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Event Summary
Information Requirements v1.2

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National E-Health Transition Authority

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Key information

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1.2	10 April 2015	

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1 Introduction

1.1 Purpose

This document presents the information requirements for event summaries, as recommended for use in Australian eHealth systems.

These information requirements are a logical set of data items for exchange and are therefore independent of any particular platform, technology, exchange format or presentation format.

They are the minimum set of data items that are recommended for implementation in any system that creates and transfers event summaries, to support the delivery of quality collaborative care. The inclusion of data in this minimum set is determined by two criteria:

a the clinical relevancy of the data; and

b the potential for the data to improve clinical safety in a collaborative care environment.

As these specifications define the information requirements for exchange, it is anticipated that some event summary templates may contain additional types of data to satisfy specific local or specialty healthcare requirements.

Additionally, the purpose of the *Event Summary Information Requirements* is to define the information needs for a national consensus on information sharing between healthcare providers in Australia, independent of exchange or presentation formats.

It is anticipated that these information requirements will:

- promote a common understanding of the requirements for the construction and use of event summaries;
- provide a common framework for development and use of semantically interoperable information components to be exchanged between applications, providers and jurisdictions;
- provide a common framework for defining queries using these information requirements at logical levels, which may be adopted for implementations in local, jurisdictional or national electronic health record environments; and
- provide a common framework for nationally defined mappings to specific exchange formats.

1.2 Intended audience

This document is intended for all interested stakeholders including:

- clinicians, such as general practitioners;
- early adopter hospitals and health departments in the process of planning, implementing or upgrading eHealth systems;
- software vendors developing eHealth system products;
- early adopter general practitioner desktop software vendors;
- senior managers and policy makers, clinical experts, health information managers, IT operations and support teams and system integrators;
- stakeholders associated with the development and use of upcoming eHealth initiatives relating to 'continuity of care'; and
- consumers and consumer representatives.

1.3 Scope exclusions

The following statements regarding scope pertain only to the information requirement specifications herein and not more broadly to the personally controlled electronic health record (PCEHR) scope of work.

The following are out of scope:

- information-gathering practices involved in the creation or modification of patient records within any given GP clinical information system (CIS);
- the way the data is transferred from GP desktop to PCEHR; or
- the formatting of information for display purposes.

1.4 Exchange and presentation formats

The information presented in this document is defined at the logical level, and is therefore independent of specific exchange or presentation formats; for example, HL7® v2.x or HL7® CDA®.[1]

Similarly, the requirement that a particular piece of data be exchanged in an event summary does not imply a requirement on the user interface. Some data elements (e.g. "Date of Birth") have a number of different presentation options available (e.g. "Birth Day" + "Year of Birth" etc.), which are not considered here. In addition, the names given to data components and data items are, in many cases, not appropriate to be used as field labels on a user interface.

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.

1.5 Adding data

A clinical information system (CIS) that generates event summaries should be capable, wherever possible, of transferring relevant data into many of the relevant sections of the event summary. This is intended to minimise data entry duplication

[1] Health Level Seven, HL7 and CDA are trademarks of Health Level Seven International.

and reduce the issues of recording data redundantly in multiple data stores. It is expected that whenever data is obtained from a CIS, following a clinical interaction with a patient, the author exercises discretion in allowing only information relevant to the ongoing care of the patient to be included in the event summary. It is also expected that the author applies due diligence to ensure that such CIS-sourced information is both current and accurate.

1.6 Outline of core components

The core components include:

- Individual
- Event details
- Event summary author
- Newly identified allergies and adverse reactions
- Medicines
- Diagnoses / interventions
- Immunisations
- Diagnostic investigations
- Document control

Each of the above components is described in the following sections, in terms of their detailed requirements and associated rationale.

2 Use of event summaries

2.1 Overview

The aim of an event summary is to provide information to an individual's PCEHR on significant healthcare events. The information included is at the discretion of the clinician, with the consent of the individual. The information may be used by the nominated healthcare provider to update their local record and the individual's shared health summary.

