedOrganization**		
SERVICE PROVIDER > PARTICIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..*	performer[serv_prov_org]/assignedEntity/representedOrganization/asOrganizationPartOf/wholeOrganization/<**Entity Identifier**>		See common pattern: Entity Identifier.
SERVICE PROVIDER > PARTICIPANT > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	performer[serv_prov_org]/assignedEntity/<**Address**>	AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.	See common pattern: Address.
SERVICE PROVIDER > PARTICIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	1..*	performer[serv_prov_org]/assignedEntity/<**Electronic Communication Detail**>		See common pattern: Electronic Communication Detail.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SERVICE PROVIDER > PARTICIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a ORGANISATION.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **ORGANISATION**	Any organisation of interest to, or involved in, the business of healthcare service provision.	1..1	n/a		Not mapped directly, encompassed implicitly in performer[serv_prov_org]/assignedEntity/representedOrganization.
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Organisation Name**	The name by which an organisation is known or called.	1..1	performer[serv_prov_org]/assignedEntity/representedOrganization/**asOrganizationPartOf/wholeOrganization/name**		
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Department/Unit**	The name by which a department or unit within a larger organisation is known or called.	0..1	performer[serv_prov_org]/assignedEntity/representedOrganization/**name**		
SERVICE PROVIDER > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > ORGANISATION > **Organisation Name Usage**	The classification that enables differentiation between recorded names for an organisation or service location.	0..1	performer[serv_prov_org]/assignedEntity/representedOrganization/asOrganizationPartOf/wholeOrganization/name/**@use**	AS 4846-2006: Health Care Provider Organisation Name Usage	
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*)		
SERVICE PROVIDER > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..0	See Known Issues		Prohibition of ENTITLEMENT is not currently mapped.
CDA Header Data Elements			Context: /ClinicalDocument/component/structuredBody/component[diag_inv]/section/entry[pend_serv]/act/		
SERVICE PROVIDER > PARTICIPANT > **Qualifications**	A list of professional certifications, and certificates recognising having passed a course.	0..0	n/a		This logical data component has no mapping to CDA.

Example 7.34. SERVICE PROVIDER as an ORGANISATION XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

<!-- Begin CDA Body -->
<component>
  <structuredBody>
    …

    <!-- Begin DIAGNOSTIC INVESTIGATIONS -->
    <component typeCode="COMP">
     <section classCode="DOCSECT" moodCode="EVN">
       …

       <!-- Begin Pending Diagnostic Investigation (REQUESTED SERVICE) -->
       <entry>
        <act classCode="ACT" moodCode="EVN">
          …

          <!-- Begin SERVICE PROVIDER as an ORGANISATION -->
          <performer typeCode="PRF">
           <assignedEntity classCode="ASSIGNED">

             <!-- id is used for system purposes such as matching -->
             <id root="db7c3d78-79e9-4d06-874e-890241cfce14"/>

             <!-- Role -->
             <code code="309964003" codeSystem="2.16.840.1.113883.6.96"
              codeSystemName="SNOMED CT"
              displayName="Radiology department"/>

             <!-- ADDRESS -->
             <addr use="WP">
              <streetAddressLine>55 Radiology Drive</streetAddressLine>
              <city>Healthville</city>
              <state>QLD</state>
              <postalCode>5555</postalCode>
              <additionalLocator>32568931</additionalLocator>
              <country>Australia</country>
             </addr>

             <!-- ELECTRONIC COMMUNICATION DETAIL -->
             <telecom use="WP" value="tel:0788888888"/>

             <representedOrganization>
              <!-- Department/Unit Name -->
              <name>Radiology Dept</name>

              <asOrganizationPartOf>
```

```xml
            <wholeOrganization>
             <!-- Organisation Name -->
             <name use="ORGB">Acme Hospital Group</name>

             <!-- Entity Identifier -->
             <ext:asEntityIdentifier classCode="IDENT">
              <ext:id assigningAuthorityName="HPI-O"
               root="1.2.36.1.2001.1003.0.8003621566684455"/>
              <ext:assigningGeographicArea classCode="PLC">
               <ext:name>National Identifier</ext:name>
              </ext:assigningGeographicArea>
             </ext:asEntityIdentifier>

            </wholeOrganization>
           </asOrganizationPartOf>

          </representedOrganization>
         </assignedEntity>
        </performer>
        <!-- End SERVICE PROVIDER as an ORGANISATION -->

       </act>
      </entry>
      <!-- End Pending Diagnostic Investigation (REQUESTED SERVICE) -->
      …

    </section>
   </component>
   <!-- End DIAGNOSTIC INVESTIGATIONS -->
   …

  </structuredBody>
 </component>
 <!-- End CDA Body -->
</ClinicalDocument>
```

Approved for external use

8 Common Patterns

8.1 code

The <code> element pattern refines the kind of act being recorded. It is of data type CD CWE (Concept Descriptor, Coded With Extensibility). It may have:

- a null attribute (*nullFlavor*)

- *originalText*

- *code* and *codeSystem*

- *qualifier* (CD)

- *translation* (CD)

- any combination of the above.

A *displayName* is highly recommended.

Where used, the *code* attribute **SHALL** contain a code from the relevant vocabulary.

Where used, the *codeSystem* attribute **SHALL** contain the OID for the relevant vocabulary. Values for coding systems can be obtained from the HL7 OID registry accessible from the HL7 home web page at www.hl7.org[1].

Where used, the *displayName* attribute **SHALL** contain a human-readable description of the code value that is provided by the code system; *displayName* is a case insensitive value except where explicitly stated otherwise by the code system. A preferred interface term for display that is not a member of the description set supplied by the code system **SHALL NOT** be used to populate the *displayName* attribute.

The *codeSystemName* **MAY** be present and, where used, **SHALL** contain a human-readable name for the coding system.

Where used, the *originalText* element **SHALL** be used to carry the full text associated with this code as selected by, typed by or displayed to the author of this statement including the contents of the *qualifier* if present.

---

[1] http://www.hl7.org

Where used, the *qualifier* element **SHALL** carry a code from the same code system as the code; for example if the main concept code is from SNOMED CT the *qualifier* also has to be taken from SNOMED CT as the use of a different code system for a *qualifier* is not allowed. The use of the *qualifier* element is governed by the code system used and cannot be used with code systems that do not provide for qualifiers (e.g. pre-coordinated systems).

Codes can be obtained from a variety of sources. Additional vocabularies are also available from the HL7 Version 3 Vocabulary tables, available to HL7 members through the HL7 web site. In some cases, the vocabularies have been specified; in others, a particular code has been fixed or there is no vocabulary specified. For guidance on coding common clinical concepts in CDA documents see *Representing Coding in CDA Documents Implementation Guidance [NEHT2011bv]*.

Where a code is used from a different code system to that specified, or where the code lies outside the reference set specified, or where a code system or reference set is not specified, the code value **SHALL** be consistent with the meaning of the associated data component from the structured content specification.

If a vocabulary is specified in this implementation guide and no suitable code can be found, the *originalText* element **SHALL** be used to carry the full text as selected by, typed by or displayed to the author of this statement.

If a vocabulary is specified in this implementation guide and it is not possible to use this vocabulary, but an alternate vocabulary is in use, the *originalText* element **SHALL** be used to carry the full text as selected by, typed by or displayed to the author of this statement. The *code* element **SHALL** be used to carry the relevant information from the alternate vocabulary and the alternate vocabulary **SHALL** be registered with HL7 and allocated an appropriate OID.

If an alternate vocabulary is in use and a translation into the specified code system is available, the *originalText* element **SHALL** be used to carry the full text as selected by, typed by or displayed to the author of this statement. The *code* element **SHALL** be used to carry the relevant information from the alternate vocabulary and the alternate vocabulary **SHALL** be registered with HL7 and allocated an appropriate OID. The *translation* element **SHALL** be used to indicate the translation code from the specified vocabulary.

Example 8.1. code

```xml
<!-- Specified code system in use -->
<code
    code="271807003"
    codeSystem="2.16.840.1.113883.6.96"
    codeSystemName="SNOMED CT"
    codeSystemVersion="20101130"
    displayName="Skin rash" />

<!-- Specified code system in use with a qualifier -->
<code
    code="23986001"
    codeSystem="2.16.840.1.113883.6.96"
    codeSystemName="SNOMED CT"
    displayName="Glaucoma" >
    <originalText>Glaucoma, left</originalText>
    <qualifier>
        <name
            code="272741003"
            codeSystem="2.16.840.1.3883.6.96"
            codeSystemName="SNOMED CT"
            displayName="Laterality" />
        <value
            code="7771000"
```

```xml
                codeSystem="2.16.840.1.113883.6.96"
                codeSystemName="SNOMED CT"
                displayName="Left"
                xsi:type="CD" />
        </qualifier>
</code>


<!-- Alternate code system in use and a translation into the specified code system is available -->
<code
    code="J45.9"
    codeSystem="2.16.840.1.113883.6.135"
    codeSystemName="icd10am"
    displayName="Asthma, unspecified">
    <originalText>Asthma</originalText>
    <translation
        code="195967001"
        codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMED CT"
        displayName="Asthma"/>
</code>


<!-- Alternate code system in use and no translation into the specified code system is available -->
<code
    code="J45.9"
    codeSystem="2.16.840.1.113883.6.135"
    codeSystemName="icd10am"
    displayName="Asthma, unspecified">
    <originalText>Asthma</originalText>
</code>


<!-- No suitable code can be found or there is no code system in use -->
<code
    <originalText>Asthma</originalText>
</code>
```

8.2 id

The <id> element pattern is of data type II (Instance Identifier). The II data type may have:

- a null attribute (*nullFlavor*)

- a *root*

- a *root* and an *extension*

- a *root* and an *extension* and an *assigningAuthorityName*

- a *root* and an *assigningAuthorityName*

- a *root* and an *assigningAuthorityName* and a *displayable*

- a *root* and an *extension* and a *displayable*

- a *root* and an *extension* and an *assigningAuthorityName* and a *displayable*

- a *root* and a *displayable*

The root attribute is **REQUIRED** and is a unique identifier that guarantees the global uniqueness of the instance identifier. The root alone **MAY** be the entire instance identifier. The root attribute **SHALL** be a UUID or OID.

The extension attribute **MAY** be present, and is a character string as a unique identifier within the scope of the identifier root.

In the case of Entity Identifier, assigningAuthorityName is **RECOMMENDED**.

Identifiers appear in this implementation guide for two different reasons. The first is that the identifier has been identified in the business requirements as relevant to the business process. These identifiers are documented in the SCSs, which make clear the meaning of this identifier.

In addition, the implementation makes clear that identifiers may also be found on many other parts of the CDA content model. These identifiers are allowed to facilitate record matching across multiple versions of related documents, so that the same record can consistently be identified, in spite of variations in the information as the record passes through time or between systems. These identifiers have no meaning in the business specification. If senders provide one of these identifiers, it **SHALL** always be the same identifier in all versions of the record, and it **SHALL** be globally unique per the rules of the II data type.

Example 8.2. id

```
<id root="2.16.840.1.113883.19" extension="123A45" />
```

```
<ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />
```

8.3 time

When a time value is supplied it **SHALL** include hours and minutes.

When a time value is supplied it **MAY** include seconds and fractions of seconds.

When a time value is supplied it **SHALL** include a time zone.

The <time> element pattern is of data type TS (Point in Time) and can also be an interval between two times (IVL_TS), representing a period of time. Both forms can either have a nullFlavor attribute or child components following allowed patterns.

A simple timestamp (point in time) will only contain a value attribute containing the time value, expressed as a series of digits as long as required or as available.

Example 8.3. Simple timestamp

```
<time value="20091030" />
```

This represents "October 30, 2009" to calendar day precision. In cases where the containing element is defined in the CDA schema as "ANY" data type, it is useful to provide an xsi:type attribute, set to the value "TS".

The period of time pattern is defined in terms of one or both of its lowest and highest values. The low and high elements are instances of the timestamp pattern described above. More complex time period concepts can be expressed by combining a high, low, or centre element with a width element.

Example 8.4. Low time

```
<period>
    <low value="20091030" />
</period>
```

This represents "a period after October 30, 2009". In cases where the containing element is defined in the CDA schema as "ANY" data type, it is useful to provide an xsi:type attribute, set to the value "IVL_TS", as in the next example.

Example 8.5. Interval timestamp 1

```
<period xsi:type="IVL_TS">
    <high value="200910301030+1000" />
</period>
```

This represents "a period before 10:30 a.m. UTC+10, October 30, 2009". A discretionary xsi:type attribute has been provided to explicitly cast the pattern to "IVL_TS".

Example 8.6. Interval timestamp 2

```
<period xsi:type="IVL_TS">
   <low value="2007" />
   <high value="2009" />
</period>
```

This represents "the calendar years between 2007 and 2009". The low element **SHALL** precede the high element. As per the previous example, a discretionary xsi:type attribute has been provided to explicitly cast the pattern to "IVL_TS".

Example 8.7. Width time

