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e-Discharge Summary
Core Information Components

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Key information

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Product or document version history

Product or document version	Date	Author	Release comments
0.01	2006-12	NEHTA	'National Discharge Summary - Data Content Specifications'
0.08	2009-02	Linda Bird	'Draft Core Discharge Summary Core Components' The essential components from the Data Content Specifications were extracted to create a first draft of the core. This draft was subsequently reviewed, amended and endorsed by NEHTA Clinical Leaders in preparation for broader external review.
0.16	2009-04	Linda Bird	Draft document distributed to external organisations for comment.
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0.25	2009-06	Linda Bird	Final document endorsed by NEHTA internal processes.
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1.1.1	2011-05-05	Rob Eastwood	Added reference to DCM in section 2.1
1.1.2	2011-12-12	Rob Eastwood	Preface: removed sentence with reference to "*the Business Requirements Specification and Solution Design"*.
1.1.2	2025-06-06	ADHA	The document presentation has been enhanced to align with current branding guidelines, however the content has not been changed.

Transition of terms

Certain terms used within the context of this document have changed. The table provides a clear comparison of the historical terms used in text and their current equivalents for your reference.

Historical term	Current term
National eHealth Transition Authority (NEHTA)	The Australian Digital Health Agency (ADHA)
Personally controlled electronic health record (PCEHR)	My Health Record (MHR)

Table of contents

Preface

Document purpose

This document presents the information components (also referred to as the 'core information components') of the e-Discharge Summary Release 1.1 package, which have been recommended for use when exchanging discharge summaries in Australia.

Please note that the core discharge summary components are a logical set of data items for exchange and, as such, are independent of any particular platform, technology, exchange format or presentation format.

The Discharge Summary package describes the specifications and guidelines for consideration by implementers when developing interoperable Discharge Summary solutions within the Australian healthcare community.

Intended audience

This document is intended for all interested stakeholders including:

- early adopter hospitals and health departments in the process of planning, implementing or upgrading discharge summary systems;
- software vendors developing discharge summary system products;
- early adopter GP desktop software vendors;
- senior managers and policy makers, clinical experts, Health Information Managers, IT operations and support teams, and system integrators; and
- technical and non-technical readers.

Document map

The following diagram represents the relationship between this document and others within the discharge summary package.

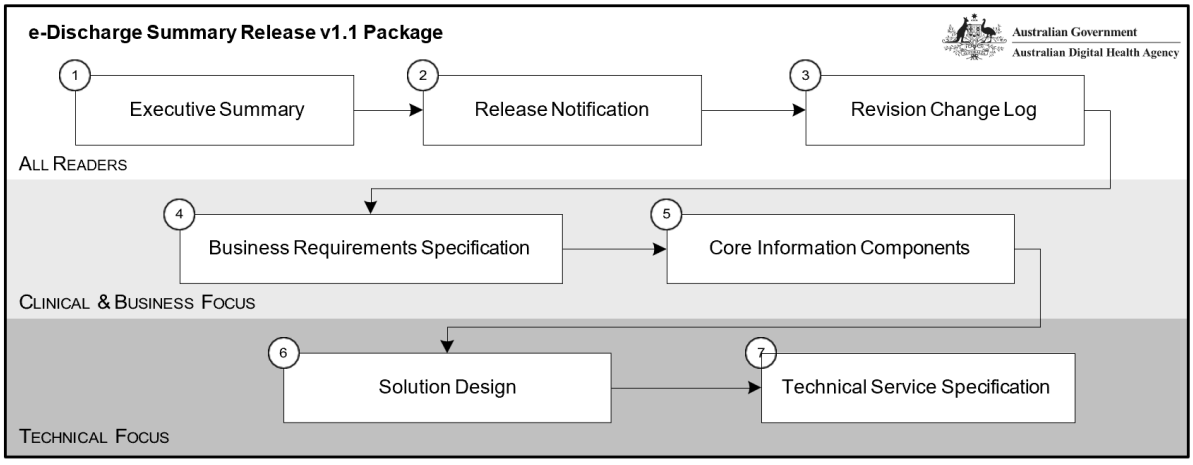

Figure 1 e-Discharge Summary package document map

The Solution Design defines Today, Tomorrow and Future solution states supported by the Business Requirements Specification. The Core Information Components document defines the minimum set of data groups and elements that are recommended for

implementation in any system that creates and transfers discharge summary information within Australia.

Document status

Final.

Definitions, acronyms and abbreviations

For lists of definitions, acronyms and abbreviations, see the Definitions section at the end of the document, on page 38.

References and related documents

For a list of all referenced documents, see the References section at the end of the document, on page 41.

1 Introduction

1.1 Overview

The discharge summary Core Information Components define the minimum set of data items that are recommended for implementation in any system that creates and transfers discharge summary information in Australia.

As this document defines the core components for these exchanges, it is anticipated that some discharge summaries will contain additional types of data to satisfy specific local requirements, or specialty healthcare requirements. It is expected that national extensions to the discharge summary Core Information Components will be defined to support particular specialty areas (e.g. Aged Care, Oncology, Obstetrics, Cardiology, Community Nursing) and that a full set of discharge summary components will be maintained to capture all nationally-agreed data groups and elements for discharge summary exchange.

Please note that the core discharge summary components are a logical set of data items for exchange, and as such are independent of any particular platform, technology, exchange format or presentation format.

1.2 Discharge Summary definition

A discharge summary is currently defined as "A collection of information about events during care by a provider or organization" [AS4700.6(Int)2007].

It comprises a document produced during a patient's stay in hospital as either an admitted or non-admitted patient, and issued when or after a patient leaves the care of the hospital.

Its primary function is to support the 'continuity of care' as the patient returns to the care of their community healthcare provider(s). The primary recipients of the discharge summary are healthcare providers who were providing the patient care prior to the hospital stay, including:

- the patient's usual GP (or primary health service, such as an Aboriginal Community Controlled Health Service);
- the referring clinician (e.g. private specialist);
- community pharmacy;
- residential Aged Care Facility where the patient usually resides; and
- other health professionals who will be involved in the patient‘s post- discharge care.

Within this primary function the purpose of the NEHTA e-Discharge Summary package is to:

- assist and improve clinician-to-clinician communication; and
- enable system-to-system communication of semantically interoperable data.

The secondary functions of the discharge summary include:

- providing summary information regarding an earlier admission on the re-presentation of the patient to acute care;
- use by clinical coders when coding a patient record;
- providing the patient with a record of their hospital admission and care; and
- use in a Personally Controlled Electronic Health Record (PCEHR), which could include national or local repositories to support coordinated care.

While it is not uncommon for paper hospital discharge summaries to also be used to support administrative and financial activities related to a patient's discharge, it is important to note that the primary purpose of the e-discharge summary content specification is to support clinical care. It is not been specifically designed to support these non-clinical uses and hence should not be used as such.

1.3 Purpose of the Core Information Components

The purpose of the discharge summary Core Information Components is to define the information requirements for a nationally-agreed discharge summary, suitable for exchange between healthcare providers in Australia, independent of exchange or presentation formats.