2.2 Example scenario

A patient, John, has a complex chronic illness and is being actively managed by his usual GP. The usual GP has regularly maintained an up-to-date shared health summary for John, which has been published to John's PCEHR. John has a holiday interstate, falls ill and needs to see a GP for management. The new GP reviews John's shared health summary to get acquainted with John's available history.

To address the presenting problem, the GP makes some changes to John's medications and decides to create an event summary and, with John's consent, publish it to the PCEHR.

On return home, John is seen by his usual GP. Rather than relying on John's memory of the recent event, she reviews the event summary written by the other GP.

The usual GP decides to incorporate the new medications listed in the event summary into her own clinical records and then updates John's shared health summary.

3 Individual

Description: The individual is the person about whom the healthcare event has been captured – that is, the subject of the information.

3.1 Individual (Core)

Data item	Req No.	Requirement statement	Rationale
Individual Healthcare Identifier (mandatory)	022082	The document **SHALL** contain the individual's Individual Healthcare Identifier (IHI).	Enables interoperability. Eliminates ambiguity. Supports the indexing of clinical documents. If an IHI is not available then the individual's PCEHR cannot be identified.
Individual's title (optional)	022081	The document **SHOULD** contain at least one title for the individual.	Titles such as 'Mrs', 'Mr', 'Dr' etc. are useful when communicating with the individual.
Individual's given name (optional)	023056	The document **SHOULD** contain at least one given name for the individual.	To enable consistent and correct identification of the individual's document. Assists in verifying that the document relates to the individual.
Individual's family name (mandatory)	023058	The document **SHALL** contain the individual's family name.	To enable consistent and correct identification of the individual. This is a required field when validating IHIs against the Healthcare Identifiers (HI) Service.
Individual's name suffix (optional)	023059	The document **SHOULD** contain the individual's name suffix where applicable.	Suffixes such as 'Snr', 'Jnr' etc. can be a useful aid in the correct and unique identification of the individual.
Individual's sex (mandatory)	024032	The document **SHALL** contain the individual's sex.	To enable consistent and correct identification of the individual. This is a required field when validating IHIs against the HI Service. The individual's sex is also useful in clinical decision making.
Individual's date of	023060	The document **SHALL** contain the individual's	To enable consistent and correct identification of the

Data item	Req No.	Requirement statement	Rationale
birth (mandatory)		date and time (time is optional) of birth. **Additional Notes** Time of birth may be recorded during care immediately following birth.	individual. This is a required field when validating IHIs against the HI Service. Date of birth is also useful in clinical decision making.
Date of birth accuracy indicator (optional)	024026	The document **SHOULD** contain a date of birth accuracy indicator.	To assist in the correct identification of the individual. It is important for clinicians to know when a provided date of birth is an approximation to assist in clinical decision making.

3.2 Individual (extension)

Data item	Req No.	Requirement statement	Rationale
Individual's address (mandatory)	024041	The document **SHALL** contain at least one address for the individual.	To enable consistent and correct identification of the individual.
Individual's electronic communication details (optional)	024042	The document **SHOULD** contain at least one set of electronic communication details for the individual. These include (but are not limited to) telephone number, mobile phone number, email address etc.	To enable electronic communication with the individual.
Indigenous status (mandatory)	024033	The document **SHALL** state whether a person identifies as being of Aboriginal and/or Torres Strait Islander origin, or give a clear indication that their indigenous status was not stated.	Members of the Indigenous community may have specific health needs and be eligible for a range of specific services. Access to this information may contribute to improved Indigenous health.

4 Event summary author

Description: The healthcare provider who has attended to the individual and decides to upload an event summary to the PCEHR.

Data item	Req No.	Requirement statement	Rationale
Healthcare provider professional role (mandatory)	024040	The document **SHALL** contain the healthcare provider's professional role (e.g. General Practitioner). This data item MAY carry a value equivalent to 'unknown'.	Describing the professional role a healthcare provider is acting in the provision of healthcare can provide context and assist in interactions between healthcare providers to the benefit of individuals receiving healthcare.
Healthcare provider organisation name (mandatory)	023070	The document **SHALL** contain the name of the organisation that the healthcare provider is representing at the time of CDA® document creation.	To enable consistent and correct identification of the healthcare provider organisation. This is a required field when validating HPI-Os against the HI Service.
Healthcare provider employer organisation address	025064	The document **SHALL** contain the healthcare provider employer organisation's address.	To ensure that contact details are always provided for the author.
Healthcare provider employer organisation electronic communication detail	025063	The document **SHALL** contain the healthcare provider employer organisation's electronic communication detail.	To ensure that contact details are always provided for the author's organisation.