```
<period>
   <high value="20091017" />
   <width value="2" unit="wk" />
</period>
```

This expresses "two weeks before October 17th, 2009". A low value can be derived from this.

8.4 Entity Identifier

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Data Elements					
Entity Identifier	A number or code issued for the purpose of identifying a participant within a healthcare context.	The cardinality of the group comes from the linking parent and the cardinality of the children data elements comes from the R-MIM diagram.	**ext:asEntityIdentifier**		See Australian Digital Health Agency CDA extension: EntityIdentifier.
			ext:asEntityIdentifier/**@classCode="IDENT"**		
			ext:asEntityIdentifier/**ext:id**		
			ext:asEntityIdentifier/ext:id/**@root**	Attribute @root **SHALL** be used, **SHALL** be an OID and **SHALL NOT** be a UUID. Attribute @root **SHALL** be a globally unique object identifier (i.e. OID) that identifies the combination of geographic area, issuer and type. If no such OID exists, it **SHALL** be defined before any identifiers can be created.	
			ext:asEntityIdentifier/ext:id/**@extension**	Attribute @extension **MAY** be used and, if it is used, **SHALL** be a unique identifier within the scope of the root that is populated directly from the designation.	
			ext:asEntityIdentifier/ext:id/**@assigningAuthorityName**	Attribute @assigningAuthorityName **SHOULD** be used and, if it is used, **SHALL** be a human-readable name for the namespace represented in the root that is populated with the issuer, or identifier type, or a concatenation of both as appropriate. This **SHOULD NOT** be used for machine readability purposes.	
			ext:asEntityIdentifier/**ext:code**		See <code> for available attributes.
			ext:asEntityIdentifier/**ext:assigningGeographicArea**		
			ext:asEntityIdentifier/ext:assigningGeographicArea/**@classCode="PLC"**		
			ext:asEntityIdentifier/ext:assigningGeographicArea/**ext:name**	Element ext:name **MAY** be used and, if it is used, **SHALL** be the range and extent that the identifier applies to the object with which it is associated that is populated directly from the geographic area. This **SHOULD NOT** be used for machine readability purposes. Element ext:name **SHALL** be populated with one of the following values sourced from *AS 5017 (2006) – Health Care Client Identification [SA2006b]*: "Local Client (Unit Record) Identifier", "Area/Region/District Identifier", "State or Territory Identifier", "National Identifier".	

Example 8.8. Entity Identifier

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<!-- person -->
<xs:asEntityIdentifier classCode="IDENT">
 <xs:id root="1.2.36.1.2001.1003.0.8003608833357361" assigningAuthorityName="IHI" />
  <xs:assigningGeographicArea classCode="PLC">
       <xs:name>National Identifier</xs:name>
      </xs:assigningGeographicArea>
</xs:asEntityIdentifier>

<xs:asEntityIdentifier classCode="IDENT">
 <xs:id root="1.2.36.1.2001.1005.29.8003621566684455" extension="542181" assigningAuthorityName="Croydon GP Centre" />
    <xs:code code="MR" codeSystem="2.16.840.1.113883.12.203" codeSystemName="Identifier Type (HL7)" />
</xs:asEntityIdentifier>

<!-- organisation -->
<ext:asEntityIdentifier classCode="IDENT">
    <ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />
    <ext:assigningGeographicArea classCode="PLC">
       <ext:name>National Identifier</ext:name>
    </ext:assigningGeographicArea>
</ext:asEntityIdentifier>
```

8.5 Person Name

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Data Elements					
PERSON NAME	The appellation by which an individual may be identified separately from any other within a social context.	Cardinality comes from linking parent.	**name**		
PERSON NAME > **Name Title**	An honorific form of address commencing a name.	0..*	name/**prefix**		
PERSON NAME > **Family Name**	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names.	1..1	name/**family**		
PERSON NAME > **Given Name**	The person's identifying names within the family group or by which the person is uniquely socially identified.	0..*	name/**given**		
PERSON NAME > **Name Suffix**	The additional term used following a person's name to identify that person.	0..*	name/**suffix**		
PERSON NAME > **Preferred Name Indicator**	A flag to indicate that this is the name a person has selected for use.	0..1	name/**@use**	A code for representing "preferred name" has been requested from HL7 International but is not currently available.	If both Preferred Name Indicator and Person Name Usage have been provided, the use attribute **SHALL** include them as space separated list of codes.
PERSON NAME > **Person Name Usage**	The classification that enables differentiation between recorded names for a person.	0..1	name/**@use**	AS 5017-2006: Health Care Client Name Usage	If both Preferred Name Indicator and Person Name Usage have been provided, the use attribute **SHALL** include them as space separated list of codes.

Example 8.9. Person Name

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<!-- registered name -->
<name use="L">
    <prefix>Ms</prefix>
    <given>Sally</given>
    <family>Grant</family>
</name>
```

8.6 Address

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Data Elements					
ADDRESS	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	Cardinality comes from linking parent.	**addr**		In an event where the address is 'Unknown' or 'Masked / Not to be disclosed for privacy reason', the following conditions **SHOULD** be applied. The nullFlavor = "UNK" **SHOULD** be permitted if the value of address is not known and the value of 'No Fixed Address Indicator' is false. The nullFlavor = "MSK" **SHOULD** be permitted if the value of address is masked and the value of 'No Fixed Address Indicator' is false. The nullFlavor = "NA" **SHOULD** be permitted if value of 'No Fixed Address Indicator' is true. (This is the same as the current CDA IG constraint). The value of the <addr> data group **SHOULD** be populated in all other circumstances.
ADDRESS > **No Fixed Address Indicator**	A flag to indicate whether or not the participant has no fixed address.	1..1	addr/**@nullFlavor**	If true, nullFlavor="NA".	
ADDRESS > **AUSTRALIAN OR INTERNATIONAL ADDRESS**	Represents a choice to be made at run-time between an AUSTRALIAN ADDRESS and an INTERNATIONAL ADDRESS.	1..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > **INTERNATIONAL ADDRESS**	The description of a non-Australian location where an entity is located or can be otherwise reached or found.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > INTERNATIONAL ADDRESS > **International Address Line**	A composite of address details comprising a low level geographical/physical description of a location that, used in conjunction with the other high level address components, i.e. international state/province, international postcode and country, forms a complete geographic/physical address.	0..*	addr/**streetAddressLine**		
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > INTERNATIONAL ADDRESS > **International State/Province**	The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country.	0..1	addr/**state**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > INTERNATIONAL ADDRESS > **International Postcode**	The alphanumeric descriptor for a postal delivery area (as defined by the postal service of a country other than Australia) aligned with locality, suburb or place for an address.	0..1	addr/**postalCode**		
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > INTERNATIONAL ADDRESS > **Country**	The country component of the address.	0..1	addr/**country**	Australia Bureau of Statistics, Standard Australian Classification of Countries (SACC) Cat. No. 1269 [ABS2008]	Use the name, not the numbered code.
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > **AUSTRALIAN ADDRESS**	The description of an Australian location where an entity is located or can be otherwise reached or found.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > **Unstructured Australian Address Line**	A composite of one or more low level standard address components describing a geographical/physical location that, used in conjunction with the other high level address components, e.g. Australian suburb/town/locality name, Australian postcode and Australian State/Territory, forms a complete geographical/physical address.	0..*	addr/**streetAddressLine**		
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > **STRUCTURED AUSTRALIAN ADDRESS LINE**	The standard low level address components describing a geographical/physical location that, used in conjunction with the other high level address components, i.e. Australian suburb/ town/locality name, Australian postcode and Australian State/Territory, form a complete geographical/physical address.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Unit Type**	The specification of the type of a separately identifiable portion within a building/complex, marina etc. to clearly distinguish it from another.	0..1	addr/**unitType**	AS 5017 (2006) - Healthcare Client Identification: Australian Unit Type [SA2006a] AS 4846 (2006) - Healthcare Provider Identification: Australian Unit Type [SA2006b]	
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Unit Number**	The specification of the number or identifier of a building/complex, marina etc. to clearly distinguish it from another.	0..1	addr/**unitID**		
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Address Site Name**	The full name used to identify the physical building or property as part of its location.	0..1	addr/**additionalLocator**		
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Level Type**	Descriptor used to classify the type of floor or level of a multistorey building/complex.	0..1	addr/**additionalLocator**	AS 5017 (2006) - Healthcare Client Identification: Australian Level Type [SA2006a] AS 4846 (2006) - Healthcare Provider Identification: Australian Level Type [SA2006b]	
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Level Number**	Descriptor used to identify the floor or level of a multistorey building/complex.	0..1	addr/**additionalLocator**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Street Number**	The numeric or alphanumeric reference number of a house or property that is unique within a street name.	0..1	addr/**houseNumber**		
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Lot Number**	The Australian Lot reference allocated to an address in the absence of street numbering.	0..1	addr/**additionalLocator**	The word "Lot" **SHOULD** precede the lot number and be separated by a space.	
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Street Name**	The name that identifies a public thoroughfare and differentiates it from others in the same suburb/town/locality.	0..1	addr/**streetName**		
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Street Type**	A code that identifies the type of public thoroughfare.	0..1	addr/**streetNameType**	AS 5017 (2006) - Healthcare Client Identification: Australian Street Type Code [SA2006a] AS 4846 (2006) - Healthcare Provider Identification: Australian Street Type Code [SA2006b]	
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Street Suffix**	Term used to qualify Australian Street Name used for directional references.	0..1	addr/**direction**	AS 5017 (2006) - Healthcare Client Identification: Australian Street Suffix [SA2006a] AS 4846 (2006) - Healthcare Provider Identification: Australian Street Suffix [SA2006b]	
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Postal Delivery Type**	Identification for the channel of postal delivery.	0..1	addr/**deliveryAddressLine**	AS 5017 (2006) - Healthcare Client Identification: Australian Postal Delivery Type Code [SA2006a] AS 4846 (2006) - Healthcare Provider Identification: Australian Postal Delivery Type Code [SA2006b]	
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Postal Delivery Number**	Identification number for the channel of postal delivery.	0..1	addr/**deliveryAddressLine**		
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > **Australian Suburb/Town/Locality**	The full name of the general locality contained within the specific address.	0..1	addr/**city**	Values in this data element **SHOULD** comply with descriptions in the Australia Post Postcode File (see www.auspost.com.au/postcodes).	
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > **Australian State/Territory**	The identifier of the Australian state or territory.	0..1	addr/**state**	AS 5017-2006 Australian State/Territory Identifier - Postal	
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > **Australian Postcode**	The numeric descriptor for a postal delivery area (as defined by Australia Post), aligned with locality, suburb or place for the address.	0..1	addr/**postalCode**	Values in this data element **SHOULD** comply with descriptions in the Australia Post Postcode File (see www.auspost.com.au/postcodes).	

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > **Australian Delivery Point Identifier**	A unique number assigned to a postal delivery point as recorded on the Australia Post Postal Address File.	0..1	addr/**additionalLocator**		
ADDRESS > **Address Purpose**	The purpose for which the address is being used by the entity.	1..1	addr/**@use**	AS 5017-2006: Health Care Client Identifier Address Purpose	Space separated list of codes.

Example 8.10. Address

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<!-- No Fixed Address -->
<addr nullFlavor="NA" />

<!-- Australian home address (unstructured) -->
<addr use="H">
    <streetAddressLine>1 Clinician Street</streetAddressLine>
    <city>Healthville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568931</additionalLocator>
</addr>

<!-- Australian business address (structured) -->
<addr use="WP">
    <houseNumber>1</houseNumber>
    <streetName>Clinician</streetName>
    <streetNameType>St</streetNameType>
    <city>Healthville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568931</additionalLocator>
</addr>

<!-- International postal address -->
<addr use="PST">
    <streetAddressLine>51 Clinician Bay</streetAddressLine>
    <city>Healthville</city>
    <state>Manitoba</state>
    <postalCode>R3T 3C6</postalCode>
    <country>Canada</country>
</addr>
```

8.7 Electronic Communication Detail

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Data Elements					
ELECTRONIC COMMUNICATION DETAIL	The electronic communication details of entities.	Cardinality comes from linking parent.	**telecom**		
ELECTRONIC COMMUNICATION DETAIL > **Electronic Communication Medium**	A code representing a type of communication mechanism.	1..1	telecom/**@value**	AS 5017-2006: Health Care Client Electronic Communication Medium > HL7:URLScheme	Makes up part of the value attribute as '**tel:**phone number', '**mailto:**email address', '**http:**URL', etc.
ELECTRONIC COMMUNICATION DETAIL > **Electronic Communication Usage Code**	The manner of use that is applied to an electronic communication medium.	0..1	telecom/**@use**	HL7: TelecommunicationAddressUse > HL7:TelecommunicationAddressUse	Space separated list of codes. The section AS 5017-2006: Health Care Client Electronic Communication Usage Code explains how to map AS 5017-2006 to HL7 TelecommunicationAddressUse (HL7 TAU) code.
ELECTRONIC COMMUNICATION DETAIL > **Electronic Communication Address**	A unique combination of characters used as input to electronic telecommunication equipment for the purpose of contacting an entity.	1..1	telecom/**@value**		Makes up part of the value attribute as 'tel:**phone number**', 'mailto:**email address**', http:**URL**', etc.