It is anticipated that these core information components will:

- Promote a common understanding of the core information components for consistent clinical interpretation when sharing discharge summaries between different clinical specialties, implementations and jurisdictions.
- Support the semantic interoperability of core information components exchanged between different implementations and jurisdictions, irrespective of the exchange format being used.
- Support cross-implementation and cross-jurisdictional querying over common discharge summary components at the logical level, as may be required for Electronic Health Record implementations.
- Provide a common framework upon which to define nationally-agreed, specialty-specific discharge summary components (e.g. for Aged Care).
- Provide a common framework for nationally-defined mappings to specific exchange formats.
- Provide a framework (along with other documents and structures) suitable for the development of national terminology sets that associate specific data items with valid values. These values will be derived from nationally endorsed terminologies maintained and distributed on behalf of Australia by NEHTA‘s National Clinical Terminology and Information Service (NCTIS). The current terminology sources that will provide this content are LOINC for defined areas of Pathology content, SNOMED CT-AU for all other clinical content and AMT for medicinal products. Administrative content will be derived either from SNOMED CT-AU or specifically defined external codesets.

It is recommended that electronic discharge summary applications must implement the core information components. It is anticipated that local extensions may be required to support specific local requirements. While it is possible for such local extensions to be achieved through negotiations and agreements between the information exchange partners, this is not a preferred option. It should be noted that data components used in local extensions should be sourced from standardised data groups and conformance rules that are developed and continue to be developed under the leadership of NEHTA. This approach is necessary to ensure interoperability and safe consumption of the interchanged information.

1.4 Methodology

The following stakeholders were invited to comment on the discharge summary Core Information Components:

- The Australian Medical Association (AMA)

- The Royal Australian College of General Practitioners (RACGP)
- The Australian General Practice Network (AGPN)
- The Australian Commission on Safety and Quality in Healthcare
- The Australian College of Rural and Remote Medicine (ACRRM)
- The Royal Australasian College of Physicians (RACP)
- The Royal Australasian College of Surgeons (RACS)
- The Royal College of Pathologists of Australasia (RCPA)
- The Royal Australian and New Zealand College of Radiologists (RANZCR)
- The Royal Australasian College of Medical Administrators (RACMA)
- College of Emergency Medicine
- State Health Departments via jurisdictional CIO‘s
- Allied Health Professions Australia
- College of Nursing
- Consumer groups including some or all of:
  - Kidney Australia
  - Diabetes Australia
  - National Heart Foundation
  - National Stroke Foundation
  - Asthma Australia
- Society of Hospital Pharmacists Australia
- Australian Healthcare and Hospitals Association
- Aged Care Association Australia
- Aged and Community Services Australia
- Royal Australian and New Zealand College of Psychiatrists

The starting point for the discharge summary Core Information Components was the National Discharge Summary Data Content Specification [NDSDCS2006] that was developed by NEHTA for exchange from an acute healthcare facility to a General Practitioner. From this, many of the optional data elements were removed to facilitate implementation, and the remaining data elements were summarised into the table shown in section 2.3.

As the core discharge summary components continue to evolve through consultation and feedback, it is intended that a full set of discharge summary components will be maintained as a superset of both the core information components and any specialty discharge summary components that are developed. For more details on NEHTA‘s full set of discharge summary components, please refer to [DS-SDT2009].

1.5 Exchange and presentation formats

The information presented here is defined at the logical clinical level, and as such is independent of any particular platform, technology, exchange format or presentation format.

Consequently, the core information components may be mapped to multiple different exchange formats. It is anticipated that such mappings will be defined and published following the endorsement of the core information components.

Similarly, the requirement that a particular piece of data be exchanged in a discharge summary does not imply any particular requirement for the user interface. Some data elements (e.g. ‘Language’) are intended purely for purposes of internal processes within the receiving system. Similarly, other data elements (e.g. ‘Date of Birth’) have a number of different presentation options available (e.g. ‘Age’, ‘Birth Day’ + ‘Year of Birth’ etc), which are not considered here. In addition to this, the names given to data components and data items are in many cases not appropriate for use as field labels on a user interface. For example, "Encounter start datetime" may be more appropriately referred to as ‘Admission date’ in a discharge summary system that supports only inpatient events.

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

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

1.6 Adding data

It is expected that the discharge summary author will use their clinical judgement to manually enter some of the data into the discharge summary Core Information Components (e.g. clinical synopsis). However, it is envisaged that Clinical Information Systems operating at the source healthcare facility (e.g. Patient Administration System, Medication Management System, etc.) should be available - whenever possible - to transfer relevant data into many of the discharge summary Core Information Components. This will minimise data entry and may reduce the issues of recording data redundantly in multiple data stores. It is expected that, where feeder systems are used, the author‘s discretion is exercised by only allowing information that is relevant to the ongoing care of the patient in the discharge summary and that the author‘s due diligence is applied to ensure that the information included from feeder system is current and accurate.

A conformant e-Discharge Summary implementation must be capable of collecting and transferring/receiving all Core Information Components (CIC) elements. However:

- Not all data elements require a value in each and every discharge summary (e.g. items that are categorised with ‘0..1’ or ‘0..Many’)
- Not all data elements are required to be displayed to users, and their labels may be different from those used in the 'Item' column of the Definition table in section 2.3.

2 Core Information Components

2.1 Overview

The discharge summary Core Information Components (as summarised in section 2.3) define the minimum set of data items that are recommended for implementation in a system that creates and exchanges Discharge Summaries within Australia.

The discharge summary Core Information Components are:

Component	**Corresponding DCM / source** ***Link*: https://www.digitalhealth.gov.au/**
Patient	(Participation Data Specification)
Nominated primary healthcare providers	(Participation Data Specification)
Facility	(Participation Data Specification)
Document author	(Participation Data Specification)
Document Recipients	(Participation Data Specification)
Encounter details	DCM: Miscellaneous (Participation Data Specification) + remaining for future development
Problems/diagnoses	DCM: Problem/Diagnosis
Clinical synopsis	DCM: Miscellaneous DCM
Diagnostic investigations	DCM: Pathology Test DCM: Imaging Test
Clinical interventions	DCM: Procedure
Current medications on discharge	DCM: Medication Action and Instruction
Ceased medications	DCM: Medication Action and Instruction
Allergies/adverse reactions	DCM: Adverse Substance Reaction
Alerts	For future development
Arranged services	For future development
Recommendations	DCM: Miscellaneous DCM
Information provided to patient and/or relevant parties	For future development
Attachments	(CDA Mapping and Implementation Guide)
Document Control	(CDA Mapping and Implementation Guide)

2.2 Definition description

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

- *Component*: a high level section or group of data elements
- *Item*: an individual data element or data group. A data item may be a single unit of data (e.g. 'Date of Birth'), or a set of data that has a standard structure (e.g. 'Address')
- *Purpose*: the main purposes for exchanging this data, including:
  - C: Clinician to Clinician Communication
  - S: System to System Communication
  - D: Decision Support
  - E: Epidemiology and Statistics
  - Q: Safety and Quality
- *Type*: the type of data associated with the component or data item. Note that this may be a simple data type (e.g. text, date) requiring a single field, or a predefined structure requiring a group of fields. For a full list of types used please refer to Section 3
- *Number of Values Allowed*: the number of times that the given component/item may be included in a Discharge Summary. For items, this is the number of times that the given item may be included, each time the component to which it belongs is included. The number of values may be either:
  - 0..1 (Zero or One): at most one data value
  - 1 (One): exactly one data value
  - 0..Many (Zero to Many): any number of data values
  - 1..Many (One to Many): at least one data value.
- *Notes*: Additional comments that clarify, explain or constrain the given data.

