Australian Government

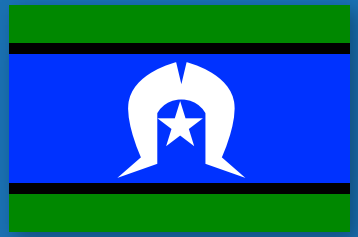
Australian Digital Health Agency

Aged Care Industry Offer Participant Onboarding

Australian Digital Health Agency

22 January 2022

Acknowledgement

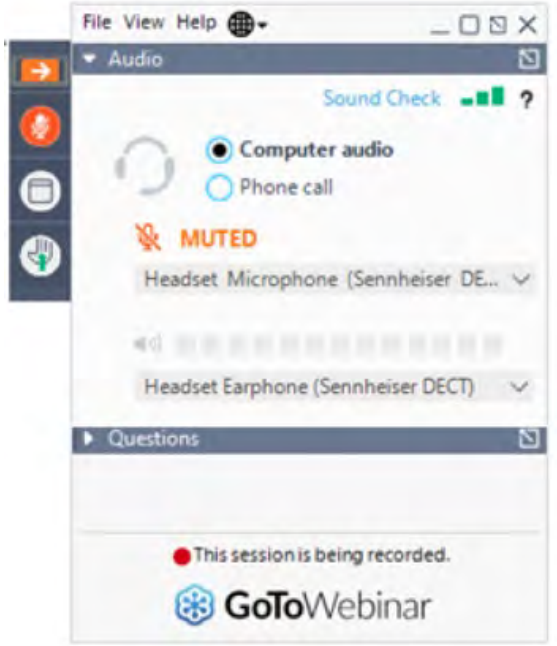


The Australian Digital Health Agency acknowledges the Traditional Owners of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to Elders past, present and emerging.

Housekeeping

About GoToWebinar

- Your microphone will be muted throughout the presentation.
- If your screen and sound don’t match you may have a poor internet connection.
- This session is being recorded and a link will be made available to your respective organisations.



Agenda

- Introduction
- Aged Care Industry Offer Deliverables
- Foundation Technical Information
  - Healthcare Identifiers Service
  - My Health Record
  - Types of Documents in My Health Record
  - My Health Record - View Service and workflows
- How we will support you
- Questions

Introduction

Odile Williams

Developer Implementation Support Manager

Partnerships Branch

Australian Digital Health Agency Representatives

Facilitator

- **Odile Williams –** Developer Implementation Support Manager

Presenters

- **David Cai -** Senior Solution Architect

Additional Panelists

- **Aleth Sakai -** Senior Project Manager Aged Care Industry Offer
- **Ben Skinner -** Senior Solution Architect
- **Paul McDonald** – Implementation Support Lead