Example 8.11. Electronic Communication Detail

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<!-- home telephone number -->
<telecom value="tel:0499999999" use="H" />


<!-- pager -->
<telecom value="tel:0499999999" use="PG" />


<!-- home email address -->
<telecom value="mailto:clinicial@clinician.com" use="H" />
```

8.8 Employment

CDA Mapping

Note

NS = 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.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Data Elements					
EMPLOYMENT DETAIL	A person's occupation and employer.	Cardinality comes from linking parent.	n/a		This logical data component has no mapping to CDA.
EMPLOYMENT DETAIL > **EMPLOYER ORGANISATION**	The organisation that the individual is working for in respect to the role they are playing in the nominated participation.	1..*	**ext:asEmployment/ext:employerOrganization** ext:asEmployment/**@classCode="EMP"**		There is a known issue in the Participation Data Specification [DH2017a] for this logical data component's cardinality. Furthermore the corresponding CDA elements ext:asEmployment and ext:employerOrganization do not allow the cardinality to be multiple. The cardinality range **SHALL** be interpreted as '1..1'.
EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..*	ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/<**Entity Identifier**>		See common pattern: Entity Identifier.

---

[2] http://www.hl7.org/oid/index.cfm?ref=footer

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Address>**	AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS. Address Purpose (addr/@use) **SHOULD** be set to Business (see AS 5017-2006: Health Care Client Identifier Address Purpose).	See common pattern: Address.
EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	1..*	ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Electronic Communication Detail>**	Electronic Communication Usage Code (telecom/@use) **SHOULD** be set to Workplace (see HL7: TelecommunicationAddressUse).	See common pattern: Electronic Communication Detail.
EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **ORGANISATION**	Any organisation of interest to, or involved in, the business of healthcare service provision.	1..1	n/a		Not mapped directly, encompassed implicitly in assignedAuthor/ext:asEmployment/employerOrganization.
EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > ORGANISATION > **Organisation Name**	The name by which an organisation is known or called.	1..1	ext:asEmployment/ext:employerOrganization/**asOrganizationPartOf/wholeOrganization/name**		
EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > ORGANISATION > **Department/Unit**	The name by which a department or unit within a larger organisation is known or called.	0..1	ext:asEmployment/ext:employerOrganization/**name**		
EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > ORGANISATION > **Organisation Name Usage**	The classification that enables differentiation between recorded names for an organisation or service location.	0..1	ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/name/**@use**	AS 4846-2006: Health Care Provider Organisation Name Usage	
EMPLOYMENT DETAIL > **Employment Type**	The basis on which the person is employed by the employer organisation.	0..1	ext:asEmployment/**ext:jobClassCode**	NS	
EMPLOYMENT DETAIL > **Occupation**	A descriptor of the class of job based on similarities in the tasks undertaken.	0..*	ext:asEmployment/**ext:jobCode**	*1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 [ABS2009]*	The corresponding CDA element ext:jobCode does not allow the cardinality to be '0..*'/multiple. The cardinality **SHALL** be interpreted as '0..1' instead of '0..*'.
EMPLOYMENT DETAIL > **Position In Organisation**	A descriptor of the job or the job role based on the management hierarchy of the organisation.	0..1	ext:asEmployment/**ext:code**	NS	

Approved for external use

Example 8.12. Employment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<!-- Begin EMPLOYMENT DETAIL -->
<ext:asEmployment classCode="EMP">

    <!-- Position In Organisation -->
    <ext:code>
        <originalText>Chief Oncologist</originalText>
    </ext:code>

    <!-- Occupation -->
    <ext:jobCode code="253314" codeSystem="2.16.840.1.113883.13.62"
        codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
        displayName="Medical Oncologist"/>"/>

    <!-- Employment Type -->
    <ext:jobClassCode code="FT" codeSystem="2.16.840.1.113883.5.1059" codeSystemName="HL7:EmployeeJobClass" displayName="full-time"/>

    <!-- Begin EMPLOYER ORGANISATION -->
    <ext:employerOrganization>

        <!-- Department/Unit -->
        <name>Oncology Ward</name>

        <asOrganizationPartOf>
            <wholeOrganization>
                <!-- Organisation Name -->
                <name use="ORGB">Acme Hospital</name>

                <!-- ELECTRONIC COMMUNICATION DETAIL -->
                <telecom value="tel:0499999999" use="WP" />

                <!-- ADDRESS -->
                <addr use="WP">
                    <houseNumber>1</houseNumber>
                    <streetName>Clinician</streetName>
                    <streetNameType>St</streetNameType>
                    <city>Healthville</city>
                    <state>QLD</state>
                    <postalCode>5555</postalCode>
                    <additionalLocator>32568931</additionalLocator>
                </addr>

                <!-- Entity Identifier -->
                <ext:asEntityIdentifier classCode="IDENT">
                    <ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455"/>
                    <ext:assigningGeographicArea classCode="PLC">
                        <ext:name>National Identifier</ext:name>
                    </ext:assigningGeographicArea>
                </ext:asEntityIdentifier>

            </wholeOrganization>
        </asOrganizationPartOf>
        <!-- End EMPLOYER ORGANISATION -->
```

```
        </ext:employerOrganization>
</ext:asEmployment>
<!-- End EMPLOYMENT DETAIL -->
```

9 Australian Digital Health Agency CDA Extensions

As part of the CDA, standard extensions are allowed as follows:

Locally-defined markup may be used when local semantics have no corresponding representation in the CDA specification. CDA seeks to standardize the highest level of shared meaning while providing a clean and standard mechanism for tagging meaning that is not shared. In order to support local extensibility requirements, it is permitted to include additional XML elements and attributes that are not included in the CDA schema. These extensions should not change the meaning of any of the standard data items, and receivers must be able to safely ignore these elements. Document recipients must be able to faithfully render the CDA document while ignoring extensions.

Extensions may be included in the instance in a namespace other than the HL7v3 namespace, but must not be included within an element of type ED (e.g., <text> within <procedure>) since the contents of an ED datatype within the conformant document may be in a different namespace. Since all conformant content (outside of elements of type ED) is in the HL7 namespace, the sender can put any extension content into a foreign namespace (any namespace other than the HL7 namespace). Receiving systems must not report an error if such extensions are present. "HL7 Clinical Document Architecture, Release 2" [HL7CDAR2]

As such the following extensions have been defined where Australian concepts were not represented in CDA.

This section is provided for clarity only. Please see the relevant mappings section where these extensions have been used for actual mapping details.

9.1 ClinicalDocument.completionCode

Figure 9.1 ClinicalDocument.completionCode shows a subset of the CDA R-MIM containing those classes with the relevant Australian Digital Health Agency CDA extension represented.
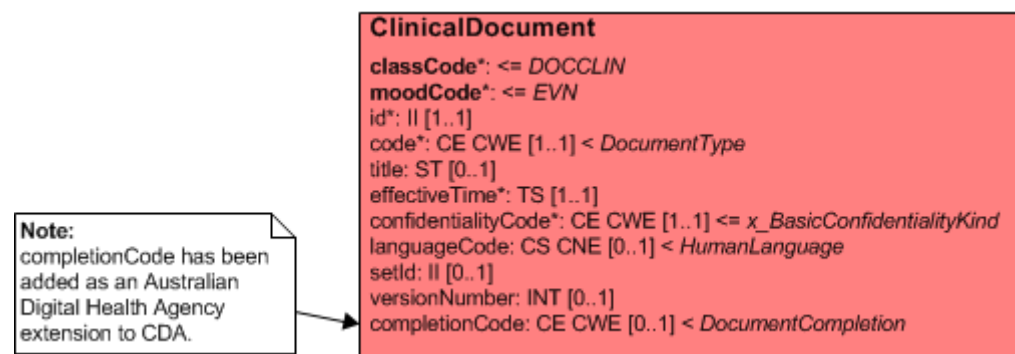
Figure 9.1. ClinicalDocument.completionCode

9.2 Multiple Birth

Figure 9.2 Multiple Birth shows a subset of the CDA R-MIM containing those classes with the relevant Australian Digital Health Agency CDA extension represented.

Note:
multipleBirthInd and multipleBirthOrderNumber have been added as Australian Digital Health Agency extensions to CDA.

Patient
classCode*: <= *PSN*
determinerCode*: <= *INSTANCE*
id: II [0..1] (Deprecated)
name: SET<PN> [0..*]
administrativeGenderCode: CE CWE [0..1] < *D:AdministrativeGender*
birthTime: TS [0..1]
multipleBirthInd: BL [0..1]
multipleBirthOrderNumber: INT [0..1]
maritalStatusCode: CE CWE [0..1] < *D:MaritalStatus*
religiousAffiliationCode: CE CWE [0..1] < *D:ReligiousAffiliation*
raceCode: CE CWE [0..1] < *D:Race*
ethnicGroupCode: CE CWE [0..1] < *D:Ethnicity*

Note:
multipleBirthInd and multipleBirthOrderNumber have been added as Australian Digital Health Agency extensions to CDA.

SubjectPerson
classCode*: <= *PSN*
determinerCode*: <= *INSTANCE*
name: SET<PN> [0..*]
administrativeGenderCode: CE CWE [0..1] < *D:AdministrativeGender*
birthTime: TS [0..1]
multipleBirthInd: BL [0..1]
multipleBirthOrderNumber: INT [0..1]

Figure 9.2. Multiple Birth

9.3 Deceased Time

Figure 9.3 Deceased Time shows a subset of the CDA R-MIM containing those classes with the relevant Australian Digital Health Agency CDA extension represented.
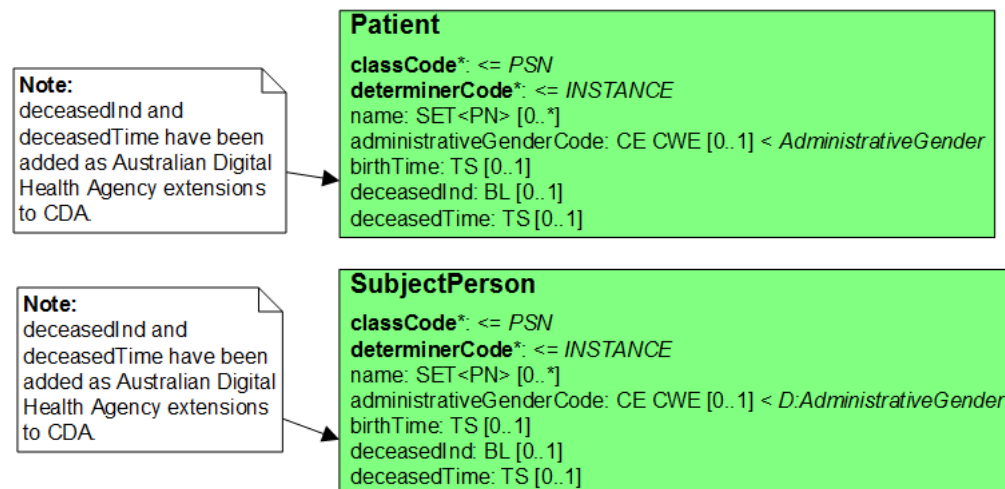
Figure 9.3. Deceased Time

9.4 EntityIdentifier

Figure 9.4 EntityIdentifier shows a subset of the CDA R-MIM containing those classes with the relevant Australian Digital Health Agency CDA extension represented.
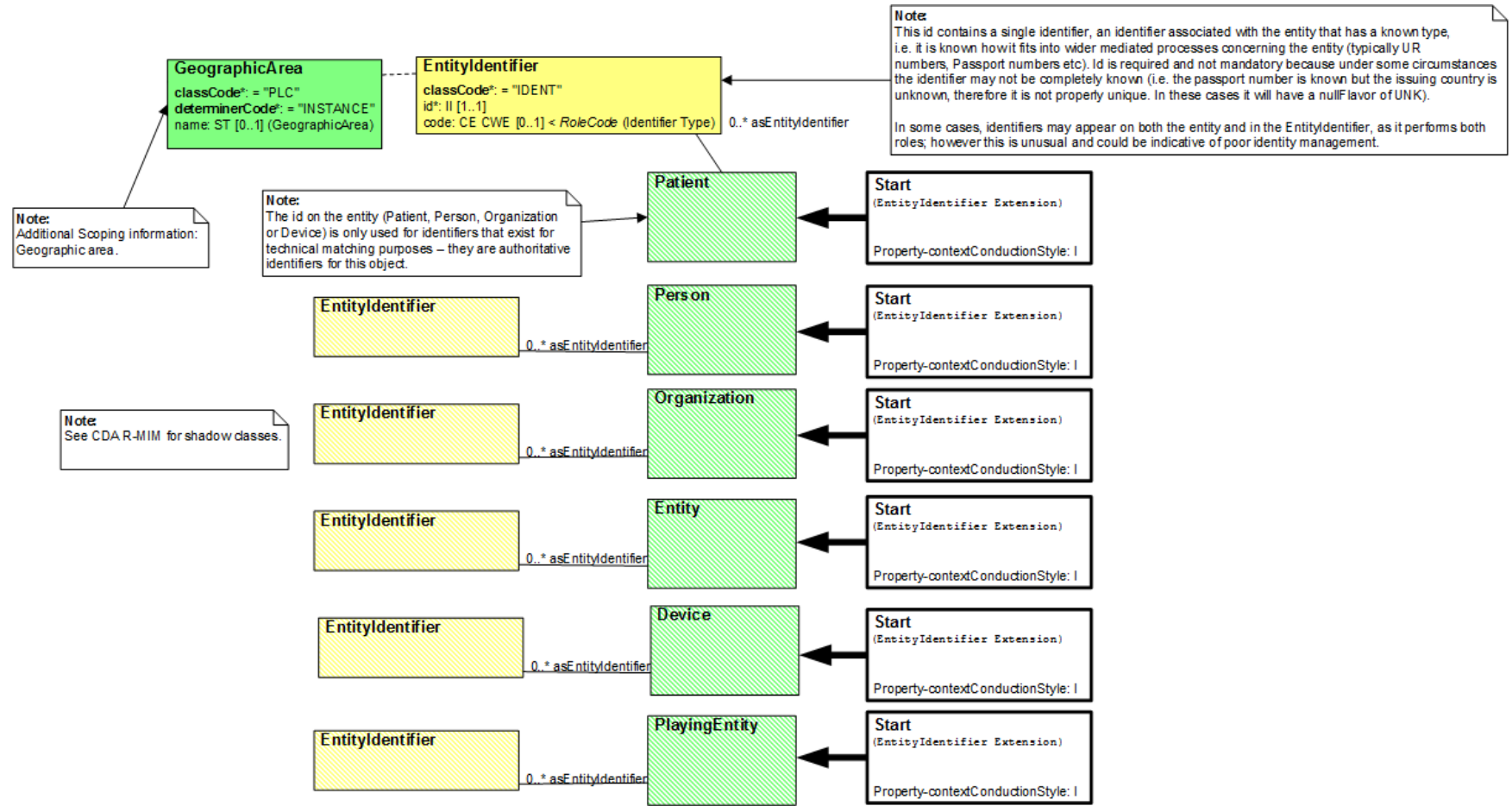
Figure 9.4. EntityIdentifier