2.3 Definition

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

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

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
Patient		C, S, D, E, Q	Participation by Non- Healthcare (Patient)	1	The patient is the person about whom the healthcare event has been captured – that is, the subject of the information.	HEALTH EVENT CONTEXT.SUBJECT OF CARE
	Person Identifier	S, D, E, Q	Unique Identifier	1..Many	The unique identifier of the patient. This must include the patient‘s Individual Healthcare Identifier (IHI) and optionally the sending facility‘s unique Medical Record Number (MRN) for the patient.	HEALTH EVENT CONTEXT.SUBJECT OF CARE.PARTICIPANT.ENTITY IDENTIFIER
	Person Name	C, S, Q	Person Name	1..Many	The patient‘s name, structured using a predefined type (for details refer to section 3.1).	HEALTH EVENT CONTEXT.SUBJECT OF CARE.PARTICIPANT.PERSON.PERSON NAME

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Date of Birth	C, S, D, E, Q	Date Time	1	The patient's date of birth. If necessary, this may be an approximation, which includes only the year, or the month and year. An estimation flag may be used to indicate whether or not the date is an estimation.	HEALTH EVENT CONTEXT.SUBJECT OF CARE.PARTICPANT.PERSON.PERSON ADDITIONAL DEMOGRAPHIC DATA.Date of Birth
	Sex	C, S, D, E, Q	Coded Text	1	The sex of the patient. Sex is the biological distinction between male and female. Where there is an inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.	HEALTH EVENT CONTEXT.SUBJECT OF CARE. PARTICPANT.PERSON.PERSON ADDITIONAL DEMOGRAPHIC DATA.Sex
	Address	C, S, E, Q	Address	1..Many	The address of the patient, recorded in a structured format (for details refer to section 3.2). Where the patient's address is not known, the address line can be populated with text entry of ‗patient has no known address.' This may include ‗No fixed address' if appropriate.	HEALTH EVENT CONTEXT.SUBJECT OF CARE.PARTICIPANT.ADDRESS

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Communication Details	C, S	Electronic Communication Details	0..Many	The patient‘s preferred means of contact should be included to facilitate clinical follow-up. Each Contact Details data item includes the medium (e.g. telephone), usage (e.g. home) and details. For details refer to section 3.2.	HEALTH EVENT CONTEXT.SUBJECT OF CARE.PARTICIPANT.ELECTRONIC COMMUNICATION DETAILS
Nominated primary healthcare providers		C, S, E	Participation	0..Many	The healthcare provider(s) (person or organisation) nominated by the patient as being primarily responsible for their ongoing healthcare. It is expected that in many cases there will only be one nominated primary healthcare provider, and that this will be a General Practitioner or General Practice. If the nominated primary healthcare provider is an individual, then Person Identifier and Name must be recorded. If the nominated primary healthcare provider is or has an organisation, then Organisation Identifier and Organisation Name must be recorded.	HEALTH PROFILE.HEALTHCARE PROVIDERS.NOMINATED PRIMARY HEALTHCARE PROVIDER

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Role	C, S, E	Codeable Text	1	The role that the nominated primary healthcare provider plays in the patient's healthcare (e.g. 'General Practitioner', 'Community Nurse').	HEALTH PROFILE.HEALTHCARE PROVIDERS.NOMINATED PRIMARY HEALTHCARE PROVIDER.Healthcare Role
	Person Identifier	S, E, Q	Unique Identifier	0..Many	The unique identifier of the individual nominated primary healthcare provider. This must include the Healthcare Provider Identifier of the individual (HPI-I).	HEALTH PROFILE.HEALTHCARE PROVIDERS.NOMINATED PRIMARY HEALTHCARE PROVIDER.PARTICIPANT.ENTITY IDENTIFIER
	Person Name	C, Q	Person Name	0..1	The name of the nominated primary healthcare provider, recorded in a structured format (for details refer to section 3.1).	HEALTH PROFILE.HEALTHCARE PROVIDERS.NOMINATED PRIMARY HEALTHCARE PROVIDER.PARTICIPANT.PERSON.PERSON NAME
	Organisation Identifier	S, E, Q	Unique Identifier	0..Many	The unique organisation identifier of the nominated primary healthcare provider. This must include the Healthcare Provider Identifier of the organisation (HPI-O).	HEALTH PROFILE.HEALTHCARE PROVIDERS.NOMINATED PRIMARY HEALTHCARE PROVIDER.PARTICIPANT.ENTITY IDENTIFIER

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Organisation Name	C, Q	Organisation Name	0..1	The name of the healthcare provider organisation at which the patient's nominated primary healthcare provider practices.	HEALTH PROFILE.HEALTHCARE PROVIDERS.NOMINATED PRIMARY HEALTHCARE PROVIDER.PARTICIPANT.ORGANISATION.ORGANISATION NAME DETAIL
	Address	C	Address	1..Many	The address of the nominated primary healthcare provider, recorded in a structured format (for details refer to section 3.2).	HEALTH PROFILE.HEALTHCARE PROVIDERS.NOMINATED PRIMARY HEALTHCARE PROVIDER.PARTICIPANT.ADDRESS
	Communication Details	C, S	Electronic Communication Details	1..Many	The nominated primary healthcare provider's preferred means of contact. Each Contact Details includes the medium (e.g. telephone), usage (e.g. work) and details. For details refer to section 3.2	HEALTH PROFILE.HEALTHCARE PROVIDERS.NOMINATED PRIMARY HEALTHCARE PROVIDER.PARTICIPANT.ELECTRONIC COMMUNICATION DETAILS
Facility		C, S, E, Q	Participation by Organisation	1	The healthcare organisation involved in the delivery of the healthcare service to the patient, at the time of discharge.	HEALTH EVENT CONTEXT.FACILITY

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Identifier	S, D, E, Q	Unique Identifier	1..Many	The unique organisation identifier of the Facility. This must include the Facility's Healthcare Provider Identifier – Organisation (HPI-O).	HEALTH EVENT CONTEXT.FACILITY.PARTICIPANT.ENTITY IDENTIFIER
	Name	S, E, Q	Organisation Name	1	The name of the healthcare facility.	HEALTH EVENT CONTEXT.FACILITY.PARTICIPANT.ORGANISATION.ORGANISATION NAME DETAIL
	Address	C	Address	1..Many	The structured address(es) of the healthcare facility (for details refer to section 3.2).	HEALTH EVENT CONTEXT.FACILITY.PARTICIPANT.ADDRESS
	Communication Details	C, Q	Electronic Communication Details	1..Many	The electronic contact details of the healthcare facility. This should include at least one method of communication (e.g. phone number). For details refer to section 3.2.	HEALTH EVENT CONTEXT.FACILITY.PARTICIPANT.ELECTRONIC COMMUNICATION DETAILS
Document author		C, S, E, Q	Participation by Healthcare Provider	1	The healthcare provider who was responsible for authoring the Discharge Summary document.	DOCUMENT CONTEXT.DOCUMENT AUTHOR
	Person Identifier	S, E, Q	Unique Identifier	1..Many	The unique individual identifier of the document author. This must include the document author's Healthcare Provider	DOCUMENT CONTEXT.DOCUMENT AUTHOR.PARTICIPANT.ENTITY IDENTIFIER