4.1 PCEHR participating healthcare provider (core)

Data item	Req No.	Requirement statement	Rationale
Healthcare Provider Identifier-Individual (mandatory)	023066	The document **SHALL** contain the Healthcare Provider Individual Identifier (HPI-I).	To enable consistent and correct identification of the healthcare provider.
Healthcare Provider Identifier-Organisation (mandatory)	023071	The document **SHALL** contain the Healthcare Provider Identifier-Organisation (HPI-O) of the organisation that the healthcare provider is representing at the time of the CDA® document creation.	To enable consistent and correct identification of the organisation or practice that the healthcare provider is representing at the time of document creation.
Healthcare provider's title (optional)	023061	The document **SHOULD** contain at least one title for the healthcare provider.	Titles such as 'Mrs', 'Mr', 'Dr' etc. are useful when communicating with the healthcare provider.
Healthcare provider given name (optional)	023062	The document **SHOULD** contain at least one given name for the healthcare provider.	To enable consistent and correct identification of the healthcare provider.
Healthcare provider family name (mandatory)	023064	The document **SHALL** contain the healthcare provider's family name.	To enable consistent and correct identification of the healthcare provider. This is a required field when validating HPI-Is against the HI Service.
Healthcare provider name suffix (optional)	023065	The document **SHOULD** contain the healthcare provider's name suffix where applicable.	To enable consistent and correct identification of the healthcare provider. Suffixes such as 'Snr', 'Jnr' etc. can be a useful aid in the correct and unique identification of the healthcare provider.

4.2 Healthcare Provider (extension)

Data item	Req No.	Requirement statement	Rationale
Healthcare provider individual's workplace address (optional)	024035	The document **SHOULD** contain the healthcare provider individual's Australian workplace address.	To enable consistent and correct identification of the healthcare provider.
Healthcare provider individual's workplace electronic communication details (optional)	024036	The document **SHOULD** contain at least one set of electronic communication details for the workplace of the individual. For example, telephone numbers, mobile phone numbers, email addresses etc. **Additional Notes** A healthcare provider may work for more than one organisation. These are the workplace communication details of the individual - not the organisation.	To enable electronic communication with the healthcare provider.

5 Event details

Description: This section captures the date of the event as well as any associated narrative in which the health provider can describe the event.

Data item	Req No.	Requirement statement	Rationale
Component	025005	The event summary **SHALL** include details regarding the event.	The narrative information regarding the individual's event is of high clinical safety value.
Reason for Visit	025006	The event summary **SHALL** include the provision for a narrative note regarding the reason for the presentation (optional to provide a value).	The narrative information regarding the individual's event is of high clinical safety value.
Event Date	025007	The event summary **SHALL** include the date on which the event occurred.	Event chronology is crucial in understanding an individual's history.

6 Newly identified allergies and adverse reactions

Description: This section includes allergies, intolerances and adverse reactions to all substances that were identified at the given event. This might include food allergies or intolerances, allergy to bee venom as well as reactions to prescription and non-prescription medicines.

These requirements have been developed in collaboration with the Medication Management Reference Group (MMRG) Project Working Group and following discussions with Standards Australia.

Data item	Req No.	Requirement statement	Rationale
Component	025008	The event summary **SHALL** include the provision to include information regarding allergies and adverse reactions. **Additional Notes** It is optional to provide values in this section.	Information regarding an individual's allergies and adverse reactions is of high clinical safety value.
	025009	The event summary **SHALL** have the option to include one (or more) allergies and adverse reactions.	Individuals often have multiple allergies and adverse reactions and allows for future decision support capability.
Agent Description	025010	Every allergy and adverse reaction listed in the event summary **SHALL** contain a description of the agent that is assessed as being associated with, or that may have caused the adverse reaction.	To support high quality safe clinical care.
	025011	Values for the description of the allergy and adverse reaction agent **SHALL** be derived from a SNOMED CT-AU or Australian Medicines Terminology (AMT) reference set, with an option for free text.	Allows for electronic transmission of clinical information and future decision support capability.