9.5 Employment

Figure 9.5 Employment shows a subset of the CDA R-MIM containing those classes with the relevant Australian Digital Health Agency CDA extension represented.
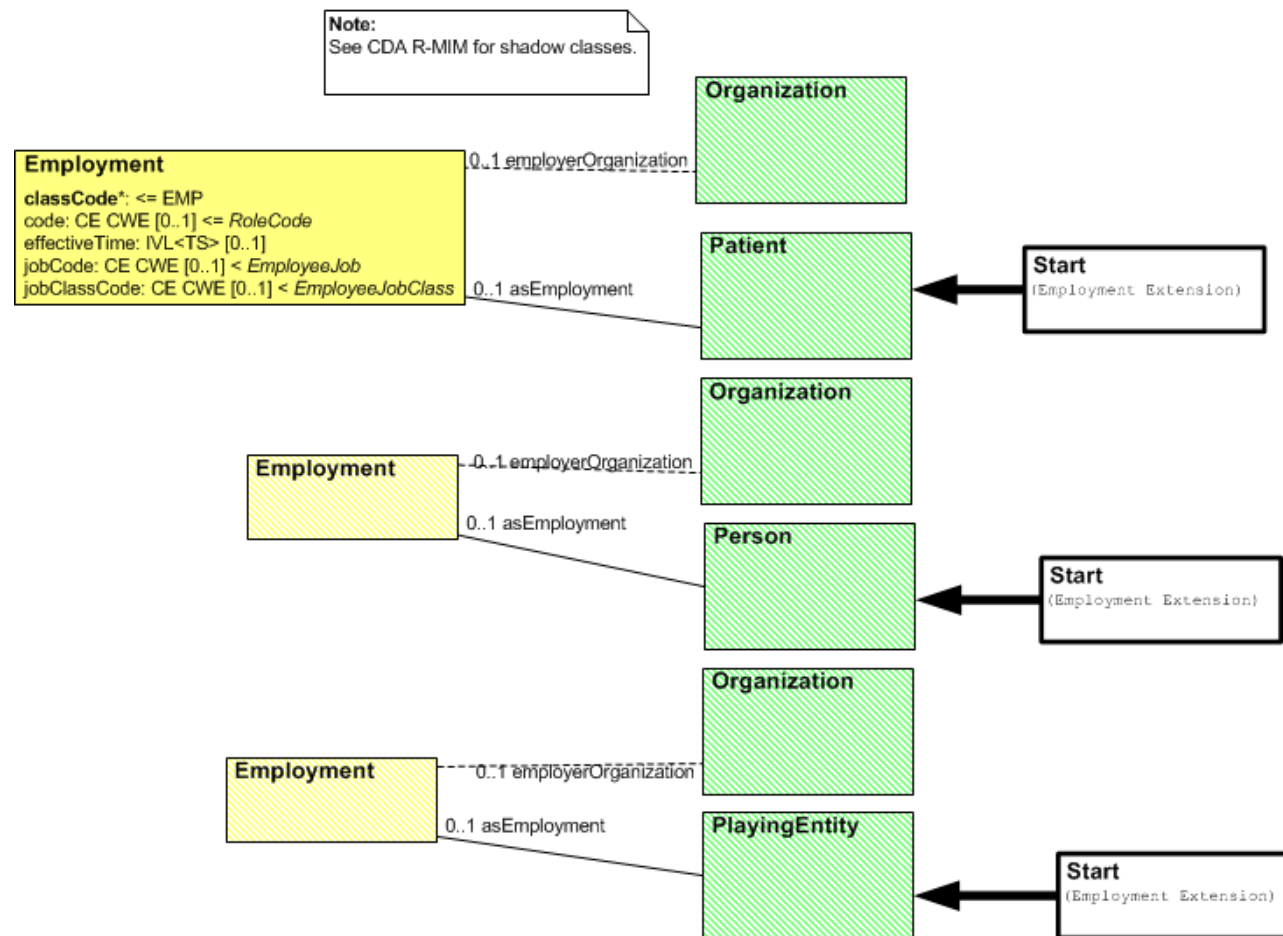
Figure 9.5. Employment

9.6 Qualifications

Figure 9.6 Qualifications shows a subset of the CDA R-MIM containing those classes with the relevant Australian Digital Health Agency CDA extension represented.
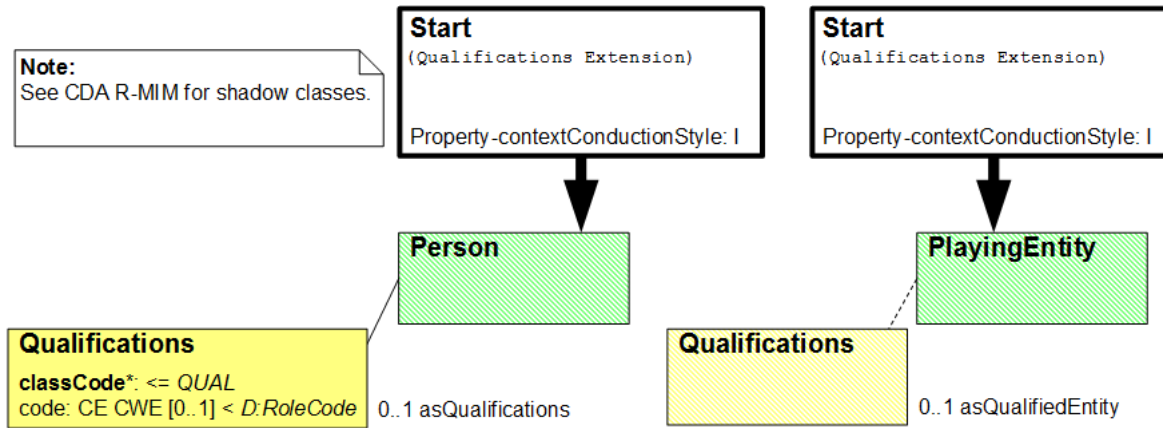
Figure 9.6. Qualifications

9.7 PersonalRelationship

Figure 9.7 PersonalRelationship shows a subset of the CDA R-MIM containing those classes with the relevant Australian Digital Health Agency CDA extension represented.
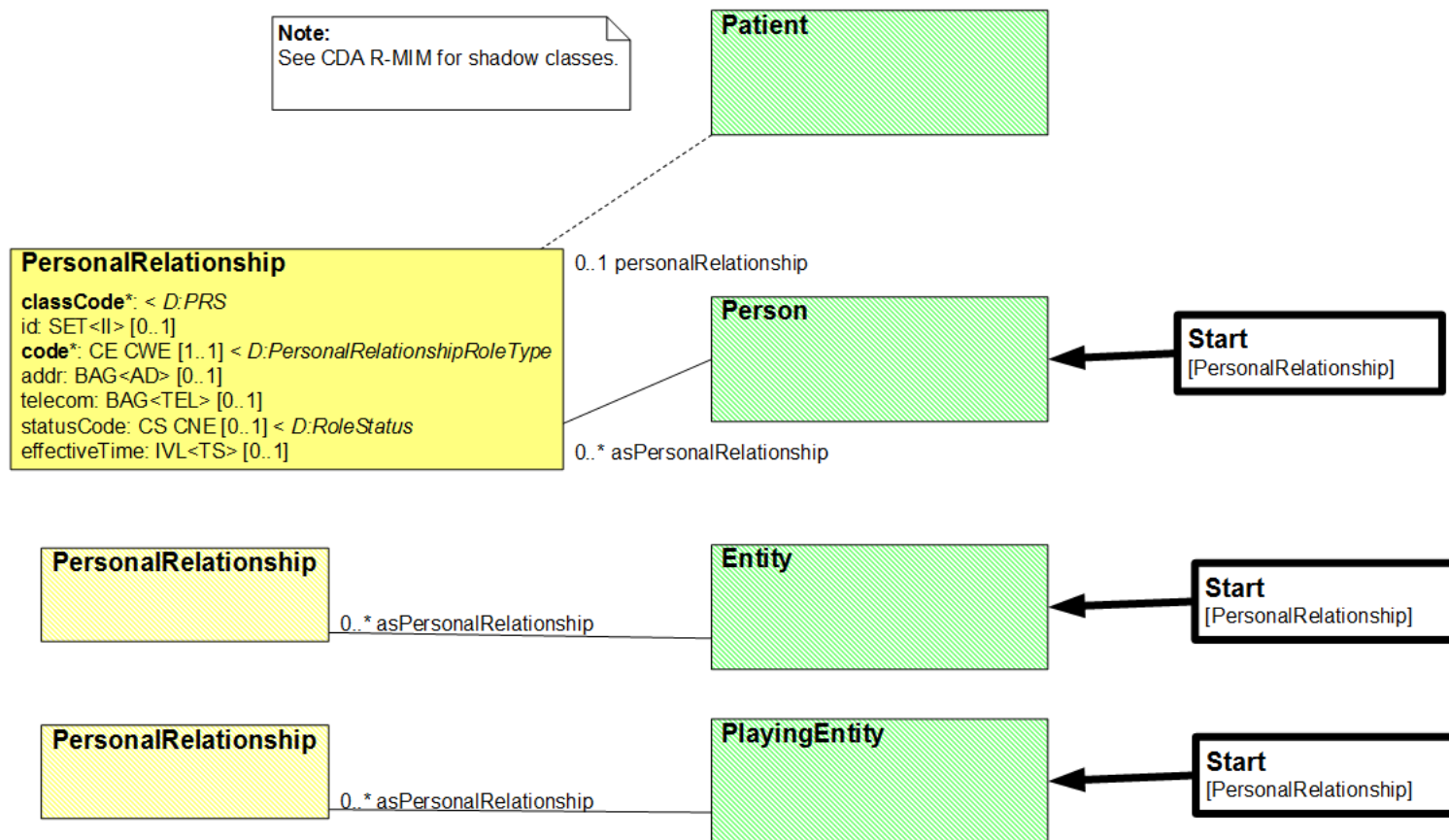
Figure 9.7. PersonalRelationship

9.8 Entitlement

Figure 9.8 Entitlement shows a subset of the CDA R-MIM containing those classes with the relevant Australian Digital Health Agency CDA extension represented.
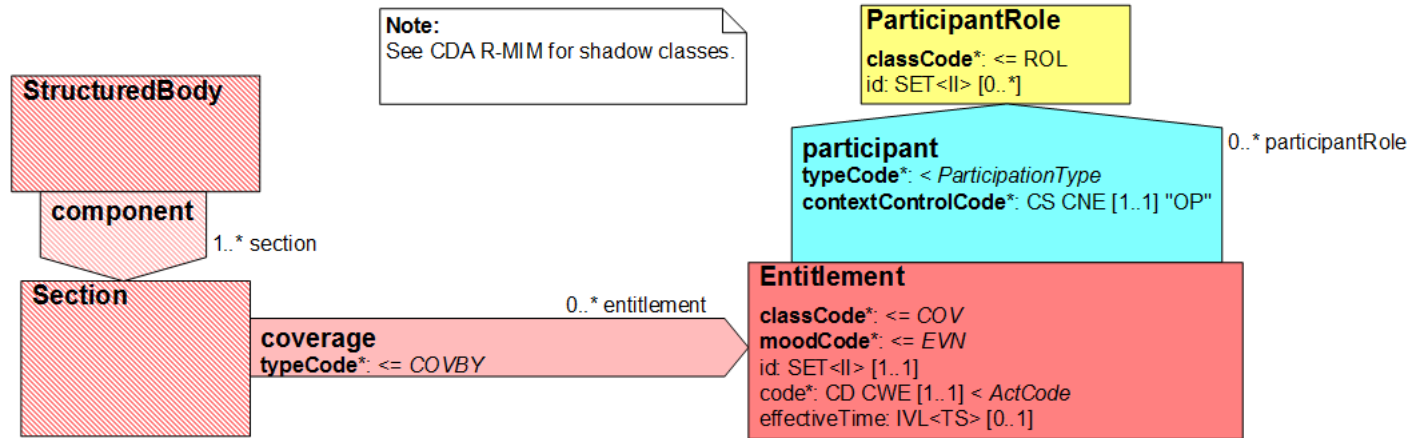
Figure 9.8. Entitlement