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					Identifier – Individual (HPI-I).	
	Person Name	C, Q	Person Name	1	The name of the document author, in a structured format (for details refer to section 3.1).	DOCUMENT CONTEXT.DOCUMENT AUTHOR.PARTICIPANT.PERSON.PERSON NAME
	Communication Details	C, Q	Electronic Communication Details	0..Many	The contact details for the document author. This should include at least one method of communication (e.g. phone number). For details refer to section 3.2.	DOCUMENT CONTEXT.DOCUMENT AUTHOR.PARTICIPANT.ELECTRONIC COMMUNICATION DETAILS
Document recipients		C, S, E, Q	Participation	1..Many	The recipients of the document. Each recipient must be either an individual person, an organisation, or a person at an organisation. If the recipient is a person then Person Identifier and Person Name is required. If the recipient is an organisation then the Organisation Identifier and Organisation Name is required.	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS
	Recipient Type	C, S, E, Q	Codeable Text	1	The type of this recipient. Valid values include ‘primary’ and ‘cc’. Each discharge summary should have at	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS.Document Recipient Type

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					least one primary recipient. It is recommended that the Primary Recipient is the usual GP and the referring provider (where they are different).	
	Organisation Identifier	S, E, Q	Unique Identifier	0..Many	The unique identifier of the organisational recipient. This must include the organisation's Healthcare Provider Identifier – Organisation (HPI-O). This must contain an Organisation Identifier when there is an Organisation Name.	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS.PARTICIPANT.ENTITY IDENTIFIER
	Organisation Name	C, Q	Organisation Name	0..1	The name of the organisational recipient. This must contain an Organisation Name when there is an Organisation Identifier.	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS.PARTICIPANT.ORGANISATION.OR GANISATION NAME DETAIL
	Person Identifier	S, E, Q	Unique Identifier	0..Many	The unique individual identifier of the individual document recipient. Must contain the recipient's Healthcare Provider Identifier – Individual (HPI-I) when relevant.	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS.PARTICIPANT.ENTITY IDENTIFIER

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					This must contain a Person Identifier when there is a Person Name.	
	Person Name	C, Q	Person Name	0..1	The name of the individual recipient (if available), in a structured format (for details refer to section 3.1). This must contain a Person Name when there is a Person Identifier.	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS. PARTICIPANT.PERSON.PERSON NAME
	Relationship to Patient	C, S, Q	Codeable Text	1	The relationship that the recipient has with the patient – e.g. ‘General Practitioner’, ‘Mother’.	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS. PARTICIPANT.Relationship to Subject of Care
	Address	C	Address	0..Many	The structured address of the recipient (for details refer to section 3.2).	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS. PARTICIPANT.ADDRESS
	Communication details	C	Electronic Communication Details	0..Many	The contact details for the document recipient. This should include at least one method of communication (e.g. phone number). For details refer to section 3.2.	DOCUMENT CONTEXT.DOCUMENT RECIPIENTS. PARTICIPANT.ELECTRONIC COMMUNICATION DETAILS
Encounter details		C, S, D, E, Q	Section	1	Encounter Details describes general details about the patient‘s stay in hospital as an admitted or non- admitted patient.	EVENT.ENCOUNTER

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Encounter DateTime Started	C, S, E, Q	Date Time	1	The date (and optionally time) that the encounter, to which this discharge summary refers, started. In the case of admitted patients, this is the date/time of their admission.	EVENT.ENCOUNTER.DateTime Encounter Started
	Encounter DateTime Ended	C, S, E, Q	Date Time	1	The date (and optionally time) that the encounter, to which this discharge summary refers, finished. In the case of admitted patients, this is the date/time of their discharge.	EVENT.ENCOUNTER. DateTime Encounter Ended
	Separation Mode	C, E	Coded Text	1	The status of the patient at separation (e.g. discharge/ transfer/ death) and/or place to which the person is released (e.g. home).	EVENT.ENCOUNTER.Separation Mode
	Location of Discharge	C	Text	1	The number or identifier of the physical location from which the patient was discharged. In the case of admitted patients, this should be the ward in which they were located at the time of discharge. For non- admitted patients, this may be the department (e.g. ‘Emergency	EVENT.ENCOUNTER.Location of Discharge

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					Department') in which the encounter occurred.	
	Specialties	C, E	Codeable Text	1..Many	A reverse chronological list of the clinical specialties under which the patient was treated during the encounter (i.e. the last specialty appears first). Each specialty should only appear once in the list, in its first (i.e. most recent) position.	EVENT.ENCOUNTER.Specialty
	Responsible Health Professional	C, E, Q	Participation by Healthcare Provider	1	The healthcare provider who was responsible for the care given to the patient, at the time of discharge.	EVENT.ENCOUNTER.RESPONSIBLE HEALTH PROFESSIONAL AT TIME OF DISCHARGE
	Other Participants	C, E, Q	Participation	0..Many	Other healthcare providers who were involved in the encounter, or individuals associated with the patient at the time of the encounter, and the role that they played – e.g. registrar, referred specialist, referring clinician, emergency contact. Only those participants who are considered to be relevant to the ongoing care of the patient should be included.	EVENT.ENCOUNTER.OTHER PARTICPANTS

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
Problems / diagnoses		C, S, D, E, Q	Section	1..Many	Describes the diagnostic labels or problem statements assigned by the healthcare provider to describe the diagnoses and health/medical problems pertaining to the patient during the encounter. This must include at least one problem/diagnosis whose type is 'Principal'. Only past history relevant to the patient's encounter should be included.	EVENT.PROBLEMS/DIAGNOSES THIS VISIT.PROBLEM/DIAGNOSIS
	Problem / Diagnosis Type	C, S, D, E, Q	Coded Text	1	The type used to categorise the problem/diagnosis. The supported Problem/Diagnosis Types include 'Principal', 'Complication' and 'Co-morbidity'.	EVENT.PROBLEMS/DIAGNOSES THIS VISIT.PROBLEM/DIAGNOSIS.Problem/Diagnosis Type
	Problem / Diagnosis Description	C, S, D, E, Q	Codeable Text	1	A description of the problem/diagnosis, which may or may not be coded.	EVENT.PROBLEMS/DIAGNOSES THIS VISIT.PROBLEM/DIAGNOSIS.Problem/Diagnosis Description
Clinical synopsis		C	Section	1	The clinical synopsis contains summary information or comments about the clinical management of the patient, and the prognosis of diagnoses/ problems	EVENT.CLINICAL SYNOPSIS

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					identified during the healthcare encounter. It may also include health related information pertinent to the patient, and a clinical interpretation of relevant investigations and observations performed on the patient (including pathology and diagnostic imaging). Please note that pathology and diagnostic imaging reports referred to in the clinical synopsis should be included in full as an attachment to the Discharge Summary. These attached investigation reports should be referenced and listed in the Investigation results section.	
	Clinical Synopsis Description	C	Text	1	The clinical synopsis, in free text.	EVENT.CLINICAL SYNOPSIS.Clinical Synopsis Description
Diagnostic investigations		C, S, D, E, Q	Section	0..Many	Describes the important diagnostic investigations performed on the patient during the healthcare event, that are considered to be relevant to the patient‘s ongoing care This allows the results to be included as an attached	EVENT.DIAGNOSTIC INVESTIGATIONS