Data item	Req No.	Requirement statement	Rationale
Reaction Type	024963	For each adverse reaction, there **SHALL** be the provision to record the type of adverse reaction. **Additional Notes** It is optional to provide a value.	When determining a treatment plan, it is often necessary to consider the patient's response to a known allergen. For example, in a medical emergency it might be appropriate to administer a medication where a minor intolerance exists; however, if the response is anaphylaxis, an alternative protocol would be sought.
	024964	The value choices for the reaction type **SHALL** be limited to a SNOMED CT-AU reference set.	A constrained vocabulary results in better consistency and encourages higher quality data entry.
Reaction Description	025012	There **SHALL** be the provision for an allergy and adverse reaction record to include the description of the reaction that was caused by or related to the exposed agent.	A description of the reaction for clinical safety allows better informed future management.
	025013	There **SHALL** be the provision for more than one reaction to be recorded for a single agent.	An individual may experience multiple adverse reactions to a single agent.
	025014	Values for the manifestation of the reaction **SHALL** be derived from a SNOMED CT-AU code set, with an option for free text.	Allows for electronic transmission of clinical information and future decision support capability.
	025015	A value for the reaction description **SHALL** only be included at the discretion of the event summary author, i.e. when it is deemed either relevant or appropriate to do so (i.e. optional to include a value).	An individual's specific reaction to a given agent may not necessarily be known. For example, an adult may report that they were told as a child that they react to a given agent, but cannot recall what happened to them specifically.

7 Medicines

Description: Medicines that the individual is taking that are considered by the healthcare provider to be relevant to the event. This list should contain prescribed medications, as well as over-the-counter medications such as aspirin and possibly complementary medicines.

These requirements have been developed in collaboration with the MMRG Project Working Group and following discussions with Standards Australia.

Note that the medicines included in the event summary do not constitute a full medications profile, but rather those that have specifically changed as a result of the event, or those directly relevant to it.

Out of scope: Note that vaccines are excluded from this section and are managed by the immunisation section.

Data item	Req No.	Requirement statement	Rationale
Component	025016	The event summary **SHALL** include the provision to include information regarding medicines. **Additional Notes** It is optional to provide values in this section.	To support safe clinical care.
	025017	Each event summary **SHALL** have the option to include one (or more) medicine.	Individuals often have multiple medicines and allows for future decision support capability.
Item Description	025018	Every medicine listed in the event summary **SHALL** include details that fully describe it, including the name of the medicine (must include the active ingredient and, where available, the brand name), strength and dose form, where appropriate.	Allows interoperability, eliminates ambiguity and is vital to support high quality safe clinical care.
	025019	If the medicine can be identified by an AMT concept, the Item Description **SHALL** be the AMT ConceptID and Preferred Term.	Allows interoperability, eliminates ambiguity and is vital to support high quality safe clinical care.

Data item	Req No.	Requirement statement	Rationale
	025020	If the medicine cannot be identified by an AMT concept, the Item Description **SHALL** allow free text.	This enables the user to enter medicines not recognised by AMT (e.g. overseas medicines taken by international patients).
Status	025021	Every medicine listed in the event summary **SHALL** include an indication of its status.	It is important for the recipient, in particular the usual GP, to differentiate which medicines may require their attention. For example a medicine with a status of "Existing - review recommended" will require action by the usual GP compared to a medicine that has been unchanged.
	025022	The medicine status vales **SHALL** be exclusively derived from a predetermined code set, that includes the following options: **Additional Notes** "Existing - changed": As a result of the event consultation, a medicine that was previously taken by the individual may actually be changed at the event as it required immediate attention. "Existing - review recommended": As a result of the event consultation, it may be recommended to the usual GP that a medicine that was previously taken by the individual be reviewed. "Existing - ceased": As a result of the event consultation, a medication that was previously taken by the individual may actually be ceased by the event clinician as it required immediate attention. "New – prescribed": As a result of the event consultation, a new medication may be prescribed	Provides clarity to other healthcare providers. This allows software to group like information together and to provide display or validation intelligence (e.g. medications with a status of 'change' must also have a value in the data item 'reason for change').