9.9 Container

Figure 9.9 Container shows a subset of the CDA R-MIM containing those classes with the relevant Australian Digital Health Agency CDA extension represented.
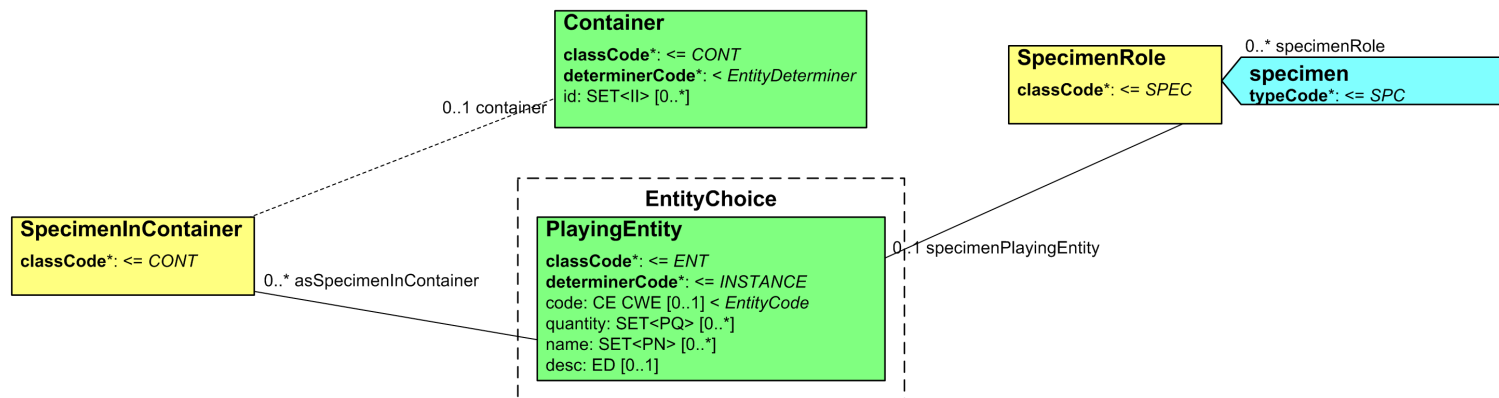
Figure 9.9. Container

10 Vocabularies and Code Sets

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When using the following vocabulary tables, if one column in the code set table is bolded, use the code in that column, otherwise use the values in all columns.

Example 10.1. One value

```
<name use="L">
    {name}
</name>
```

Example 10.2. All values

```
<code
    code="103.16044.4.1.1"
    codeSystem="1.2.36.1.2001.1001"
    codeSystemName="NCTIS Data Components"
    displayName="Additional Comments" />
```

10.1 HL7: TelecommunicationAddressUse

Code	Value
H	Home
HP	Primary Home
HV	Vacation Home
WP	Workplace
AS	Answering Service
EC	Emergency Contact

Code	Value
MC	Mobile Contact
PG	Pager

10.2 AS 5017-2006 Health Care Client Identifier Sex

displayName	code	codeSystemName	codeSystem
Male	M	AS 5017-2006 Health Care Client Identifier Sex	2.16.840.1.113883.13.68
Female	F	AS 5017-2006 Health Care Client Identifier Sex	2.16.840.1.113883.13.68
Intersex or Indeterminate	I	AS 5017-2006 Health Care Client Identifier Sex	2.16.840.1.113883.13.68
Not Stated/Inadequately Described	N	AS 5017-2006 Health Care Client Identifier Sex	2.16.840.1.113883.13.68

10.3 AS 5017-2006: Health Care Client Name Usage

Code Set AS 5017-2006 mapped to HL7 Entity Name Use Code

When referencing the following vocabulary tables, if one column in the code set table is bolded, use the code in that column; otherwise use the values in all columns.

Note

CDA Release 2 uses HL7 Data Types Release 1. For some of the AS 5017-2006 values, there are no satisfactory equivalents in the HL7 Entity Name Use R1 code set. In these cases (marked R2), an HL7 Entity Name Use R2 code has been used.

Note

In cases (marked EXT) where there are no suitable HL7 codes, extension codes have been created.

AS 5017-2006 Code	AS 5017-2006 Alternative Code	AS 5017-2006 Descriptor	HL7 Entity Name Use Code	HL7 Entity Name Use Name	HL7 Name Use Definition
1	L	Registered Name (Legal Name)	**L**	(R1) Legal	(R1) Known as/conventional/the one you use.
2	R	Reporting Name	**C**	(R1) License	(R1) As recorded on a license, record, certificate, etc. (only if different from legal name).
3	N	Newborn Name	**NB**	(EXT)	(EXT)
4	B	Professional or Business Name	**A**	(R1) Artist/Stage	(R1) Includes writer's pseudonym, stage name, etc.
5	M	Maiden Name (Name at birth)	**M**	(R2) Maiden Name	A name used prior to marriage.
8	O	Other Name (Alias)	**P**	(R1) Pseudonym	(R1) A self-asserted name that the person is using or has used.

10.4 AS 4846-2006: Health Care Provider Organisation Name Usage

Code Set AS 5017-2006 Organisation Name Usage mapped to HL7 Name Use Code

When referencing the following vocabulary tables, if one column in the code set table is bolded, use the code in that column; otherwise use the values in all columns.

Note

There are no suitable HL7 codes, so extension codes have been created.

AS 4846-2006 Code	AS 4846-2006 Alternative Code	AS 4846-2006 Descriptor	HL7 Name Use Code	HL7 Name Use Name	HL7 Name Use Definition
1	U	Organizational unit/section/division name	**ORGU**	(EXT)	(EXT)
2	S	Service location name	**ORGS**	(EXT)	(EXT)
3	B	Business name	**ORGB**	(EXT)	(EXT)
4	L	Locally used name	**ORGL**	(EXT)	(EXT)
5	A	Abbreviated name	**ORGA**	(EXT)	(EXT)
6	E	Enterprise name	**ORGE**	(EXT)	(EXT)
8	X	Other	**ORGX**	(EXT)	(EXT)
9	Y	Unknown	**ORGY**	(EXT)	(EXT)

10.5 AS 5017-2006: Health Care Client Source of Death Notification

displayName	code	codeSystemName	codeSystem
Official death certificate or death register	D	AS 5017-2006 Health Care Client Source of Death Notification	2.16.840.1.113883.13.64
Health Care Provider	H	AS 5017-2006 Health Care Client Source of Death Notification	2.16.840.1.113883.13.64
Relative	R	AS 5017-2006 Health Care Client Source of Death Notification	2.16.840.1.113883.13.64
Other	O	AS 5017-2006 Health Care Client Source of Death Notification	2.16.840.1.113883.13.64
Unknown	U	AS 5017-2006 Health Care Client Source of Death Notification	2.16.840.1.113883.13.64

10.6 AS 5017-2006: Health Care Client Identifier Address Purpose

AS 5017-2006 mapped to HL7 AddressUse Code

When referencing the following vocabulary tables, if one column in the code set table is bolded, use the code in that column; otherwise use the values in all columns.

AS 5017-2006 Code	AS 5017-2006 Alternative Code	AS 5017-2006 Descriptor	HL7 AddressUse Code	HL7 AddressUse Name	HL7 AddressUse Definition
1	B	Business	**WP**	Work Place	An office address. First choice for business related contacts during business hours.
2	M	Mailing or Postal	**PST**	Postal Address	Used to send mail.
3	T	Temporary Accommodation (individual provider only)	**TMP**	Temporary Address	A temporary address, may be good for visit or mailing.
4	R	Residential (permanent) (individual provider only)	**H**	Home Address	A communication address at a home.
9	U	Not Stated/Unknown/Inadequately Described	**In this case simply omit the Address Use Code**		

10.7 AS 5017-2006: Health Care Client Electronic Communication Medium

When referencing the following vocabulary tables, if one column in the code set table is bolded, use the code in that column; otherwise use the values in all columns.

AS 5017-2006 Code	AS 5017-2006 Descriptor	AS 5017-2006 Alternative Code	HL7 URLScheme Code	HL7 URLScheme Name	HL7 URLScheme Definition
1	Telephone (excluding mobile telephone)	T	**tel**	Telephone	A voice telephone number.
2	Mobile (cellular) telephone NOTE: Mobile will also need a TelecommunicationAddress Use code of MC (Mobile Contact) (see HL7: Telecommu-nicationAddressUse)	M	**tel**	Telephone	A voice telephone number.
3	Facsimile machine	F	**fax**	Fax	A telephone number served by a fax device.
4	Pager NOTE: Pager will also need a TelecommunicationAddress Use code of PG (Pager) (see HL7: TelecommunicationAd-dressUse)	P	**tel**	Telephone	A voice telephone number.
5	Email	E	**mailto**	Mailto	Electronic mail address.

AS 5017-2006 Code	AS 5017-2006 Descriptor	AS 5017-2006 Alternative Code	HL7 URLScheme Code	HL7 URLScheme Name	HL7 URLScheme Definition
6	URL	U	Use the most appropriate code from the list below:		
			file	File	Host-specific local file names. Note that the file scheme works only for local files. There is little use for exchanging local file names between systems, since the receiving system likely will not be able to access the file.
			ftp	FTP	The File Transfer Protocol (FTP).
			http	HTTP	Hypertext Transfer Protocol.
			mllp	MLLP	The traditional HL7 Minimal Lower Layer Protocol. The URL has the form of a common IP URL e.g., mllp://<host>:<port>/ with <host> being the IP address or DNS hostname and <port> being a port number on which the MLLP protocol is served.
			modem	Modem	A telephone number served by a modem device.
			nfs	NFS	Network File System protocol. Some sites use NFS servers to share data files.
			telnet	Telnet	Reference to interactive sessions. Some sites, (e.g., laboratories) have TTY based remote query sessions that can be accessed through telnet.

10.8 AS 5017-2006: Health Care Client Electronic Communication Usage Code

AS 5017-2006 mapped to HL7 TelecommunicationAddressUse (HL7 TAU) Code

When referencing the following vocabulary tables, if one column in the code set table is bolded, use the code in that column; otherwise use the values in all columns.

Code	Descriptor	Alternative Code	HL7 TAU Code	HL7 TAU Name	HL7 TAU Description
1	Business	B	**WP**	Work place	An office address. First choice for business related contacts during business hours.
2	Personal	P	**H**	Home address	A communication address at a home, attempted contacts for business purposes might intrude privacy and chances are one will contact family or other household members instead of the person one wishes to call. Typically used with urgent cases, or if no other contacts are available.
3	Both business and personal use	A	**WP H**	Both Work place and Home address	

10.9 AS 5017-2006 Australian State/Territory Identifier - Postal

Code	Descriptor
NSW	New South Wales
VIC	Victoria
QLD	Queensland
SA	South Australia
WA	Western Australia
TAS	Tasmania
NT	Northern Territory
ACT	Australian Capital Territory
U	Unknown

10.10 AS 5017-2006 Health Care Client Identifier Date Accuracy Indicator

The data elements that use this value set consist of a combination of three codes, each of which denotes the accuracy of one date component:

A – The referred date component is accurately known.

E – The referred date component is an estimate.

U – The referred date component is unknown.

The data elements that use this value set contain positional fields (DMY).

Field 1 (D) – refers to the accuracy of the day component.

Field 2 (M) – refers to the accuracy of the month component.

Field 3 (Y) – refers to the accuracy of the year component.

Note

The order of the date components in the HL7 date and time datatypes (YYYYMMDD) is the reverse of that specified above.