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					report, or as a reference (i.e. link) to where the results are located. Pending results can be indicated using a Result Status of 'pending'.	
	Investigation Type	C, S, D, E, Q	Codeable Text	1	The type or category of investigation performed on the patient – e.g. 'Pathology', 'Diagnostic Imaging'.	EVENT.DIAGNOSTIC INVESTIGATIONS.DIAGNOSTIC INVESTIGATION.Diagnostic Investigation Type
	Investigation Name	C. S, D, E, Q	Codeable Text	1	The name of the investigation performed on the patient – e.g. 'INR'.	EVENT.DIAGNOSTIC INVESTIGATIONS.DIAGNOSTIC INVESTIGATION.Diagnostic Investigation Name
	Investigation Date	C, S, D, E, Q	DateTime	1	The date and/or datetime that the diagnostic investigation was performed (in the case of diagnostic imaging investigations), or the specimen was taken (in the case of pathology investigations).	EVENT.DIAGNOSTIC INVESTIGATIONS.DIAGNOSTIC INVESTIGATION.DateTime of Diagnostic Investigation
	Result Status	C, S, Q	Codeable Text	1	The status of the investigation result – e.g. 'pending', 'interim', 'final'.	EVENT.DIAGNOSTIC INVESTIGATIONS.DIAGNOSTIC INVESTIGATION.Result Status
	Document Control	C, S, E, Q	Document Control	0..1	Information about the attached results or pending result (such as the version	EVENT.DIAGNOSTIC INVESTIGATIONS.DIAGNOSTIC

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					number, identifiers, document type, status and date attested) that will assist in the processing and document management of the attachment.	INVESTIGATION.REPORT ATTACHMENT.DOCUMENT CONTROL
	EITHER					
	Link	C, S, E, Q	Link	0..1	A reference to an external repository where the investigation results are stored.	EVENT.DIAGNOSTIC INVESTIGATIONS.DIAGNOSTIC INVESTIGATION.REPORT ATTACHMENT.Link or Data
	OR					
	Data	C, S, E, Q	Encapsulated Data	0..1	The actual content of the investigation report. The report may use one of a variety of formats (as indicated in the Document Control details), including PDF, structured text, or XML using a NEHTA-defined template.	EVENT.DIAGNOSTIC INVESTIGATIONS.DIAGNOSTIC INVESTIGATION.REPORT ATTACHMENT.Link or Data
Clinical interventions		C, S, E	Section	0..Many	Describes the clinical interventions (including operations and procedures) performed on the patient during the healthcare encounter.	EVENT.CLINICAL INTERVENTIONS PERFORMED THIS VISIT.CLINICAL INTERVENTION

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Clinical Intervention Description	C, S, E	Codeable Text	1	A separate description should be included for each Clinical Intervention performed. Information pertaining to a related complication may also be included.	EVENT.CLINICAL INTERVENTIONS PERFORMED THIS VISIT.CLINICAL INTERVENTION.Clinical Intervention Description
Current medications on discharge		C, S, D, E, Q	Section	1..Many	Medications that the patient will continue or commence on discharge.	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE
	Discharge Medications Indicator	C, S, E, Q	Coded Text	1	Indicates whether or not the patient is known to be taking any medications on discharge. For example ‘Known’ or ‘None known’ IF Known THEN	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.KNOWN MEDICATIONS If MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.KNOWN MEDICATIONS.Known Medications Type = ‘Current Medications on Discharge’ and MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.KNOWN MEDICATIONS.Known Medications Value = ‘Known’ THEN
	Status	C, S, Q	Coded Text	1	The status of the medication item at the time of discharge (e.g. ‘New’, ‘Unchanged’, ‘Dose increased’, ‘Dose decreased’, ‘Withheld’).	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.Item Status
	Item Description	C, S, D, E, Q	Codeable Text	1	The details that fully describe a medication, including the name of the	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.ITEM.Item Description

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					medication (active ingredients or brand name), strength and dose form, where appropriate.	
	Dose Instructions	C, Q	Text	1	A description of how a particular product is being taken by the patient as at the date of discharge, or is intended to be taken immediately following discharge. This must include the route, dose quantity, frequency and any additional instructions required to safely describe the appropriate dosage. This should also include the administration schedule. In discharge summary systems, which support atomic dosage instructions, this item only needs to be populated when the atomic dosage items are not.	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.DOSAGE.Dose Instruction
	Reason for Medication	C, D, E, Q	Codeable Text	0..1	The clinical justification (e.g. specific therapeutic effect intended) for the use of the medication. For inpatient discharge summaries, this should be recorded.	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.Reason for Medication

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Duration	C, S, E	Time Interval and Coded Text	0..1	The time period (optionally including start date, end date and length of time) that the patient has taken or will take the prescribed medication. If no end date is supplied, then the medication is ongoing. If the length of time post discharge is required, then this can be derived for display.	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.Medication Duration
	Changes Made	C, Q	Codeable Text	0..1	A description of any change made during the healthcare encounter, where the change is intended to continue after discharge.	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.CHANGE DETAILS.Changes Made
	Reason for Change	C, Q	Text	0..1	The justification for the stated change in medication.	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.CHANGE DETAILS.Reason for Change
	Quantity Supplied	C, S, Q	Text	0..1	The quantity of medication supplied by the facility to the patient, with which the patient is discharged.	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.Unit of Use Quantity Dispensed
	Additional Comments	C, Q	Text	0..1	Any additional information that may be needed to ensure the continuity of supply, continued proper use, or appropriate medication management – e.g. ‘Patient requires an	MEDICATIONS.CURRENT MEDICATIONS ON DISCHARGE.ITEM DETAIL.Additional Comments.

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					administration aid', 'Patient will require new script in 3 days of discharge', 'Dosage to be reviewed in 10 days', 'Target INR for warfarin management', or 'Recommence post-discharge' (for medications with status of 'Withheld'.	
Ceased medications		C, S, D, E, Q	Section	1..Many	Medications that the patient was taking at the start of the healthcare encounter (e.g. on admission), that have been stopped during the encounter or on discharge, and that are not expected to be recommenced.	MEDICATIONS.CEASED MEDICATIONS
	Ceased Medications Indicator	C, S, E, Q	Coded Text	1	Indicates whether or not the patient has any known ceased medications during the healthcare encounter or on discharge. For example 'Known', 'None known'.	MEDICATIONS.CEASED MEDICATIONS.KNOWN MEDICATIONS
					IF Known THEN	If MEDICATIONS.CEASED MEDICATIONS.KNOWN MEDICATIONS.Known Medications Type = 'Ceased Medications' and MEDICATIONS.CEASED MEDICATIONS.KNOWN MEDICATIONS.Known Medications Value = 'Known'

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
						THEN
	Item Description	C, S, D, E, Q	Codeable Text	1	The name of the medication, as described by the prescriber or pharmacist. This description should include the active ingredient names, brand name, strength and dose form of the medication, where appropriate.	MEDICATIONS.CEASED MEDICATIONS.ITEM DETAIL.ITEM.Item Description
	Reason for Ceasing	C, Q	Text	1	The reason that the medication was ceased.	MEDICATIONS.CEASED MEDICATIONS.ITEM DETAIL.CHANGES MADE
Allergies / Adverse reactions		C, S, D, E, Q	Section	1..Many	Describes the known adverse reactions for the patient (including allergies and intolerances), and any relevant reaction details.	HEALTH PROFILE.ADVERSE REACTIONS
	Adverse Reactions Indicator	C, S, E, Q	Coded Text	1	Indicates the status of knowledge about the patient‘s Adverse Reactions. For example ‘Known’, ‘None known’, ‘Unknown’, ‘Not asked’.	HEALTH PROFILE.ADVERSE REACTIONS.Known Adverse Reactions Value
					IF Known THEN	If HEALTH PROFILE.ADVERSE REACTIONS.Known Adverse Reactions Value = ‘Known’ THEN