Data item	Req No.	Requirement statement	Rationale
		for the individual. "New – prescription recommended": As a result of the event consultation, it may be recommended that the usual GP prescribe a new medicine to be taken by the individual. The addition may not be urgent or there may be an arrangement that all medicine changes are to be enacted by the GP as the coordinator of the individual's overall care.	
Dose Instructions	025023	Every medicine listed in the event summary **SHALL** include the dose instructions, describing how the individual is taking, or should be taking, the medicine.	Vital to support high quality safe clinical care.
Reason for Medicine	025024	There **SHALL** be the provision for a medicine record to include the reason (indication) for the individual to be taking the medicine.	It is important for the GP and other recipients to understand the rationale for relevant medicine, particularly given that some medications may have multiple purposes.
	025025	A Reason for Medicine value for a given medicine **SHALL** only be included when it is either relevant or appropriate to do so (i.e. optional to include a value).	The reason an individual may be taking an over-the-counter or complementary medicine may not be clear to the event summary author.
Additional Comments	025026	There **SHALL** be provision for a medicine record to include additional information that may be needed to ensure the continuity of supply, continued proper use, or appropriate medication management. **Additional Notes** This may include comments regarding medication duration.	To allow the provision of additional medicine information if the clinician considers it will contribute to the future care of the patient.

Data item	Req No.	Requirement statement	Rationale
	025027	A value for Additional Comments for a given medication **SHALL** only be included when it is deemed by the event summary author to be either relevant or appropriate to do so (i.e. optional to include a value).	Not always required.
Reason for Change	025028	There **SHALL** be the provision for a medication record to include the reason that the change was made (or recommended to be made) to a medicine as a result of the event consultation.	It is particularly important for any medicine changes to be well understood by the recipients of the document.
	025029	An event summary **SHALL** include a description of the reason for change for a given medicine, if the status of that medicine is: - "Existing - changed" - "Existing - review recommended" - "Existing - ceased"	Only medicines that have been changed/ceased (or recommended to be changed/ceased) should logically require a reason for that change.

8 Diagnoses / interventions

Scope: Data structure for capturing information about diagnoses and interventions that are relevant to the particular clinical event. That is, diagnoses that were identified at the event or that are significant to it or any interventions performed during the event or those occurring in the past that are significant to it.

Data item	Req No.	Requirement statement	Rationale
Component	025030	The event summary **SHALL** include the provision to include information regarding diagnoses and procedures. **Additional Notes** It is optional to provide values in this section.	Information regarding an individual's diagnoses and interventions is vital to support high quality safe clinical care.
	025031	Each event summary **SHALL** have the option to include one (or more) diagnoses or interventions.	Individuals often have multiple entries in medical history and this allows for future decision support capability.
Diagnosis and Intervention Description	025032	Every diagnoses and interventions item listed in the event summary **SHALL** contain a description.	This provides the content for the diagnoses and interventions.
	025033	Values for the description of the diagnosis and intervention items **SHALL** be derived from SNOMED CT-AU with the option for free text.	Allows for electronic transmission of clinical information and future decision support capability.
Diagnosis and Intervention comments	025035	There **SHALL** be the provision for a diagnosis and intervention record to include an additional comment.	Provides flexibility to add context or notes etc.

9 Immunisations

Description: A section that groups together details of immunisation/vaccination program(s) that has/have been administered (or have been reported as administered) to the person/individual by a health care provider during the event.

These requirements have been developed in collaboration with the MMRG Project Working Group and following discussions with Standards Australia.