The possible combinations are as follows:

code	descriptor
AAA	Accurate date
AAE	Accurate day and month, estimated year
AEA	Accurate day, estimated month, accurate year
AAU	Accurate day and month, unknown year
AUA	Accurate day, unknown month, accurate year
AEE	Accurate day, estimated month and year
AUU	Accurate day, unknown month and year
AEU	Accurate day, estimated month, unknown year
AUE	Accurate day, unknown month

code	descriptor
EEE	Estimated date
EEA	Estimated day and month, accurate year
EAE	Estimated day, accurate month
EEU	Estimated day and month, unknown year
EUE	Estimated day, unknown month, estimated year
EAA	Estimated day, accurate month and year
EUU	Estimated day, unknown month and year
EAU	Estimated day, accurate month, unknown year
EUA	Estimated day, unknown month, accurate year
UUU	Unknown date
UUA	Unknown day and month, accurate year
UAU	Unknown day, accurate month, unknown year
UUE	Unknown day and month, estimated year
UEU	Unknown day, estimated month, unknown year
UAA	Unknown day, accurate month and year
UEE	Unknown day, estimated month and year
UAE	Unknown day, accurate month, estimated year
UEA	Unknown day, estimated month, accurate year

10.11 NCTIS: Admin Codes - Document Status

displayName	code	codeSystemName	codeSystem
Interim	I	NCTIS Document Status Values	1.2.36.1.2001.1001.101.104.20104
Final	F	NCTIS Document Status Values	1.2.36.1.2001.1001.101.104.20104
Withdrawn	W	NCTIS Document Status Values	1.2.36.1.2001.1001.101.104.20104

10.12 NCTIS: Admin Codes - Global Statement Values

displayName	code	codeSystemName	codeSystem
None known	01	NCTIS Global Statement Values	1.2.36.1.2001.1001.101.104.16299
Not asked	02	NCTIS Global Statement Values	1.2.36.1.2001.1001.101.104.16299
None supplied	03	NCTIS Global Statement Values	1.2.36.1.2001.1001.101.104.16299

10.13 NCTIS: Admin Codes - Entitlement Type

displayName	code	codeSystemName	codeSystem
Medicare Benefits	1	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Pensioner Concession	2	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Commonwealth Seniors Health Concession	3	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Health Care Concession	4	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Repatriation Health Gold Benefits	5	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Repatriation Health White Benefits	6	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Repatriation Health Orange Benefits	7	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Safety Net Concession	8	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Safety Net Entitlement	9	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Medicare Prescriber Number	10	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Medicare Pharmacy Approval Number	11	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047

10.14 HL7 v3 CDA: Act.moodCode

Code	Value	Definition
EVN	Event	The entry defines an actual occurrence of an event.
INT	Intent	The entry is intended or planned.
APT	Appointment	The entry is planned for a specific time and place.
ARQ	Appointment Request	The entry is a request for the booking of an appointment.
PRMS	Promise	A commitment to perform the stated entry.
PRP	Proposal	A proposal that the stated entry be performed.
RQO	Request	A request or order to perform the stated entry.
DEF	Definition	The entry defines a service (master).

10.15 METeOR 291036: Indigenous Status

displayName	code	codeSystemName	codeSystem
Aboriginal but not Torres Strait Islander origin	1	METeOR Indigenous Status	2.16.840.1.113883.3.879.291036
Torres Strait Islander but not Aboriginal origin	2	METeOR Indigenous Status	2.16.840.1.113883.3.879.291036
Both Aboriginal and Torres Strait Islander origin	3	METeOR Indigenous Status	2.16.840.1.113883.3.879.291036
Neither Aboriginal nor Torres Strait Islander origin	4	METeOR Indigenous Status	2.16.840.1.113883.3.879.291036
Not stated/inadequately described	9	METeOR Indigenous Status	2.16.840.1.113883.3.879.291036

10.16 NCTIS: Admin Codes - Result Status

displayName	definition	code	codeSystemName	codeSystem
Registered	No result yet available.	1	NCTIS Result Status Values	1.2.36.1.2001.1001.101.104.16501
Interim	This is an initial or interim result: data may be missing or verification not been performed.	2	NCTIS Result Status Values	1.2.36.1.2001.1001.101.104.16501
Final	The result is complete and verified by the responsible practitioner.	3	NCTIS Result Status Values	1.2.36.1.2001.1001.101.104.16501
Amended	The result has been modified subsequent to being Final, and is complete and verified by the practitioner.	4	NCTIS Result Status Values	1.2.36.1.2001.1001.101.104.16501
Cancelled / Aborted	The result is not available because the examination was not started or completed.	5	NCTIS Result Status Values	1.2.36.1.2001.1001.101.104.16501

10.17 HL7 V3: ObservationInterpretationNormality

displayName	code	codeSystemName	codeSystem
Abnormal	A	HL7 ObservationInterpretationNormality	2.16.840.1.113883.5.83
Abnormal alert	AA	HL7 ObservationInterpretationNormality	2.16.840.1.113883.5.83
High alert	HH	HL7 ObservationInterpretationNormality	2.16.840.1.113883.5.83
Low alert	LL	HL7 ObservationInterpretationNormality	2.16.840.1.113883.5.83
High	H	HL7 ObservationInterpretationNormality	2.16.840.1.113883.5.83
Low	L	HL7 ObservationInterpretationNormality	2.16.840.1.113883.5.83
Normal	N	HL7 ObservationInterpretationNormality	2.16.840.1.113883.5.83

10.18 CodeSystem OIDs

Note

This table is provided as a quick look up table; it is not an exhaustive identification of all code systems referenced in this implementation guide. The entries in the codeSystem (Name) column enable identification of the codeSystem OID to be used, but may not be the proper name of that codeSystem, i.e. the value of the codeSystemName attribute. The value of codeSystemName **SHOULD** be the name associated with the OID in the [HL7 OID Registry](1).

codeSystem (OID)	codeSystem (Name)
1.2.36.1.2001.1001.101	NCTIS Data Components
1.2.36.1.2001.1001.101.104.16047	NCTIS Entitlement Type Values
1.2.36.1.2001.1001.101.104.16299	NCTIS Global Statement Values
1.2.36.1.2001.1001.101.104.16127	NCTIS Request Urgency Values
1.2.36.1.2001.1001.101.104.20104	NCTIS Document Status Values
2.16.840.1.113883.13.74	HL7 Diagnostic service section ID
2.16.840.1.113883.5.83	HL7 ObservationInterpretationNormality
2.16.840.1.113883.12.123	HL7 Result Status
2.16.840.1.113883.12.62	1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations
2.16.840.1.113883.12.62	1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1
2.16.840.1.113883.13.64	AS 5017-2006 Health Care Client Source of Death Notification
2.16.840.1.113883.13.65	AIHW Mode of Separation
2.16.840.1.113883.13.63	AS 5017-2006 Health Care Client Identifier Geographic Area
2.16.840.1.113883.13.68	AS 5017-2006 Health Care Client Identifier Sex
2.16.840.1.113883.3.879.291036	METeOR Indigenous Status
2.16.840.1.113883.6.96	SNOMED CT
2.16.840.1.113883.6.96	SNOMED CT-AU
1.2.36.1.2001.1004.100	Australian Medicines Terminology (AMT) v2

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[1] http://www.hl7.org/oid/index.cfm?ref=footer

codeSystem (OID)	codeSystem (Name)
2.16.840.1.113883.6.96	Australian Medicines Terminology (AMT) v3
2.16.840.1.113883.6.1	LOINC

10.19 HL7: Diagnostic Service Section ID

displayName	code	codeSystemName	codeSystem
Audiology	AU	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Bedside ICU Monitoring	ICU	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Blood Bank	BLB	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Blood Gases	BG	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Cardiac Catheterization	CTH	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Cardiac Ultrasound	CUS	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
CAT Scan	CT	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Chemistry	CH	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Cineradiograph	XRC	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Cytopathology	CP	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Electrocardiac (e.g., EKG, EEC, Holter)	EC	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Electroneuro (EEG, EMG,EP,PSG)	EN	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Hematology	HM	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Immunology	IMM	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Laboratory	LAB	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Microbiology	MB	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Mycobacteriology	MCB	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Mycology	MYC	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Nuclear Magnetic Resonance	NMR	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Nuclear Medicine Scan	NMS	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Nursing Service Measures	NRS	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
OB Ultrasound	OUS	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Occupational Therapy	OT	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74

displayName	code	codeSystemName	codeSystem
Other	OTH	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Outside Lab	OSL	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Pharmacy	PHR	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Physical Therapy	PT	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Physician (Hx. Dx, admission note, etc.)	PHY	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Pulmonary Function	PF	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Radiation Therapy	RT	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Radiograph	RX	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Radiology	RAD	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Radiology Ultrasound	RUS	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Respiratory Care (therapy)	RC	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Serology	SR	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Surgical Pathology	SP	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Toxicology	TX	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Vascular Ultrasound	VUS	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74
Virology	VR	HL7 Diagnostic service section ID	2.16.840.1.113883.12.74

10.20 HL7: Result Status

HL7 Table 0123 - Result Status

displayName	code	codeSystemName	codeSystem
Correction to results	C	HL7 Result Status	2.16.840.1.113883.12.123
Final results; results stored and verified. Can only be changed with a corrected result.	F	HL7 Result Status	2.16.840.1.113883.12.123
No results available; specimen received, procedure incomplete	I	HL7 Result Status	2.16.840.1.113883.12.123
Order received; specimen not yet received	O	HL7 Result Status	2.16.840.1.113883.12.123
Preliminary: A verified early result is available, final results not yet obtained	P	HL7 Result Status	2.16.840.1.113883.12.123
Results stored; not yet verified	R	HL7 Result Status	2.16.840.1.113883.12.123
No results available; procedure scheduled, but not done	S	HL7 Result Status	2.16.840.1.113883.12.123
Some, but not all, results available	A	HL7 Result Status	2.16.840.1.113883.12.123
No results available; Order canceled	X	HL7 Result Status	2.16.840.1.113883.12.123
No order on record for this test. (Used only on queries)	Y	HL7 Result Status	2.16.840.1.113883.12.123
No record of this patient. (Used only on queries)	Z	HL7 Result Status	2.16.840.1.113883.12.123

Appendix A. CDA Narratives

CDA requires that each section in its body include a narrative block, containing a clinically complete version of the section's encoded content using custom hypertext markup defined by HL7. The narrative is the human-readable and attestable part of a CDA document, and **SHALL** stand alone as an accurate representation of the content of the document without any need to consult entries in the body.

There is no canonical markup for specific CDA components, but some conformance points apply:

- The narrative block **SHALL** be encapsulated within the text component of the CDA section.

- The narrative contents **SHALL** conform to the requirements specified in the CDA Rendering Specification.

  - In accordance with the requirement to completely represent section contents, values of codedText or codeableText data elements defined in the SCS **SHALL** include an originalText or a displayName component (or both). Where available, the originalText **SHOULD** be found in the narrative, otherwise the displayName **SHOULD** be found in the narrative.

- The narrative contents **SHALL** completely and accurately represent the clinical information encoded in the section. Content **SHALL NOT** be omitted from the narrative.

- The narrative **SHALL** conform to the content requirements of the CDA specification [HL7CDAR2] and the XML Schema.

Clinical judgement is required to determine the appropriate presentation for narrative. We may release additional guidance in this regard. The examples provided in sections of this document offer some guidance for narrative block markup and may be easily adapted as boilerplate markup.

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Approved for external use

Appendix B. Log of Changes

This appendix lists the major changes and fixes applied to this CDA Implementation Guide. A single change is likely to be listed multiple times, as changes are listed in order of appearance and categorised by location in the document. For example, a cardinality change may appear in both the Data Hierarchy and CDA Mapping table.

Changes from Version 1.1 dv014 2017-05-08 to Version 1.1 dv022 2018-07-09

ID	Document Ref		Change Type	Change Detail	Change Initiated By	Rationale For Change	Date Changed
	Section	Section Name					
1	3	Service Referral Data Hierarchy	Normative Impact	SERVICE REFERRAL DETAIL > REQUESTED SERVICE > SERVICE PROVIDER: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.	Agency	Information requirements change.	26 Feb 2018
2	5.1	ClinicalDocument	Normative Impact	ClinicalDocument/templateId/@root corrected to "1.2.36.1.2001.1001.100.1002.231".	Agency	Defect correction - retired OID arc of ".101." was erroneously included.	16 Aug 2017
3	5.1.2	InformationRecipient	Normative Impact	informationRecipient: cardinality changed from 1..1 to 0..1 in line with requirement to record the referee as an information recipient.	Agency	Information requirements change.	26 Feb 2018
4	6.1.4.1	PRIMARY CARE PROVIDER as a PERSON	Normative Impact	EMPLOYER ORGANISATION > ADDRESS: added missing constraint AUSTRALIAN OR INTERNATIONAL ADDRESS SHALL be instantiated as an AUSTRALIAN ADDRESS" and "Address Purpose (addr/@use) SHALL be set to Business".	Agency	Defect correction.	08 Oct 2017
				EMPLOYER ORGANISATION > ELECTRONIC COMMUNICATION DETAIL: added missing constraint "Electronic Communication Usage Code (telecom/@use) SHALL be set to Workplace".			
5	7.1.1.1.1	SERVICE PROVIDER	Normative Impact	SERVICE PROVIDER: cardinality changed from 1..1 to 0..1 in line with requirement to optionally record the referee.	Agency	Information requirements change.	26 Feb 2018
6	7.1.1.1.1.1	SERVICE PROVIDER as a PERSON	Normative Impact	SERVICE PROVIDER: cardinality changed from 1..1 to 0..1 in line with requirement to optionally record the referee.	Agency	Information requirements change.	26 Feb 2018
7	7.1.1.1.1.1	SERVICE PROVIDER as an ORGANISATION	Normative Impact	SERVICE PROVIDER: cardinality changed from 1..1 to 0..1 in line with requirement to optionally record the referee.	Agency	Information requirements change.	26 Feb 2018
8	7.1.4.2	Known Medication (MEDICATION INSTRUCTION)	Normative Impact	Medication Instruction Comment: corrected displayName for code 103.16044 from "Medication Instruction Comment" to "Additional Comments".	Agency	Defect correction	11 Nov 2017
9	8.4	Entity Identifier	No Normative Impact	ext:asEntityIdentifier/ext:assigningGeographicArea/ext:name: corrected rule on permissible values to be expressed as a constraint instead of a linked value set.	Agency	Defect correction	04 May 2018
10	8.6	Address	No Normative Impact	ADDRESS: Clarified scope of guidance on nullFlavor use; it applies to all participants that make use of the common pattern.	Agency	Improved guidance	15 Nov 2017

Changes from Version 1.0 2016-06-27 to Version 1.1 2017-05-08

Note

This specification includes typographical, stylistic, and editorial corrections to rebrand the document from the National E-Health Transition Authority (NEHTA) to the Australian Digital Health Agency (the Agency).