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Agent Description	C, S, D, E, Q	Codeable Text	1	The agent/substance causing the adverse reaction experienced by the patient.	HEALTH PROFILE.ADVERSE REACTIONS.ADVERSE REACTION.Agent Description
	Reaction Description	C, S, D, E, Q	Codeable Text	0..Many	The signs and/or symptoms experienced or exhibited by the patient as a consequence of the adverse reaction to the specific agent/substance. The severity of the reaction and certainty may be included in this description, where appropriate.	HEALTH PROFILE.ADVERSE REACTIONS.ADVERSE REACTION.REACTION DETAIL.Reaction Description
Alerts		C, Q	Section	0..Many	Describes alerts pertaining to the patient that may require special consideration or action by the recipients.	HEALTH PROFILE.ALERTS
	Alert Type	C, S, Q	Codeable Text	1	The type of alert (e.g. infection risk, special needs, clinical, discharge circumstances, vulnerable families, psychosocial alerts etc).	HEALTH PROFILE.ALERTS.ALERT.Alert Type
	Alert Description	C, S, Q	Codeable Text	1	Describes the nature of the alert.	HEALTH PROFILE.ALERTS.ALERT.Alert Description
Arranged services		C, S, E, Q	Section	0..Many	Describes clinical services that have been provided for or arranged for the patient. This can include	PLAN.ARRANGED SERVICES

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					appointments related to clinical follow up. If the service provision has not been confirmed then, the service date and/or provider may not be recorded.	
	Service Description	C, S, E, Q	Codeable Text	1	A description of the arranged service.	PLAN.ARRANGED SERVICES.ARRANGED SERVICE.Arranged Service Description
	Service Date	C, S, Q	DateTime or Time Interval	0..1	The datetime or date range at/during which the arranged service is scheduled to be provided to the patient.	PLAN.ARRANGED SERVICES.ARRANGED SERVICE.Service Commencement Window
	Service Provider	C, S, E, Q	Participation	0..1	The provider (individual or organisation) that has been requested to provide the service. This may include their role, identifiers, name, address and contact details.	PLAN.ARRANGED SERVICES.ARRANGED SERVICE.SERVICE PROVIDER
	Service Booking Status	C, S, Q	Codeable Text	1	An indication of the booking status of the arranged service – e.g. ‘requested’, ‘tentative’, ‘confirmed’.	PLAN.ARRANGED SERVICES.ARRANGED SERVICE.Service Booking Status
Recommendations		C, S, E	Section	1..Many	Recommendations to a recipient healthcare provider and/or patient that are relevant to the continuity of care and	PLAN.RECOMMENDATIONS AND INFORMATION PROVIDED.RECOMMENDATIONS PROVIDED

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					management of the patient after discharge.	
	Recommendation To	C, S, E	Participation	1	The individual or organisation, who will be receiving a copy of the discharge summary, and to which the recommendation is directed.	PLAN.RECOMMENDATIONS AND INFORMATION PROVIDED.RECOMMENDATIONS PROVIDED.RECOMMENDATION RECIPIENT
	Recommendation Note	C	Text	1	Details of the recommendation given by the healthcare provider from the facility.	PLAN.RECOMMENDATIONS AND INFORMATION PROVIDED.RECOMMENDATIONS PROVIDED.Recommendation Note
Information provided to patient and/or relevant parties		C, Q	Section	0..1	Details of the information and education that has been provided to and discussed with the patient, their family, carer and/or other relevant parties, including awareness or lack of awareness of diagnosed conditions, and relevant health management. An indication of whether or not the patient or carer has understood the information or instructions provided may also be relevant.	PLAN.RECOMMENDATIONS AND INFORMATION PROVIDED.INFORMATION PROVIDED.
	Information Provided Description	C, Q	Text	1	A description of the information that has been provided to the patient.	PLAN.RECOMMENDATIONS AND INFORMATION PROVIDED.INFORMATION PROVIDED.Information Provided to Subject of Care and/or Relevant Parties

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
Document control		C, S, E, Q	Document Control	1	Versioning and other document control information associated with the Discharge Summary document. These details are required for the technical exchange of the document and do not necessarily need to be displayed to the user. However, there may be value in displaying some items (e.g. Version Number, Date Attested, Document Status, etc.).	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL
	Document Instance Identifier	S, Q	Unique Identifier	1	The universally unique identifier of this instance of the Discharge Summary document.	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Document Instance Identifier
	Document Set Identifier	S, Q	Unique Identifier	1	The universally unique identifier of the set of documents related to the same healthcare encounter, of which the Discharge Summary document is a versioned instance.	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Document Set Identifier
	Version Number	C, S, Q	Integer	1	The version number of the Discharge Summary document instance.	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Version Number

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	Document Originating System Identifier	S, E, Q	Unique Identifier	1	A universally unique identifier of the system used to create the Discharge Summary document.	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Document Originating System Identifier
	Business Document Type	C, S, Q	Coded Text	1	The name of the Discharge Summary document type used – e.g. 'Discharge Summary'	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Document Type
	Business Document Type Version Number	S, Q	Integer	1	The version number of the Discharge Summary document type used to create the Discharge Summary.	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Document Type Version Number
	DateTime Attested	C, S, Q	Date Time	1	The date/time when the Discharge Summary document was attested (or finalised, or signed off) by the document authoriser.	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.DateTime Attested
	Document Status	C, S, Q	Coded Text	1	The status of the document (e.g. 'Interim', 'Final', 'Amended')	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Document Status
	Language	S, Q	Coded Text	1	The language primarily used within the document (e.g. 'en-AU')	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.Language
Attachments		C, S, E, Q	Attachment	0..Many	Documents that have been attached to the Discharge Summary (as a link or as data), because they are relevant to the ongoing	ATTACHMENTS

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
					care of the patient. For example a care plan, or a health assessment.	
	Document Name	C	Text	1	The name of the attached document, to be used when referencing the attachment (e.g. 'Care Plan')	ATTACHMENTS.ATTACHMENT.Document Name
	Document Control	C, S, E, Q	Document Control	0..1	Information about the attachment (such as the version number, identifiers, document type and date attested) that will assist in the processing and document management of the attachment.	ATTACHMENTS.ATTACHMENT.DOCUMENT CONTROL.
	Section Reference	C,S	Codeable Text	0..Many	The section in the Discharge Summary from which the attachment should be referenced – e.g. Pathology, Physical Assessment. This information may be used to organise references to the attachments into appropriate groups.	ATTACHMENTS.ATTACHMENT.Section Reference
	EITHER					
	Link	C, S, E, Q	Link	0..1	A reference to an external repository where the attachment is stored.	ATTACHMENTS.ATTACHMENT.Link or Data

Component	Item	Purpose	Type	Number of Values Allowed	Notes	Mapping to Discharge Summary Structured Document Template v2.0
	OR					
	Data	C, S, E, Q	Encapsulated Data	0..1	The actual content of the attachment. The attachment may use one of a variety of formats (as indicated in the Document Control details), including PDF, structured text or XML structured using a NEHTA-defined template.	ATTACHMENTS.ATTACHMENT.Link or Data

Table 1 Core Information Component definition

3 Data component and data item types

3.1 Data component types

The following data component types are referred to in the Discharge Summary Core Information Component definition. For more details, please refer to [DS-SDT2009].