Deliverables

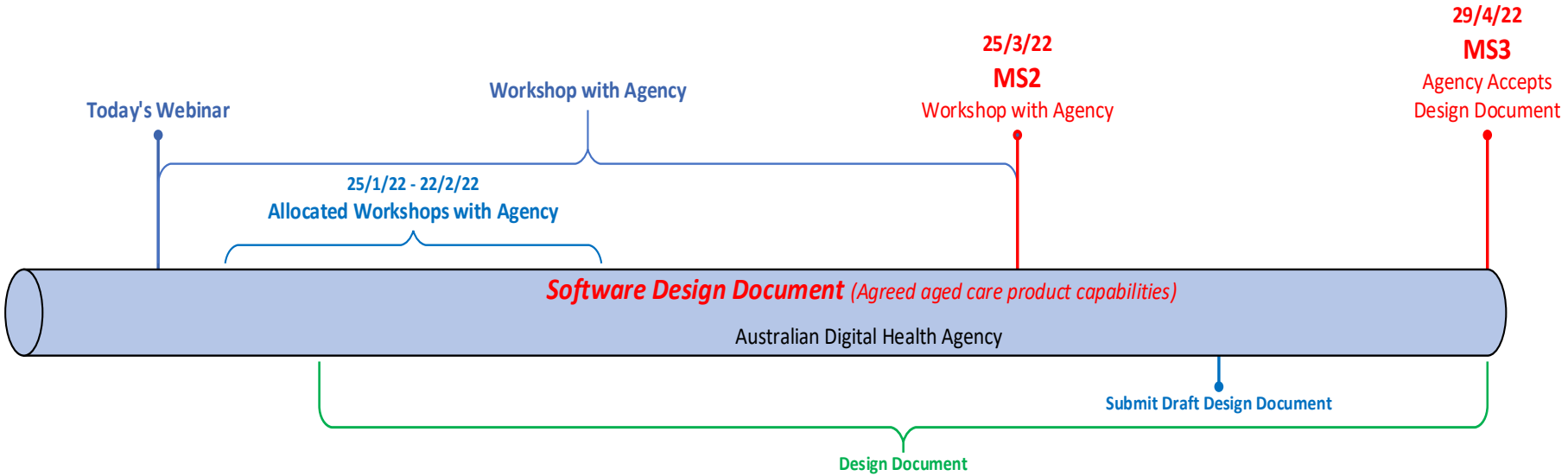
Odile Williams

Developer Implementation Support Manager

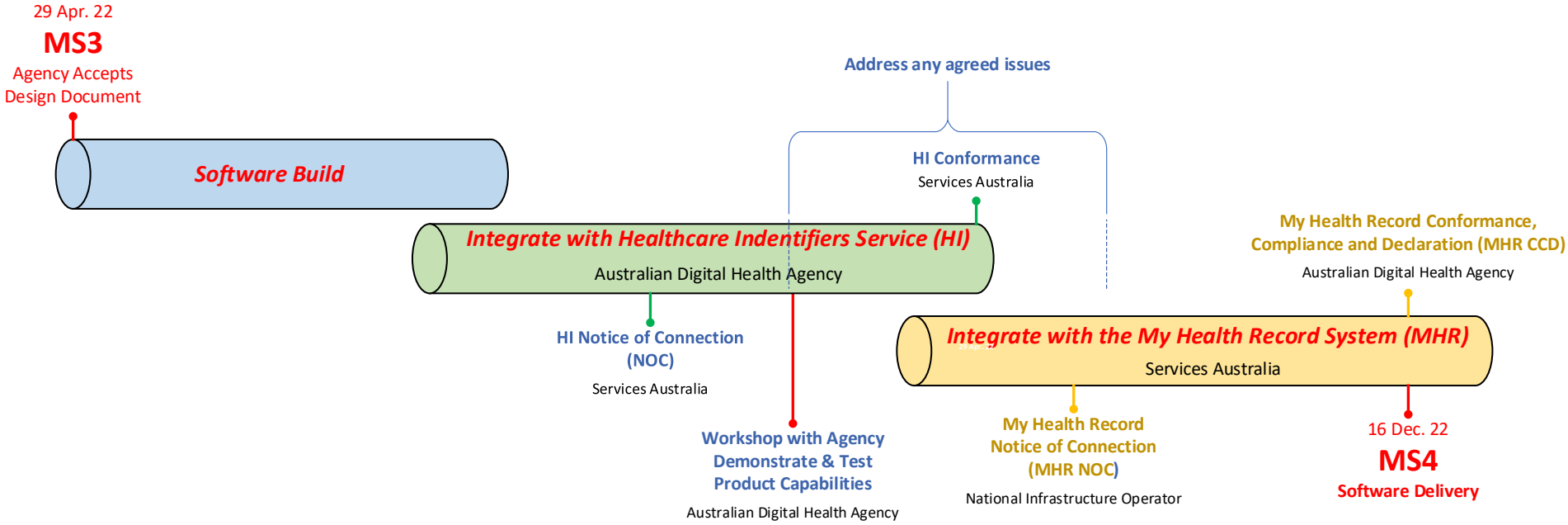
Contract Milestones

Milestone	Title	Description	Due date
1	Contract Execution	The contractor and the Agency execute this contract	Upon execution
2	Workshop	Workshop attendance and completion of draft planning document for the enhanced contractor product	By 25/03/22
3	Design Document	Contractor delivery of the Detailed Software Design Document for the enhanced contractor product (**Conditional on Agency Acceptance**)	By 29/04/22
4	Software Delivery	Completion of a software demonstration of the enhanced contractor product with the Agency demonstrating all functionality per the agreed design document (**Conditional on Agency Acceptance**) and **achieving** production access to MHR	By 16/12/22

Timeline – Workshop & Software Design Document



Timeline – Software Delivery



Workshop

- **Prior:** Strongly suggest go through the information (and links) from this webinar.
- **Duration:** 4 hrs
- **Who (Roles):**
  - Key developer(s)
  - Project Manager
  - Product Owner
- **Bookings:**
  - Remaining timeslots – Contact help @digitalhealth.gov.au
  - Book ASAP – but ensure you will be ready.
  - Please nominate at least 3 free timeslots that suit.
  - Other times will be available, but may be limited due to other Agency priorities.
- **Milestone Completion by:** 25/03/2022

Design Document

- Discussed in full at the workshop.
- Please submit draft ASAP.
- It will take time to turn-around your submission. There are other participants and staff have other tasks and priorities.
- Avoid undertaking substantial software development before your design has been accepted by the Agency.
- If you believe any requirements should not apply to your product, you will need to provide the Agency with justification and this will have to be formally accepted by the Agency.