All XML fragments have been reviewed and updated to align with the semantic changes defined in the CDA Mapping tables.

All CDA R-MIM representations have been reviewed and updated to align with the semantic changes defined in the CDA Mapping tables.

ID	Document Ref		Change Type	Change Detail	Change Initiated By	Rationale For Change	Date Changed
	Section	Section Name					
1	1.5	Document Map	No Normative Impact	Replaced reference to superseded Participation Data Specification v3.2 with Participation Data Specification v3.3.	Agency	Update of superseded specification.	15 Feb 2017

ID	Document Ref		Change Type	Change Detail	Change Initiated By	Rationale For Change	Date Changed
	Section	Section Name					
2	3	Service Referral Data Hierarchy	Normative Impact	REQUESTED SERVICE > Requested Service Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.	Agency	Alignment with updates to the cardinality of technical identifiers & changes to the logical model (SCS).	15 Sept 2016
				Communication Alert Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
				Alert Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
				Current Service (REQUESTED SERVICE) > Requested Service Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
				Adverse Reaction Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
				Medication Instruction Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
				Problem/Diagnosis Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
				Procedure Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
				Uncategorised Medical History Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
				Pathology Test Result Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
				Examination Comment not included in the data hierarchy to align to SCS data hierarchy which no longer includes this data element.			
				Imaging Examination Result Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
				Pending Diagnostic Investigation (REQUESTED SERVICE) > Requested Service Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
3	4	Administrative Observations	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	17 Oct 2016
4	5.1	ClinicalDocument	Normative Impact	ClinicalDocument/templateId/@extension updated to "1.1".	Agency	Change for a new version of the CDA-IG.	16 Oct 2016
				ClinicalDocument/code: identified codeSystemName attribute as optional.			
5	5.1	ClinicalDocument	No Normative Impact	Context: added label "CDA Header Data Element".	Agency	Defect correction.	17 Oct 2016
6	5.1.1	LegalAuthenticator	Normative Impact	legalAuthenticator/assignedEntity/assignedPerson: changed cardinality from 0..1 to 1..1.	Agency	Alignment to Agency conformance requirements	24 Feb 2017
7	5.1.1	LegalAuthenticator	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	17 Oct 2016
8	5.1.2	InformationRecipient	Normative Impact	informationRecipient: cardinality changed from 0..* to 1..1 in line with requirement to record the referee as an information recipient.	Agency	Defect correction: correctly represent the referee as an information recipient.	20 Jan 2017
				informationRecipient/@typeCode: added missing value typeCode="PRCP" and removed Vocab column entry.			
				InformationRecipient/intendedRecipient/@classCode: added missing value classCode="ASSIGNED".			
				informationRecipient/intendedRecipient/id: added missing constraint to set the value of id to be the same as the referee (SERVICE REFERRAL DETAIL > REQUESTED SERVICE > SERVICE PROVIDER).			
				informationRecipient/intendedRecipient/informationRecipient/<Entity Identifier>: added missing constraint to set the value of one entity identifier to be the same as the entity identifier of the referee (SERVICE REFERRAL DETAIL > REQUESTED SERVICE > SERVICE PROVIDER).			
				informationRecipient/intendedRecipient/receivedOrganization/<Entity Identifier>: added missing constraint to set the value of one entity identifier to be the same as the entity identifier of the referee (SERVICE REFERRAL DETAIL > REQUESTED SERVICE > SERVICE PROVIDER).			

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	Section	Section Name					
9	5.1.2	InformationRecipient	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	17 Oct 2016
10	5.1.3	Custodian	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	17 Oct 2016
11	6.1	SERVICE REFERRAL	Normative Impact	Removed REFEREE (6.1.5.1 REFEREE as a PERSON, and 6.1.5.2 REFEREE as an ORGANISATION). REFEREE incorrectly duplicated 5.1.2 InformationRecipient.	Agency	Defect correction.	20 Dec 2016
12	6.1	SERVICE REFERRAL	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	17 Oct 2016
				RELATED DOCUMENT: added row in mapping table for missing SCS Data Component.			
				DateTime Attested: removed comment "Required CDA element" as it is not relevant in this context.			
13	6.1.1	SUBJECT OF CARE	Normative Impact	Sex (administrativeGenderCode): added prohibition of @nullFlavor.	Agency	Defect correction.	10 Sept 2016
				Indigenous Status (ethnicGroupCode): added prohibition of @nullFlavor.			
14	6.1.1	SUBJECT OF CARE	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	17 Oct 2016
				Added prohibition of Relationship to Subject of Care - n/a no mapping to CDA.			
15	6.1.2	DOCUMENT AUTHOR	Normative Impact	Relationship to Subject of Care: corrected invalid Xpath.	Agency	Defect correction.	08 Oct 2016
16	6.1.2	DOCUMENT AUTHOR	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	17 Oct 2016
17	6.1.3.1	PATIENT NOMINATED CONTACT as a PERSON - Healthcare or Human Services Provider	Normative Impact	Relationship to Subject of Care: corrected invalid Xpath.	Agency	Defect correction.	16 Sept 2016
18	6.1.3.1	PATIENT NOMINATED CONTACT as a PERSON - Healthcare or Human Services Provider	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	17 Oct 2016
				EMPLOYER ORGANISATION > ADDRESS: added missing row for ADDRESS 0..*.			
				EMPLOYER ORGANISATION > ELECTRONIC COMMUNICATION DETAIL: added missing row for ELECTRONIC COMMUNICATION DETAIL 0..*.			
19	6.1.3.2	PATIENT NOMINATED CONTACT as a PERSON - Not a Healthcare or Human Services Provider	Normative Impact	Relationship to Subject of Care: added missing design rows for Relationship to Subject of Care and fixed invalid Xpath.	Agency	Defect correction.	16 Sept 2016
20	6.1.3.2	PATIENT NOMINATED CONTACT as a PERSON - Not a Healthcare or Human Services Provider	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	17 Oct 2016
				EMPLOYER ORGANISATION > ADDRESS: added missing row for ADDRESS 0..*.			
				EMPLOYER ORGANISATION > ELECTRONIC COMMUNICATION DETAIL: added missing row for ELECTRONIC COMMUNICATION DETAIL 0..*.			
21	6.1.3.3	PATIENT NOMINATED CONTACT as an ORGANISATION	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	18 Oct 2016
22	6.1.4.1	PRIMARY CARE PROVIDER as a PERSON	Normative Impact	Relationship to Subject of Care: corrected invalid Xpath.	Agency	Defect correction.	08 Oct 2016
23	6.1.4.1	PRIMARY CARE PROVIDER as a PERSON	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	17 Oct 2016
				EMPLOYER ORGANISATION > ADDRESS: added missing row for ADDRESS 0..*.			
				EMPLOYER ORGANISATION > ELECTRONIC COMMUNICATION DETAIL: added missing row for ELECTRONIC COMMUNICATION DETAIL 0..*.			
24	6.1.4.2	PRIMARY CARE PROVIDER as an ORGANISATION	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	08 Oct 2016
25	6.1.5.1	INTERESTED PARTY as a PERSON	Normative Impact	Relationship to Subject of Care: corrected invalid Xpath.	Agency	Defect correction.	08 Oct 2016
26	6.1.5.1	INTERESTED PARTY as a PERSON	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
				Qualifications: corrected cardinality range from 0..* to 0..1.			05 May 2016

ID	Document Ref		Change Type	Change Detail	Change Initiated By	Rationale For Change	Date Changed
	Section	Section Name					
27	6.1.5.2	INTERESTED PARTY as an ORGANISATION	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
28	7.1	SERVICE REFERRAL	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
29	7.1.1	SERVICE REFERRAL DETAIL	Normative Impact	SERVICE REFERRAL DETAIL: corrected invalid Xpaths for title by removing erroneous "/".	Agency	Defect correction.	28 Feb 2017
				SERVICE REFERRAL DETAIL: corrected invalid Xpaths for text by removing erroneous "/".			
				Section Type: corrected invalid Xpaths which include the attributes of the code element but miss inclusion of the code element itself.			
30	7.1.1	SERVICE REFERRAL DETAIL	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
31	7.1.1.1	REQUESTED SERVICE	Normative Impact	REQUESTED SERVICE: removed erroneous constraint enforcing default typeCode on the entry.	Agency	Defect correction.	27 Oct 2016
				Service Description: added constraint "NS" to the Vocab column.			
				Request Validity Period: identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided.			
				Requested Service Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
32	7.1.1.1	REQUESTED SERVICE	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
33	7.1.1.1.1.1	SERVICE PROVIDER as a PERSON	Normative Impact	Context: removed additional incorrect classes from Xpath "component[req_serv]/section/" and corrected label from [ref] to [ref_det].	Agency	Defect correction.	02 Sept 2016
				SERVICE PROVIDER: corrected cardinality from 0..1 to 1..1.			
				SERVICE PROVIDER: Amended constraint to correctly reference informationRecipient "SERVICE PROVIDER as an ORGANISATION SHALL be recorded as SERVICE PROVIDER as an ORGANISATION (performer) and as InformationRecipient."			
				Relationship to Subject of Care: corrected invalid Xpath.			
34	7.1.1.1.1.1	SERVICE PROVIDER as a PERSON	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
				Participation Type: corrected wording of SCS constraint from "Service Provider" to "Referee".			
35	7.1.1.1.1.2	SERVICE PROVIDER as an ORGANISATION	Normative Impact	Context: removed additional incorrect classes from Xpath "component[req_serv]/section/" and corrected label from [ref] to [ref_det].	Agency	Defect correction.	02 Sept 2016
				SERVICE PROVIDER: Amended constraint to correctly reference informationRecipient "SERVICE PROVIDER as an ORGANISATION SHALL be recorded as SERVICE PROVIDER as an ORGANISATION (performer) and as InformationRecipient."			
				Organisation Name: corrected invalid Xpath case "asOrganizationPartof" to "asOrganizationPartOf".			
36	7.1.1.1.1.2	SERVICE PROVIDER as an ORGANISATION	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
				Participation Type: corrected wording of SCS constraint from "Service Provider" to "Referee".			
				Organisation Name Usage: removed erroneous data component "Organisation Name Detail" from the SCS Data Component entry.			
37	7.1.1.2	RELATED DOCUMENT	Normative Impact	RELATED DOCUMENT: removed erroneous constraint enforcing default typeCode on the entry.	Agency	Defect correction.	27 Oct 2016
				RELATED DOCUMENT: identified act/id attribute as optional.			
				Document Title: identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided.			
38	7.1.1.2	RELATED DOCUMENT	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016