3.1.1 Adverse reaction

Describes the known adverse reactions experienced by the patient and any relevant reaction details.

3.1.2 Alert

Describes information pertaining to a patient that may:

- Need special consideration by a healthcare provider before making a decision to avert an unfavourable healthcare event.
- Need consideration and/or action by a healthcare provider or facility in relation to the care and safety of the patient, staff and/or other individuals.
- Notify the healthcare provider of special circumstances that may be relevant in delivering care and/or interacting with the patient.

3.1.3 Attachment

Documents that have been attached to the Discharge Summary (either as a link or as data), because they are relevant to the ongoing care of the patient. For example, the original referral, relevant pathology reports, relevant diagnostic imaging reports, referral letters, a care plan, and assessments.

3.1.4 Document control

Versioning and other document control information associated with the Discharge Summary document. These details are required for the technical exchange of the document and do not necessarily need to be displayed to the user. However, there may be value in displaying some items (e.g. Version Number, Date Attested, Document Status etc).

3.1.5 Item detail

Describes a single unique medication product.

3.1.6 Participation

Refers to the individuals, organisations and IT systems operating within a defined healthcare domain, and the roles that these entities play within that domain.

3.1.7 Organisation name

The name by which an organisation is known, which includes the following sub-elements:

- Organisation Name (Text)
- Department/Unit (Text)
- Organisation Name Usage (Coded Text)
- Organisation Name Usage Date Range (Time Interval).

3.1.8 Participation by organisation

Refers to an organisation operating within a defined healthcare domain, and the roles that it plays within that domain. It includes the following sub- elements:

- Participation Type (Codeable Text)
- Healthcare Role (Codeable Text)
- Participation Period (TimeInterval)
- Unique Identifier (Entity Identifier)
- Address (Address)
- Electronic Communication (Electronic Communication Details)
- Organisation Name (Organisation Name).

3.1.9 Participation by person

Refers to an individual within a defined healthcare domain, and the roles that he or she plays within that domain.

3.1.10 Participation by healthcare provider

Refers to a Healthcare Provider Individual operating within a defined healthcare domain, and the roles that he or she plays within that domain. It includes the following sub-elements:

- Participation Type (Codeable Text)
- Healthcare Role (Codeable Text)
- Participation Period (TimeInterval)
- Entity Identifier (UniqueIdentifier)
- Address (Address)
- Electronic Communication (Electronic Communication Detail)
- Person Name (Person Name)
- Healthcare Provider Practice (Healthcare Provider Practice Detail)
- Employer Organisation Detail (Employer Organisation Detail)

3.1.11 Participation by non-healthcare provider (patient)

This data group is most often used for a subject of care (patient). It includes the following sub-elements:

- Participation Type (Codeable Text)
- Healthcare Role (Codeable Text)
- Participation Period (TimeInterval)
- Entity Identifier (UniqueIdentifier)
- Address (Address)
- Electronic Communication (Electronic Communication Detail)
- Person Name (Person Name)
- Relationship to Subject of Care (Codeable Text)

- Employment Detail (Employment Detail)
- Demographic Data (Demographic Data)

3.1.12 Participation by non-healthcare provider (person)

This data group is used where the participant is a person who is not participating in the role of a healthcare provider and is not the patient, e.g. carer, document recipient related to the subject of care (patient), recipient of a recommendation. The role of these persons is neither a healthcare provider nor a subject of care. It includes the following sub-elements:

- Participation Type (Codeable Text)
- Healthcare Role (Coded Text)
- Entity Identifier (UniqueIdentifier)
- Address (Address)
- Electronic Communication (Electronic Communication Detail)
- Person Name (Person Name)
- Relationship to Subject of Care (Codeable Text)
- Employment Detail (Employment Detail)

3.1.13 Person name

Captures the name details of a person. A person may have more than one name recorded. It includes the following sub-elements:

- Name Title (List of Text)
- Family Name (Text)
- Given Name (List of Text)
- Name Suffix (List of Coded Text)
- Preferred Name Indicator (Boolean)
- Name Conditional Use Flag (Coded Text)
- Person Name Usage
- Person Name Usage Date Range

3.1.14 Recommendation

Recommendations to a recipient healthcare provider and/or patient that are relevant to the continuity of care and management of the patient after discharge.

3.1.15 Requested service

Describes a clinical referral or a service requested for, planned for, or provided to the patient.

3.1.16 Section

Groups related information together and provides a way to navigate through the data items within the document.

3.2 Data types

This section briefly describes the data types referred to in the Discharge Summary Core Information Component definition. For more details, please refer to [DS-SDT2009].

3.2.1 Address

An Address is a structured description of a physical or postal location, which includes the following sub-elements:

- No Fixed Address Indicator (Boolean)
- Address Line (Text)
- Suburb/Town/Locality (Codeable Text)
- State/Territory/Province (Codeable Text)
- Postcode (Codeable Text)
- Country (Codeable Text)
- Australian Delivery Point Identifier (Identifier)
- Address Purpose (Coded Text)
- Address Purpose Date Range (Time Interval)

3.2.2 Any

This item type is used where the data type may vary considerably depending on the context – e.g. free text, numeric values, or data structures.

3.2.3 Boolean

A simple datatype, which has one of two values: true and false.

3.2.4 Codeable text

Codeable Text is a flexible datatype used to hold either free text or coded text. Codeable Text includes the following sub-elements:

- Display Name (Text)
- Original Text (Text)
- Translation (Coded Text)
- Code (Text)
- Code System (UUID)
- Code System Name (Text)
- Code System Version (Text)
- Value Set (Text)
- Value Set Version (Text)

3.2.5 Coded text

Coded Text is used to hold both a text description and code mappings. Coded Text includes the following sub-elements:

- Display Name (Text)

- Original Text (Text)
- Translation (Coded Text)
- Code (Text)
- Code System (UUID)
- Code System Name (Text)
- Code System Version (Text)
- Value Set (Text)
- Value Set Version (Text).

3.2.6 Date time

Data Time is used to specify a single date and/or time. String representations of known dates should conform to the non-extended format within [ISO21090-2008] – that is 'YYYYMMDDHHMMSS.UUUU[+|-ZZzz]'.

3.2.7 Electronic communication details

Electronic Communication Details is used to describe methods for electronically contacting a person or organisation, including telephone numbers, fax numbers, pager numbers, email addresses and URLs. Electronic Communication Details include the following sub-elements:

- Electronic Communication Medium (Coded Text)
- Electronic Communication Usage Code (Coded Text)
- Electronic Communication Details (Text).

3.2.8 Encapsulated data

Data that is primarily intended for human interpretation or for further machine processing, outside the scope of this specification. This includes unformatted or formatted written language, multimedia data, or structured information as defined by a different standard (e.g. XML-signatures).

3.2.9 Unique identifier

A number or code issued for the purpose of identifying an entity (person, organisation or organisation sub-unit) within a healthcare context.

For further description of Unique Identifier details, please refer to the NEHTA Participation Data Specification, Version 2.0 — 30 Nov 2009 [PDS2009].

3.2.10 Integer

The mathematical datatype comprising the exact integral values [ISO11404- 2007].