Software Delivery

- Build the agreed software design document product capabilities into your product.
- After the build is substantively complete, but before completion of My Health Record conformance test, workshop with Agency to demonstrate and test incorporation of product capabilities agreed in the design.
- Address any agreed material usability issues discovered in the workshop.
- Successfully complete all applicable conformance and notice-of-connection tests required to secure production access to the Healthcare Identifiers Service and the My Health Record System.

Scope – Stream dependent

	CIS	EMM	CIS + EMM
Healthcare Identifiers (HI) Service Integration	✓	✓	✓
My Health Record Viewing	✓	✓	✓
Advanced Care Planning (ACP) document Creation	✓		✓
Prescription Record Creation		✓	✓
Dispense Record Creation		✓	✓
Documents upload to My Health Record	✓	✓	✓

Technical

David Cai

Senior Solution Architect, Enterprise Architecture

Certificates and Authentication

National Authentication Service for Health (NASH)

To connect to the Healthcare Identifiers Service and My Health Record system

- NASH SHA-2 certificates using the **X.509 profile**
- Used for mutual HTTPS authentication and signing of payloads.
- You must develop for using **SHA-2** NASH PKI organisation certificates for this Industry Offer.
- New developers need to register in the Services Australia Health Systems Developer Portal (https://healthsoftware.humanservices.gov.au/claiming/ext-vnd/), submit an Interface Agreement to Services Australia. When approved, the confirmation email will detail how to apply for the test data/test certificates.
- The Healthcare Identifiers Service has worked with **Medicare Site certificates**, however for this Industry Offer, **NASH SHA-2 certificates must be used**.

Clinical Information System (CIS) Vs Contracted Service Provider (CSP)

CIS	CSP
Most commonly used when software is installed **on premises**.	Most commonly used in **cloud or centralised installations**.
NASH certificates: • Installed on premises. • Tied to the organisation (HPI-O). • Might be used by more than one application.	NASH certificates: • Tied to the software provider CSP. (CSP given permission via HPOS). • CSP may use the healthcare organisation's certificate. (Not recommended for CSPs with a large base).

Technical
Healthcare Identifiers (HI) Service

David Cai

Senior Solution Architect, Enterprise Architecture

Healthcare Identifiers Service (HI Service)

HI Service Identifier	Assigned to
Individual Healthcare Identifier (IHI)	Healthcare consumers (Who received the service)
Healthcare Provider Identifier Individual (HPI-I)	Healthcare providers (Who provided the service)
Healthcare Provider Identifier Organisation (HPI-O)	Organisations e.g. General Practices, Pharmacies and Hospitals (Where the service was performed)

Retrieve an IHI

Search inputs for an **Individual Healthcare Identifier >**

Patient demographics
(name, sex, DoB)

and either

Identifier

(Medicare number, DVA number, IHI)

or

Patient address

(Australian street address, postal address, unstructured street address, international address)

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Retrieve an HPI-I

Search inputs for a **Healthcare Provider Identifier - Individual >**

Clinician demographics

(family name as a minimum, sex, DoB)

and either

Identifier

(AHPRA number, HPI-I)

or

Clinician address

(Australian street address, postal address, international address)

A clinician's HPI-I is required when **authoring** a clinical document to be uploaded to the My Health Record system.

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Technical
My Health Record

David Cai

Senior Solution Architect, Enterprise Architecture

My Health Record system

A secure online summary of an individual's health information available to all Australians. It is **document centric** and uses SOAP based web services:

1. **Record Access Service**
    - Allows software to know if a patient has a record
    - Allows software to gain access to the patient's record for viewing purposes
2. **Document Exchange Service**
    - Allows exchanging of CDA® documents
    - Upload, Replace, Remove and Download
3. **View Service**
    - Aggregated views of information from multiple documents
    - CDA ® and XML supported

1. **Record Access** service

doesPCEHRExist

Checks if a patient has an advertised My Health Record.

Checks if the organisation has access to the patient's My Health Record.

Gain Access

Gains access to the patient's record.

Used to enter access codes.

Used to assert emergency access.

Patient Controls

Individuals can **control what information** is in their My Health Record, and which healthcare provider organisations can access their record.

- Authority to Upload & Patient Instruction

  You can upload to a patient's record unless they instruct you not to.

- Hidden Records

  Patients can hide their record so providers cannot automatically discover it.

- Record Access Code (RAC)

  Patients can choose to Restrict Access to their record to only those organisations provided with a RAC.