Data item	Req No.	Requirement statement	Rationale
Component	025036	The event summary **SHALL** include the provision to include information regarding immunisations. **Additional Notes** It is optional to provide values in this section.	Supports decisions regarding appropriate immunisation.
	025037	Each event summary **SHALL** have the option to include one (or more) immunisations.	An individual would typically have multiple immunisations.
Vaccine Name	025038	Every immunisation included in the event summary **SHALL** include the name of the immunisation.	Ensures unambiguous identification of the particular immunisation.
	025039	If the immunisation can be identified by an AMT concept, this **SHALL** be the AMT ConceptID and Preferred Term.	Allows interoperability, eliminates ambiguity and is vital to support high quality safe clinical care.
	025040	If the immunisation cannot be identified by an AMT concept, the item description **SHALL** allow free text.	This allows entry of vaccinations not recognised by AMT (e.g. vaccinations administered overseas).

10 Diagnostic investigations

Description: Describes any diagnostic investigations performed on, or requested for, the individual, relevant to the event.

Pending results can be indicated using a result status of 'pending'.

Data item	Req No.	Requirement statement	Rationale
Component	025041	An event summary **SHALL** have the provision for diagnostic results. **Additional Notes** It is optional to provide values in this section.	The inclusion of diagnostic investigation results can provide recipients with important supporting information to the assessment and plans.
	025042	Multiple diagnostic investigations **SHALL** be allowed to be conveyed in an event summary.	This allows all relevant diagnostic investigation reports to be included, at the discretion of the author.
Investigation Type	025043	Each investigation included in an event summary **SHALL** include designation of the 'investigation type'. **Additional Notes** For example, 'Pathology'.	This allows software at either end to group like investigation types together, thereby aiding readability.
Investigation Name	025044	Each investigation included in an event summary **SHALL** include the name of that investigation.	To support safe clinical care. Eliminates ambiguity.
Result Status	025045	Each investigation included in an event summary **SHALL** include the status of that investigation. **Additional Notes** For example, 'final', 'pending'.	To support safe clinical care.
Result content	025046	There **SHALL** be the provision for diagnostic investigations to be associated with an event summary as embedded text.	Basic text data may be embedded in the event summary where required.

11 Document control

Description: A section that describes information about the event summary document.

Much of the information contained in document control is technical in nature and as such is not described here. Elements with clinical relevance are described below.

Data item	Req No.	Requirement statement	Rationale
Component	025047	Each event summary document **SHALL** include metadata about the document.	Document management requirements.
	025048	Document control information is predominantly technical and as such does not require display for end users.	Technical requirement.
Document Status	025049	Each event summary **SHALL** include the status of the document.	Provides assurance to the reader that they are looking at the latest document.
	025050	Values for Document Status **SHALL** be sourced from a coded reference set that includes 'Interim', 'Final', 'Amended'.	Assists clarity.
DateTime Attested	025051	The date/time when the event summary document was attested (or finalised, or signed off) by the document author.	Clinical safety requirement to ensure that the reader knows exactly when the document was written.

Acronyms

Abbreviation	Meaning
AMT	Australian Medicines Terminology
CDA®	Clinical Document Architecture
GP	general practitioner
HL7®	Health Level 7
HPI-I	Healthcare Provider Identifier – Individual
HPI-O	Healthcare Provider Identifier – Organisation
IHI	Individual Healthcare Identifier – Individual (Subject of Care)
MMRG	NEHTA Medication Management Reference Group
PCEHR	personally controlled electronic health record
RACGP	Royal Australian College of General Practitioners
SNOMED CT	Systematized Nomenclature of Medicine - Clinical Terms
SNOMED CT-AU	Australian extension to SNOMED CT