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ID	Document Ref		Change Type	Change Detail	Change Initiated By	Rationale For Change	Date Changed
	Section	Section Name					
39	7.1.1.3	Interpreter Required Alert (COMMUNICATION ALERT)	Normative Impact	Alert Description: identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided.	Agency	Alignment with updates to the cardinality of technical identifiers & changes to the logical model (SCS).	27 Oct 2016
				Alert Description: moved mapping rows from Detailed Clinical Model Identifier to Alert Description.			
				Detailed Clinical Model Identifier: moved mapping rows to Alert Description and declared n/a.			
				Communication Alert Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
40	7.1.1.3	Interpreter Required Alert (COMMUNICATION ALERT)	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
41	7.1.1.4	Other Alerts (ALERT)	Normative Impact	Other Alerts (ALERT): removed erroneous constraint enforcing default typeCode on the entry.	Agency	Alignment with updates to the cardinality of technical identifiers & changes to the logical model (SCS).	27 Oct 2016
				Other Alerts (ALERT): removed constraint "observation/@nullFlavor SHALL NOT be present."			
				Alert Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
42	7.1.1.4	Other Alerts (ALERT)	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	21 Oct 2016
43	7.1.2	CURRENT SERVICES	Normative Impact	CURRENT SERVICES: corrected invalid Xpaths for title by removing erroneous "/".	Agency	Defect correction.	28 Feb 2017
				CURRENT SERVICES: corrected invalid Xpaths for text by removing erroneous "/".			
				Section Type: corrected invalid Xpaths which include the attributes of the code element but miss inclusion of the code element itself.			
44	7.1.2	CURRENT SERVICES	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
45	7.1.2.1	Current Service (REQUESTED SERVICE)	Normative Impact	Current Service (REQUESTED SERVICE): removed erroneous constraint enforcing default typeCode on the entry.	Agency	Alignment with updates to the cardinality of technical identifiers & changes to the logical model (SCS).	24 Jan 2017
				Service Category: added constraint "NS" to the Vocab column.			
				Service Description: added constraint "NS" to the Vocab column.			
				Current Service (REQUESTED SERVICE): removed constraint "act/@nullFlavor SHALL NOT be present."			
				Requested Service Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
46	7.1.2.1	Current Service (REQUESTED SERVICE)	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
47	7.1.2.1.1	SERVICE PROVIDER	Normative Impact	Organisation Name: corrected invalid Xpath case "asOrganizationPartof" to "asOrganizationPartOf".	Agency	Defect correction.	18 Sept 2016
48	7.1.2.1.1	SERVICE PROVIDER	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
				Organisation Name Usage: removed erroneous data component "Organisation Name Detail" from the SCS Data Component entry.			
49	7.1.3	ADVERSE REACTIONS	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
50	7.1.3.1	EXCLUSION STATEMENT - ADVERSE REACTIONS	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
51	7.1.3.2	ADVERSE REACTION	Normative Impact	Adverse Reaction Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.	Agency	Alignment with updates to the cardinality of technical identifiers & changes to the logical model (SCS).	04 Mar 2017
				Manifestation: identified observation/id attribute as optional.			
				Reaction Type: included constraint on value set to prohibit Drun interaction and its children.			
52	7.1.3.2	ADVERSE REACTION	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
53	7.1.4	Medications (MEDICATION ORDERS)	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
54	7.1.4.1	EXCLUSION STATEMENT - MEDICATIONS	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016

ID	Document Ref		Change Type	Change Detail	Change Initiated By	Rationale For Change	Date Changed
	Section	Section Name					
55	7.1.4.2	Known Medication (MEDICATION INSTRUCTION)	Normative Impact	Medication Instruction Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.	Agency	Alignment with updates to the cardinality of technical identifiers & changes to the logical model (SCS).	27 Oct 2016
56	7.1.4.2	Known Medication (MEDICATION INSTRUCTION)	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
57	7.1.5	Past and Current Medical History (MEDICAL HISTORY)	Normative Impact	Section Type: added missing value code/@code="101.16117".	Agency	Defect correction.	15 Sept 2016
58	7.1.5	Past and Current Medical History (MEDICAL HISTORY)	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
59	7.1.5.1	PROBLEM/DIAGNOSIS	Normative Impact	Problem/Diagnosis Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.	Agency	Alignment with updates to the cardinality of technical identifiers & changes to the logical model (SCS).	15 Sept 2016
				Detailed Clinical Model Identifier: corrected the value for the SNOMED CT code system name in the constraint to "SNOMED CT".			
				Date of Resolution/Remission: corrected the type for observation/value from interval timestamp (IVL_TS) to timestamp (TS).		Defect correction.	05 May 2017
60	7.1.5.1	PROBLEM/DIAGNOSIS	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
61	7.1.5.2	PROCEDURE	Normative Impact	Procedure Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.	Agency	Alignment with updates to the cardinality of technical identifiers & changes to the logical model (SCS).	27 Oct 2016
62	7.1.5.2	PROCEDURE	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
63	7.1.5.3	UNCATEGORISED MEDICAL HISTORY ITEM	Normative Impact	Uncategorised Medical History Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.	Agency	Alignment with updates to the cardinality of technical identifiers & changes to the logical model (SCS).	15 Sept 2016
				Detailed Clinical Model Identifier: corrected nullFlavor constraint to align to SCS "code/@nullFlavor SHALL NOT be present".			
64	7.1.5.3	UNCATEGORISED MEDICAL HISTORY ITEM	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
65	7.1.6	DIAGNOSTIC INVESTIGATIONS	Normative Impact	DIAGNOSTIC INVESTIGATIONS: relaxed constraint section to "title SHALL be present where narrative (section/text) is present."	Agency	Defect correction.	15 Sept 2016
66	7.1.6	DIAGNOSTIC INVESTIGATIONS	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016

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ID	Document Ref		Change Type	Change Detail	Change Initiated By	Rationale For Change	Date Changed
	Section	Section Name					
67	7.1.6.1	PATHOLOGY TEST RESULT	Normative Impact	PATHOLOGY TEST RESULT: relaxed constraint section to "title SHALL be present where narrative (section/text) is present."	Agency	Defect correction.	24 Jan 2017
				Test Result Name (Pathology Test Result Name): Amended the constraint in the Vocab column from SHOULD to SHALL.			
				Diagnostic Service: corrected the value for the SNOMED CT code system name in the constraint to "SNOMED CT".			
				Overall Pathology Test Result Status: corrected the value for the SNOMED CT code system name in the constraint to "SNOMED CT".			
				Overall Pathology Test Result Status: identified observation/id attribute as optional.			
				Pathological Diagnosis: corrected the value for the SNOMED CT code system name in the constraint to "SNOMED CT".			
				Conclusion (Pathology Test Conclusion): corrected the value for the SNOMED CT code system name in the constraint to "SNOMED CT".			
				Conclusion (Pathology Test Conclusion): identified observation/id attribute as optional.			
				Test Requested Name: Amended the constraint in the Vocab column from SHOULD to SHALL.			
				Observation DateTime: identified observation/id attribute as optional.			
				Pathology Test Result Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
68	7.1.6.1	PATHOLOGY TEST RESULT	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
69	7.1.6.1.1	Test Specimen Detail (SPECIMEN)	Normative Impact	Side: corrected the value for the SNOMED CT code system name in the constraint to "SNOMED CT".	Agency	Defect correction.	07 Oct 2016
				Anatomical Location Image: identified observationMedia/id attribute as optional.			
				Image: identified observationMedia/id attribute as optional.			
70	7.1.6.1.1	Test Specimen Detail (SPECIMEN)	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
71	7.1.6.1.2	Result Group (PATHOLOGY TEST RESULT GROUP)	Normative Impact	Result Group (PATHOLOGY TEST RESULT GROUP): identified organizer/id attribute as optional.	Agency	Defect correction.	15 Sept 2016
				Pathology Test Result Group Name: Amended the constraint in the Vocab column from SHOULD to SHALL.			
				Result (INDIVIDUAL PATHOLOGY TEST RESULT): identified observation/id attribute as optional.			
				Individual Pathology Test Result Name: Amended the constraint in the Vocab column from SHOULD to SHALL.			
				Individual Pathology Test Result Comment: corrected the value for the SNOMED CT code system name in the constraint to "SNOMED CT".			
				Individual Pathology Test Result Reference Range Guidance: corrected the value for the SNOMED CT code system name in the constraint to "SNOMED CT".			
				Individual Pathology Test Result Status: corrected the value for the SNOMED CT code system name in the constraint to "SNOMED CT".			
72	7.1.6.1.2	Result Group (PATHOLOGY TEST RESULT GROUP)	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
73	7.1.6.1.2.1	Individual Pathology Test Result Value Reference Ranges (REFERENCE RANGE DETAILS)	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
74	7.1.6.1.2.2	Result Group Specimen Detail (SPECIMEN)	Normative Impact	Side: corrected the value for the SNOMED CT code system name in the constraint to "SNOMED CT".	Agency	Defect correction.	07 Oct 2016
				Anatomical Location Image: identified observationMedia/id attribute as optional.			
				Image: identified observationMedia/id attribute as optional.			

ID	Document Ref		Change Type	Change Detail	Change Initiated By	Rationale For Change	Date Changed
	Section	Section Name					
75	7.1.6.1.2.2	Result Group Specimen Detail (SPECIMEN)	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
76	7.1.6.2	IMAGING EXAMINATION RESULT	Normative Impact	IMAGING EXAMINATION RESULT: relaxed constraint section to "title SHALL be present where narrative (section/text) is present."	Agency	Defect correction.	15 Sept 2016
				Side: corrected the value for the SNOMED CT code system name in the constraint to "SNOMED CT".			
				Anatomical Location Image: identified observationMedia/id attribute as optional.			
				Imaging Examination Result Status: corrected the value for the SNOMED CT code system name in the constraint to "SNOMED CT".			
				Examination Comment: removed from the mapping table to align to SCS data hierarchy which no longer includes this data element.			
				Imaging Examination Result Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
77	7.1.6.2	IMAGING EXAMINATION RESULT	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
78	7.1.6.2.1	Result Group (IMAGING EXAMINATION RESULT GROUP)	Normative Impact	Result Group (INDIVIDUAL IMAGING EXAMINATION RESULT): identified organizer/id attribute as optional.	Agency	Defect correction.	03 June 2016
				Result Group (INDIVIDUAL IMAGING EXAMINATION RESULT): corrected Xpaths removing erroneous "/".			
				Result (INDIVIDUAL IMAGING EXAMINATION RESULT): identified observation/id attribute as optional.			
				Result Comment: identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided.			
				Side: corrected the value for the SNOMED CT code system name in the constraint to "SNOMED CT".			
				Anatomical Location Image: identified observationMedia/id attribute as optional.			
79	7.1.6.2.1	Result Group (IMAGING EXAMINATION RESULT GROUP)	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
80	7.1.6.2.1.1	Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS)	Normative Impact	Context: corrected typo "ccomponent" to "component" in Context Xpath.	Agency	Defect correction.	15 Jan 2017
81	7.1.6.2.1.1	Imaging Examination Result Value Reference Ranges (REFERENCE RANGE DETAILS)	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
82	7.1.6.2.2	EXAMINATION REQUEST DETAILS	Normative Impact	Image: identified observationMedia/id attribute as optional.	Agency	Defect correction.	07 Oct 2016
83	7.1.6.2.2	EXAMINATION REQUEST DETAILS	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
84	7.1.6.3	Pending Diagnostic Investigation (REQUESTED SERVICE)	Normative Impact	Pending Diagnostic Investigation (REQUESTED SERVICE): removed erroneous constraint enforcing default typeCode on the entry.	Agency	Alignment with updates to the cardinality of technical identifiers & changes to the logical model (SCS).	07 Mar 2017
				Requested Service Instance Identifier: cardinality changed from 1..1 to 0..1 in line with changes in the SCS.			
				Detailed Clinical Model Identifier: corrected Xpath from component[pend_service] to entry[pend_service].			
				Detailed Clinical Model Identifier: identified codeSystemName attribute as optional. A link to a table of code system names and OIDs is provided.			
85	7.1.6.3	Pending Diagnostic Investigation (REQUESTED SERVICE)	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
86	7.1.6.3.1.1	SERVICE PROVIDER as a PERSON	Normative Impact	Context: removed additional incorrect classes from Xpath "component[req_serv]/section/" and corrected identification of the entry to entry[pend_serv].	Agency	Defect correction.	20 July 2016
87	7.1.6.3.1.1	SERVICE PROVIDER as a PERSON	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
				Participation Type: corrected wording of SCS constraint from "Service Provider" to "Referee".			

ID	Document Ref		Change Type	Change Detail	Change Initiated By	Rationale For Change	Date Changed
	Section	Section Name					
88	7.1.6.3.1.2	SERVICE PROVIDER as an ORGANISATION	Normative Impact	Context: corrected Xpath to "/ClinicalDocument/component/structuredBody/component[diag_inv]/section/entry[pend_serv]/act/".	Agency	Defect correction.	15 Sept 2016
				SERVICE PROVIDER: corrected cardinality from 1..1 to 0..1.			
				Organisation Name: corrected invalid Xpath case "asOrganizationPartof" to "asOrganizationPartOf".			
89	7.1.6.3.1.2	SERVICE PROVIDER as an ORGANISATION	No Normative Impact	Context: added leading "/" to beginning of Context Xpath.	Agency	Defect correction.	07 Oct 2016
				Participation Type: corrected wording of SCS constraint from "Service Provider" to "Referee".			
				Organisation Name Usage: removed erroneous data component "Organisation Name Detail" from the SCS Data Component entry.			
90	8.1	code	No Normative Impact	Added statement on the use of the qualifier CDA element.	Agency	Improved guidance.	31 Oct 2016
91	8.6	Address	Normative Impact	Australian Lot Number: added constraint "The word 'Lot' SHOULD precede the lot number and be separated by a space.	Agency	Alignment with Participation Data Specification v3.3.	25 Jan 2016
				Australian Suburb/Town/Locality: corrected Vocab constraint "should" to be bold and uppercase.			
				Australian Postcode: corrected Vocab constraint "should" to be bold and uppercase.			
92	9	Australian Digital Health Agency CDA Extensions	No Normative Impact	Added missing section 9.7 PersonalRelationship.	Agency	Defect correction.	10 Oct 2016
				Removed unneeded section 9.5 Administrative Gender Code.			
				Removed unneeded section 9.6 Birth Time.			
93	Reference List		Normative Impact	Participation Data Specification: replaced reference to superseded v3.2 with v3.3.	Agency	Alignment to Participation Data Specification v3.3.	27 Jan 2017
				Conformance Profile: Replace v1.6 with v1.7.		Use latest version of specification.	05 May 2017

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