- Limited Document Access Code (LDAC)

  Restricting access to certain documents and controlling who can view these by providing the LDAC.

- Removing Documents

  Patients can remove documents from within their record.

- Emergency Access

  Providers can override access controls in an emergency.

2. **Documents Exchange** service

Uploading clinical documents such as Specialist Letter, Prescription Record and Event Summaries from the clinical software to the patient's My Health Record.

Removing clinical documents.

Viewing clinical documents via the clinical software.

Downloading and importing clinical documents via the clinical software.

Technical
Types of Documents in My Health Record

David Cai

Senior Solution Architect, Enterprise Architecture

Shared Health Summary

A **Shared Health Summary** is a clinical document that summarises a patient's health status at a point in time, and includes information about their allergies and adverse reactions, medicines, medical history and immunisations.

A **Shared Health Summary** can be created or updated at any consultation, with the permission of the patient.

The document is rendered with the Agency's XSLT Stylesheet

This is an example clinical document, data is for demonstration purposes only

Shared Health Summary

13 Feb 2014

Mr Frank **HARDING** DoB 4 Oct 1949 (64y) SEX Male IHI 8003 6086 6670 1594 MRN 34902

START OF DOCUMENT

City Medical Centre

Author Dr Charley Fletcher (General Medical Practitioner)
Phone (07) 3720 2801

Adverse Reactions

Adverse Reactions

Agent	Adverse Reaction
Penicillins	Diarrhoea

Medications

Medications

Medicine	Dose	Reason
Somac 40mg Tablets	1 tablet daily	GORD
Buscopan 40mg Tablets	2 tablets 4 times daily	GORD
Astrix 100mg Tablets	1 tablet daily	
Tritace 10mg Capsules	1 capsule daily	

Medical History

Diagnoses

Problem/Diagnosis	Date of Onset	Comment
Diabetes insipidus	1 Jan 1999	

Medical History - Procedures - Exclusion Statement

Exclusion Statement
None known

Immunisations

Immunisations - Exclusion Statement

Exclusion Statement
None known

ADMINISTRATIVE DETAILS

Patient

Name	Mr Frank HARDING
Sex	Male
Indigenous Status	Neither Aboriginal nor Torres Strait Islander origin
Date of Birth	4 Oct 1949 (64y)
IHI	8003 6086 6670 1594
Entitlements	3950302571 (Medicare Benefits)
Home Address	1 Australia Lane, North Adelaide, SA, 5006, Australia

Author

Name	Dr Charley Fletcher (General Medical Practitioner) (HPI-I: 8003612033304560)
Organisation	City Medical Centre (HPI-O: 8003622038904560)
Work Place	3 HENRI PL, 80 Stamford Road, PEARCE, SA, 5006, Australia
Phone	(07) 3720 2801 (Workplace)