Glossary

Term	Meaning
Australian Medicines Terminology (AMT)	The intended national standard coding system for selecting, recording and communicating categorical descriptive medicines information within and between Australian eHealth applications.
Clinical Document Architecture (CDA®)	An XML-based markup standard intended to specify the encoding, structure and semantics of clinical documents exchanged between health software systems.
clinical document	A digital file containing personal health information about an individual, containing unstructured (narrative) information and, optionally, structured (atomic) information.
clinical information system (CIS)	A system that deals with the collection, storage, retrieval, communication, and use of health-related data, information and knowledge pertaining to subjects of care. The system may comprise one or more applications or components.
event summary	An event summary is a clinical document that may be uploaded to an individual's eHealth record summarising one or more episodes of care. Source: http://www.ehealth.gov.au/internet/ehealth/publishing.nsf/Content/glossary
GP desktop	Examples of clinical information systems that are used by GPs to manage their patients.
HPI-I	Healthcare Provider Identifier – Individual The Healthcare Provider Identifier for individuals (HPI-I) is a 16-digit unique number used to identify providers who deliver healthcare in the Australian healthcare setting.
HPI-O	Healthcare Provider Identifier – Organisation The Healthcare Provider Identifier for Organisations (HPI-O) is a 16-digit unique number used to identify organisations who deliver care in the Australian healthcare setting.
IHI	Individual Healthcare Identifier – Individual (Subject of Care) An IHI is a unique 16-digit number that identifies individuals within Australia who receive healthcare, for example Australian citizens, permanent residents or visitors to Australia.
jurisdictions	Australian state and territory government health departments.
MAY	When appearing in an information requirement, the verb **MAY** indicates an optional requirement.
nominated healthcare provider	A nominated healthcare provider is the author of a shared health summary. Under the *Personally Controlled Electronic Health Records Act* 2012, a nominated healthcare provider must be a medical practitioner, a registered nurse or an Aboriginal or Torres Strait Islander health practitioner. The healthcare provider and the individual must agree that, for the purposes of the eHealth record system, the healthcare provider is the individual's nominated healthcare provider. Source: http://www.ehealth.gov.au/internet/ehealth/publishing.nsf/Content/glossary
PCEHR system	National eHealth infrastructure for managing records in eHealth records. The PCEHR system includes the PCEHR repository and the national prescription and dispense repository.
SHALL	When appearing in a requirement, the verb **SHALL** indicates a mandatory requirement. Its negative form **SHALL NOT** indicates a prohibition.
SHOULD	When appearing in a requirement, the verb **SHOULD** indicates a recommendation. Its negative form **SHOULD NOT** indicates an option that is not recommended.

Term	Meaning
SNOMED CT	SNOMED Clinical Terms (SNOMED CT®) is the internationally pre-eminent clinical terminology that has been identified as the preferred national terminology for Australia and has been endorsed by all Australian governments. Source: http://www.nehta.gov.au/our-work/clinical-terminology/snomed-clinical-terms SNOMED® and SNOMED CT® are registered trademarks of the International Health Terminology Standards Development Organisation.
SNOMED CT-AU	The Australian extension to SNOMED CT.

Appendix A Change log

This appendix lists the major changes and fixes applied to this document.

A.1 Changes from Version 1.0 (14 Sep 2011) to Version 1.1 (24 Oct 2011)

ID	Section	Change Detail	Rationale
1	All	Incorporated feedback from Clinical Safety and the Privacy Unit.	Updates
2	10	Removed 'diagnostic imaging' and URL link references	

A.2 Changes from Version 1.1 (24 Oct 2011) to Version 1.2 (10 Apr 2015)

ID	Section	Change Detail	Rationale
1	3	Requirements for Individual have been updated to align with current methodology.	To ensure that document modelling is appropriate.
2	3.1	Requirement #023060 Added clarification about individual date of birth, that time values are supported during care immediately following birth.	Providing clarification on use of date values.
3	4	Requirements for event summary author have been updated to align with current methodology.	To ensure that document modelling is appropriate.
4	4	Added requirement #025064 mandating the Healthcare Provider Employer Organisation's address.	The author's organisation address must always be supplied.
5	4	Added requirement #025063 mandating the Healthcare Provider Employer Organisation Electronic Communication Detail.	The author's organisation electronic communication detail must always be supplied.
6	6	Modified requirement #025011 to allow AMT as well as SNOMED CT-AU.	Alignment with current medications management initiatives.
7	6	Added requirements #024963 & #024964 for new data element 'Reaction Type'.	Providing additional clinical content for allergies and adverse reactions.
8		Grammatical revisions & editorial updates throughout.	