3.2.11 Link

A link is a reference or pointer to an object, data or application that exists logically or is stored electronically in a computer system (e.g. URL or path).

3.2.12 Quantity

Used for recording real world measurements and observations. It includes the magnitude value and the units, and may also include its precision.

3.2.13 Quantity range

Two Quantity values that define the minimum and maximum values (i.e. lower and upper bounds). This is typically used for defining the valid range of values for a particular measurement or observation. Unbounded quantity ranges can be defined by not including a minimum and/or a maximum Quantity value.

3.2.14 Text

Text refers to a character string (with optional language indicator). Unless otherwise constrained by an implementation, it can be any combination of alphanumeric characters or symbols from the Unicode character set. This is sometimes referred to as free text.

3.2.15 Time interval

A time interval is a period of time, which may have a Start DateTime, an End Date Time and/or a Duration/Width.

Definitions

This section explains the specialised terminology used in this document.

Shortened terms

This table lists abbreviations and acronyms in alphabetical order.

Term	Description
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AMA	Australian Medical Association
CC	Core Connectivity
CI	Clinical Information
CIO	Chief Information Officer
CT	Clinical Terminology
EHR	Electronic Health Record
GP	General Practitioner
HI	Healthcare identifiers
HPI	Healthcare Provider Identifier
ICT	Information and Communication Technology
INR	International Normalisation Ratio
IT	Information Technology
NASH	National Authentication Service for Health
NEHTA	National E-Health Transition Authority
PCEHR	Personally Controlled Electronic Health Record
RACGP	The Royal Australian College of General Practitioners
RACMA	The Royal Australasian College of Medical Administrators
RACP	The Royal Australasian College of Physicians
RACS	The Royal Australasian College of Surgeons
RANZCR	The Royal Australian and New Zealand College of Radiologists
RCPA	The Royal College of Pathologists of Australasia
SDT	Structured Document Template
SIL	Service Instance Locator
SNOMED CT	Systemised Nomenclature of Medicine, Clinical Terminology
UUID	Universally Unique Identifier

Glossary

This table lists specialised terminology in alphabetical order.

Term	Description
Admitting doctor	The clinician, with the appropriate delegated authority, who decides that a patient should be admitted to the hospital.
Author	The medical officer chiefly responsible for completing the discharge summary.
Authoriser	The clinician responsible for authorising the release and distribution of the discharge summary.
Business Architect	A Business Architect is anyone looks at the way work is being directed and accomplished, and then identifies, designs and oversees the implementation of improvements that are harmonious with the nature and strategy of the organisation. Source: http://www.businessarchitects.org
Contributor	Other clinical staff who can complete specific sections of the Discharge Summary.
Development Team	The Developer writes the code for the specifications that the Development leads provide. Source: http://www.developer.com
Discharge summary administrator	Responsible for the non-technical administration of the discharge summary system and processes.
Distribution list	List of all planned unambiguously recipients of a discharge summary instance.
Distributor	Can distribute discharge summaries that have already been finalised and distributed. Typically this would be Medical Records staff who receive requests from GPs.
Electronic Signature	An electronic signature refers to a form of authentication for the web services and includes signed certificates.
Endpoint	Where a web service connects to the network. Source: http://www.looselycoupled.com/glossary/endpoint
Exception list	List of discharge summaries received by a Practice that have anomalies that need to be resolved through human intervention.
Interim discharge summary	A discharge summary released to provide information to recipients with the understanding that the information contained may not be complete and is subject to change/amendment.
Interoperability	The ability of software and hardware on multiple machines from multiple vendors to communicate. Source: http://foldoc.org/interoperability
Non-admitted Patient	Patients who are admitted for dialysis, same day radiotherapy and other procedures involving repetitive one day admissions would not normally require a discharge summary are referred to as non-admitted patients.

Term	Description
Persistent Data	Persistent Data denotes information that is infrequently accessed and not likely to be modified. It out lasts the execution of a particular program.
Solutions Architect	The Solutions Architect is typically responsible for matching technologies to the problem being solved. Source: http://www.developer.com
Summary Health Profile	A standard specification of demographic and health/clinical data contents used to capture information about the health status of a patient at a specific point-in-time. It is intended to provide crucial health status information to facilitate the delivery of safe, quality care to the patient, especially in unplanned/emergency situations.
Technical Architect	The technical architect is responsible for transforming the requirements into a set of architecture and design documents that can be used by the rest of the team to actually create the solution. Source: http://www.developer.com
Treating doctor	The clinician responsible chiefly responsible for the care of the patient during an inpatient episode.
Worklist	List of discharge summaries currently assigned to a particular clinician.

References

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

Package documents

The documents listed below are part of the suite delivered in the discharge summary package.

Discharge Summary Package Documents			
[REF]	Document Name	Publisher	Link
[DS-ES2010]	e-Discharge Summary Release 1.1 – Executive Summary v1.0	NEHTA 2010	https://developer.digitalhealth.gov.au/resources/edischarge-summary-v1-1 Open menu: e-Discharge Summary Package 1.1
[DS-RN2010]	e-Discharge Summary Release 1.1 – Release Notification v1.0		
[DS-BRS2010]	e-Discharge Summary Release 1.1 – Business Requirements Specification v1.0		
[DS-SD2010]	e-Discharge Summary Release 1.1 – Solution Design v1.0		
[DS-CIC2010]	e-Discharge Summary Release 1.1 – Core Information Components v1.0		
[DS-TSS2010]	e-Discharge Summary Release 1.1 - Technical Service Specification v1.0		

References

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

Reference Documents			
[REF]	Document Name	Publisher	Link
[AS4700.6(Int)2007]	Interim Australian Standard, Implementation of Health Level Seven (HL7) Version 2.5, Part 6: Referral, discharge and health record messaging	Standards Australia 2007	http://infostore.saiglobal.com/store/ Search "AS 4700.6(Int)-2007".
[DS-SDT2009]	Discharge Summary - Core, Structured Document Template (20090826) (v2.1)	NEHTA 2009	http://nehta.gov.au/connecting-australia/terminology-and-information/clinical-information-mi Open menu: Clinical Information Structured Document Templates
[ISO11404-2007]	ISO/IEC 11404:2007 Information technology - General-Purpose Datatypes (GPD)	ISO 2007	http://www.iso.org Search "11404:2007".

Reference Documents			
[ISO21090- 2008]	ISO/DIS 21090 Health Informatics - Harmonized data types for information interchange	ISO 2008	http://www.iso.org Search "21090" using 'Standards under development'.
[NDSDCS2006]	National Discharge Summary Data Content Specifications v1.0	NEHTA 2006	https://developer.digitalhealth.gov.au/ Search "discharge content".
[PDS2009]	Participation Data Specification v2.0	NEHTA 2009	http://www.nehta.gov.au/connecting-australia/terminology-and-information/clinical-information-mi Open menu: Clinical Information Data Specification – Specifications, Context and Requirements

Related reading

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

Related Documents			
[REF]	Document Name	Publisher	Link
[IF2007]	Interoperability Framework v2.0	NEHTA 2008	https://developer.digitalhealth.gov.au/resources/interoperability-framework-interoperability-framework-v2-0
[ATS5820-2010]	Australian Technical Specification - E-Health Web Services Profiles	Standards Australia 2010	http://www.e-health.standards.org.au/Home/Publications.aspx
[NEHTAWEB]	NEHTA Web Site	NEHTA 2008	https://developer.digitalhealth.gov.au/