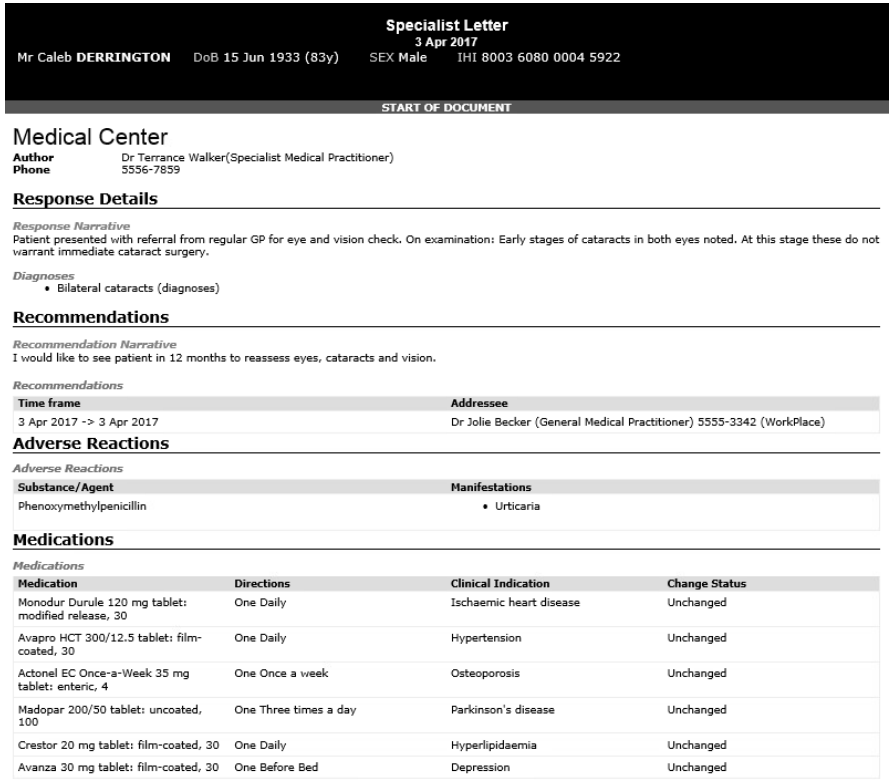
Clinical Document Details

Document Type	Shared Health Summary
Creation Date/Time	13 Feb 2014 12:40+1000
Date/Time Attested	13 Feb 2014 12:40+1000
Document ID	34902 (1fdb1249-fe21-4816-95e0-704179d04ce5)
Document Set ID	1fdb1249-fe21-4816-95e0-704179d04ce5
Document Version	1
Completion Code	Final

END OF DOCUMENT

Specialist Letter

Specialist Letter documents are used in replying to a referral or reporting on a health event and contain information related to the event or the requested diagnosis or treatment by a specialist.



Specialist Letter
3 Apr 2017
Mr Caleb **DERRINGTON** DoB 15 Jun 1933 (83y) SEX Male IHI 8003 6080 0004 5922

START OF DOCUMENT

Medical Center
Author Dr Terrance Walker(Specialist Medical Practitioner)
Phone 5556-7859

Response Details

Response Narrative
Patient presented with referral from regular GP for eye and vision check. On examination: Early stages of cataracts in both eyes noted. At this stage these do not warrant immediate cataract surgery.

Diagnoses
- Bilateral cataracts (diagnoses)

Recommendations

Recommendation Narrative
I would like to see patient in 12 months to reassess eyes, cataracts and vision.

Recommendations

Time frame	Addressee
3 Apr 2017 -> 3 Apr 2017	Dr Jolie Becker (General Medical Practitioner) 5555-3342 (WorkPlace)

Adverse Reactions

Adverse Reactions

Substance/Agent	Manifestations
Phenoxymethylpenicillin	• Urticaria

Medications

Medications

Medication	Directions	Clinical Indication	Change Status
Monodur Durule 120 mg tablet: modified release, 30	One Daily	Ischaemic heart disease	Unchanged
Avapro HCT 300/12.5 tablet: film-coated, 30	One Daily	Hypertension	Unchanged
Actonel EC Once-a-Week 35 mg tablet: enteric, 4	One Once a week	Osteoporosis	Unchanged
Madopar 200/50 tablet: uncoated, 100	One Three times a day	Parkinson's disease	Unchanged
Crestor 20 mg tablet: film-coated, 30	One Daily	Hyperlipidaemia	Unchanged
Avanza 30 mg tablet: film-coated, 30	One Before Bed	Depression	Unchanged

ADMINISTRATIVE DETAILS

Patient

Name	Mr Caleb DERRINGTON
Sex	Male
Indigenous Status	Neither Aboriginal nor Torres Strait Islander origin
Date of Birth	15 Jun 1933 (83y)
IHI	8003 6080 0004 5922
Entitlements	29507907111 (Medicare Benefits)
Home Address	4 Old Tenterfield Rd, Paddys Flat, NSW, 2469, Australia
Phone	0700000000 (Home)

Author

Name	Dr Terrance Walker (Specialist Medical Practitioner)
Organisation	Medical Center
Department	Ophthalmology
Work Place	14 Smith Road, Brisbane, QLD, 4122, Australia
Phone	5556-7859 (Workplace)

Clinical Document Details

Document Type	Specialist Letter
Creation Date/Time	3 Apr 2017 07:29+1000
Date/Time Attested	3 Apr 2017 07:30+1000
Document ID	2.25.290059848158562939332133331976851078912
Document Version	1
Completion Code	Final

Referrer

Name	Dr Jolie Becker
Address	**Work Place:** 14 Arafura, Brisbane, QLD, 4122, Australia
Contact details	5555-3342 (Workplace)
Organisation	Medical Center

Participants

Name	Contact	Address	Organisation	Department
Dr Jolie Becker (Usual GP)	Not Provided	**Work Place:** 14 Arafura, Brisbane, QLD, 4122, Australia	Medical Center	

END OF DOCUMENT

Prescription Record

Prescription Record documents can be used to share information about prescribed medications via the individual's digital health record.

eHealth Prescription Record
3 Apr 2017
Mr Caleb **DERRINGTON** DoB 15 Jun 1933 (83y) SEX Male IHI 8003 6080 0004 5922

START OF DOCUMENT

Medical Center
Prescriber Dr Terrance Walker(Specialist Medical Practitioner)

Prescription Item

Prescription Item

Field	Value
Therapeutic Good Identification	E-Mycin 400 mg tablet: film-coated, 25
Date and Time Prescription Expires	3 Apr 2018 10:04+1000
Directions	Every 6 hours
Route	Oral route
Quantity Description	25
Maximum Number of Repeats (Number of Repeats)	1
Brand Substitution Permitted	True
Prescription Item Identifier	0fb247f0-dc74-4d4a-bd73-b96d3eb3e952

Administrative Observations

Demographic Data

Field	Value
Age	83 year(s)

ADMINISTRATIVE DETAILS

Patient

Name	Mr Caleb DERRINGTON
Sex	Male
Indigenous Status	Neither Aboriginal nor Torres Strait Islander origin
Date of Birth	15 Jun 1933 (83y)
IHI	8003 6080 0004 5922
Entitlements	29507906211 (Medicare Benefits)
Home Address	66 Amiens Rd, Aarons Pass, NSW, 2850, Australia
Phone	07 0000 0000 (Home)

Prescriber Organisation

Name	Medical Center
Work Place	64 Arafura, Brisbane, QLD, 4122, Australia
Phone	0345754522 (Workplace)
Email	company@email.com (Workplace)

Prescriber

Name	Dr Terrance Walker (Specialist Medical Practitioner)
Work Place	64 Arafura, Brisbane, QLD, 4122, Australia
Contact Details	Not Provided

Clinical Document Details

Document Type	eHealth Prescription Record
Creation Date/Time	3 Apr 2017 10:04+1000
Date/Time Attested	3 Apr 2017 10:04+1000
Document ID	2.25.281609395158105446909677377061541978018
Document Version	1
Replaces Document ID	499d08ed-b77a-4be8-a507-a94541a9f474 (1.2.76.56.4567.6543.45)

END OF DOCUMENT

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Event Summary

An **Event Summary** is a clinical document which summarises a significant consultation with a patient.

E.g., broken leg, chest pains, or any condition or episode that the healthcare provider deems to be clinically significant.

Event Summary
22 Nov 2017
Mr Caleb **DERRINGTON** DoB 15 Jun 1933 (84y*) SEX Male IHI 8003 6080 0004 5922

START OF DOCUMENT

Medical Center

Author Dr Terrance Walker(General Medical Practitioner)
Phone 04555555555
Encounter Period no information

Event Details

Regular visit

Medications

Medications

Medication	Directions	Clinical Indication	Change Status
Monodur 120mg Tablet	1 Tablet Daily	0	Changed (done)

Diagnoses/Interventions

Medical History

Item	Date
Hypertension	

ADMINISTRATIVE DETAILS

Patient

Name	Mr Caleb DERRINGTON
Sex	Male
Indigenous Status	Neither Aboriginal nor Torres Strait Islander origin
Date of Birth	15 Jun 1933 (84y) * Age is calculated from date of birth
IHI	8003 6080 0004 5922
Entitlements	2950790711 (Medicare Benefits)
Home Address	4 Old Tenterfield Road, Paddys Flat, NSW, 2632, Australia
Phone	0455555555 (Home)
Email	patient@testemail.com (Home)

Author

Name	Dr Terrance Walker (General Medical Practitioner)
Organisation	Medical Center
Work Place	400 George Street, Brisbane, QLD, 4000, Australia
Phone	04555555555 (Workplace)

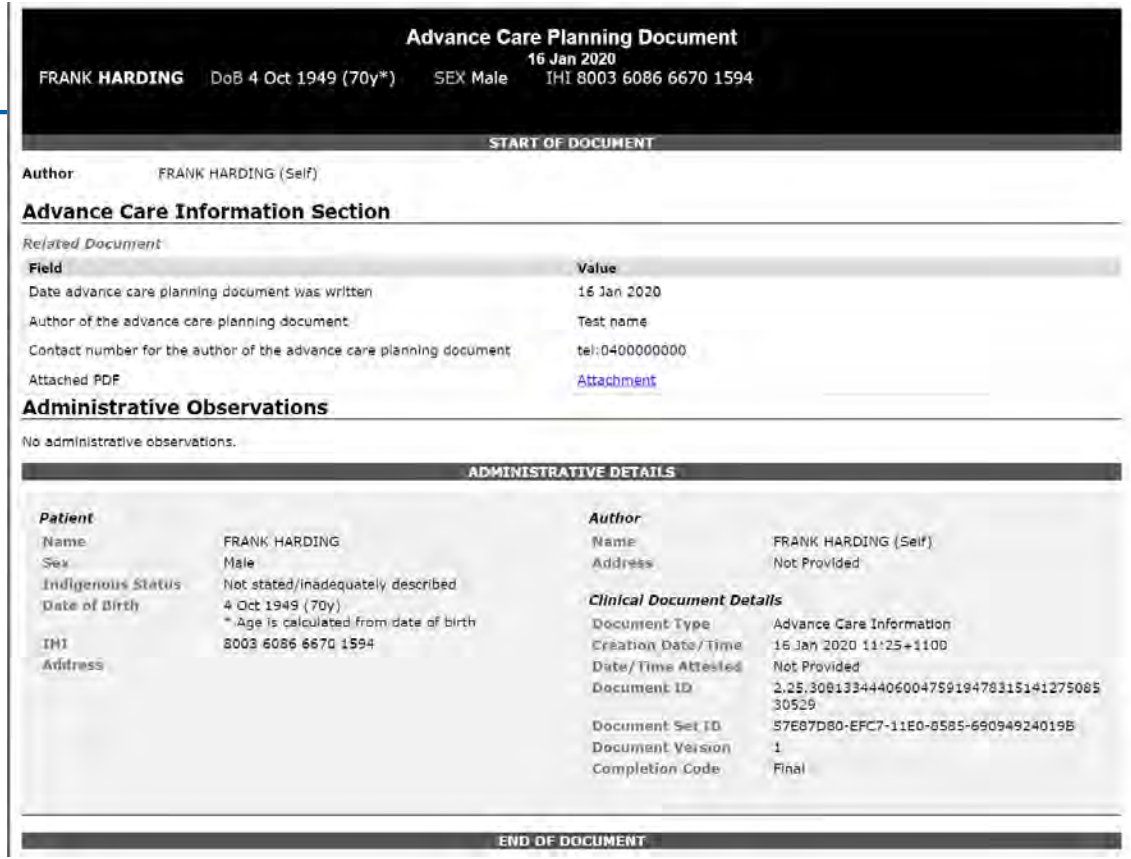
Clinical Document Details

Document Type	Event Summary
Creation Date/Time	22 Nov 2017 09:22+1000
Date/Time Attested	22 Nov 2017 09:22+1000
Document ID	2.25.177970224472382623607658455935929300186
Document Set ID	8986c98f-ecfa-48e9-931c-02e58deccc45
Document Version	1
Completion Code	Final

END OF DOCUMENT

Advanced Care Plan

An **Advanced Care Plan** can include a statement by a competent person expressing decisions about his or her future care, should they become incapable of participating in medical treatment decisions.
These statements are currently recorded in paper-based advance care directives which are uploaded as attachments to the CDA document.



Advance Care Planning Document
16 Jan 2020
FRANK **HARDING** DoB 4 Oct 1949 (70y*) SEX Male IHI 8003 6086 6670 1594

START OF DOCUMENT

Author FRANK HARDING (Self)

Advance Care Information Section

Related Document

Field	Value
Date advance care planning document was written	16 Jan 2020
Author of the advance care planning document	Test name
Contact number for the author of the advance care planning document	tel:0400000000
Attached PDF	Attachment

Administrative Observations

No administrative observations.

ADMINISTRATIVE DETAILS

Patient

Name	FRANK HARDING
Sex	Male
Indigenous Status	Not stated/inadequately described
Date of Birth	4 Oct 1949 (70y) * Age is calculated from date of birth
IHI	8003 6086 6670 1594
Address	

Author

Name	FRANK HARDING (Self)
Address	Not Provided

Clinical Document Details

Document Type	Advance Care Information
Creation Date/Time	16 Jan 2020 11:25+1100
Date/Time Attested	Not Provided
Document ID	2.25.30813344406004759194783151412750853052 9
Document Set ID	57E87D80-EFC7-11E0-8585-69094924019B
Document Version	1
Completion Code	Final

END OF DOCUMENT

Other Documents

Other documents include

Pathology Report,

Diagnostic Imaging Report,

Dispense Records,

Medicare Documents,

Discharge Summaries,

Goals of Care Documents,

Advanced Care Directives,

Patient Entered Information.

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Technical
My Health Record - View Service and workflows

David Cai

Senior Solution Architect, Enterprise Architecture

View service

A **My Health Record View** is dynamically generated by the My Health Record system to provide a summary of information in a My Health Record at a point in time. Types of views include:

Health Record Overview

A **Health Record Overview** summarises information in an individual's My Health Record and provides access to all the other My Health Record Views. It is intended to serve as the "home screen" displayed when an individual's record is first opened.

Prescription and Dispense View

A **Prescription and Dispense View** summarises information about medication prescriptions and dispensations contained in an individual's My Health Record and provides a mechanism to list, group and sort prescription and dispense information.

Medicare Overview

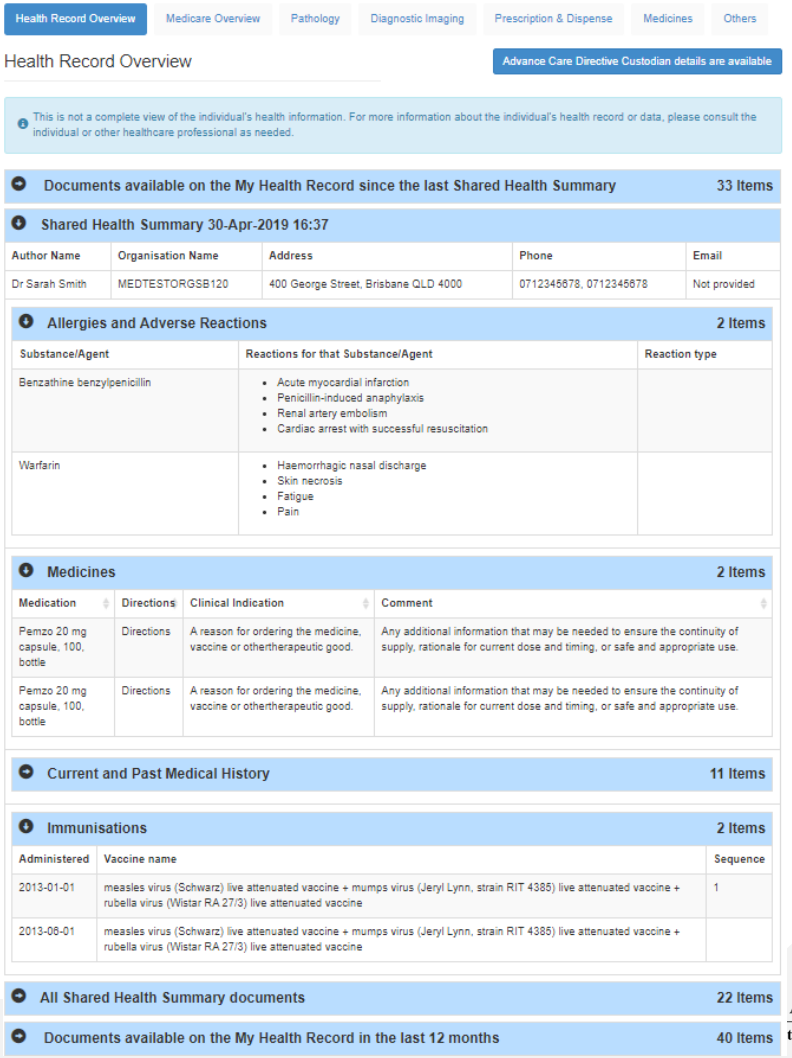
A **Medicare Overview** provides an overview of information in an individual's My Health Record sourced from Medicare documents.

Diagnostics Views

Share information about pathology tests and diagnostic imaging examinations via an individual's My Health Record. Provide a mechanism to list, group and sort the reports in clinical software.

Example 1
Health Record Overview

Provides a summary of an individual's My Health Record and is intended to serve as the "home screen" displayed when an individual's record is first opened.



Health Record Overview | Medicare Overview | Pathology | Diagnostic Imaging | Prescription & Dispense | Medicines | Others

Health Record Overview

Advance Care Directive Custodian details are available

This is not a complete view of the individual's health information. For more information about the individual's health record or data, please consult the individual or other healthcare professional as needed.

Documents available on the My Health Record since the last Shared Health Summary — 33 Items

Shared Health Summary 30-Apr-2019 16:37

Author Name	Organisation Name	Address	Phone	Email
Dr Sarah Smith	MEDTESTORGSB120	400 George Street, Brisbane QLD 4000	0712345678, 0712345678	Not provided

Allergies and Adverse Reactions — 2 Items

Substance/Agent	Reactions for that Substance/Agent	Reaction type
Benzathine benzylpenicillin	• Acute myocardial infarction • Penicillin-induced anaphylaxis • Renal artery embolism • Cardiac arrest with successful resuscitation	
Warfarin	• Haemorrhagic nasal discharge • Skin necrosis • Fatigue • Pain	

Medicines — 2 Items

Medication	Directions	Clinical Indication	Comment
Pemzo 20 mg capsule, 100, bottle	Directions	A reason for ordering the medicine, vaccine or othertherapeutic good.	Any additional information that may be needed to ensure the continuity of supply, rationale for current dose and timing, or safe and appropriate use.
Pemzo 20 mg capsule, 100, bottle	Directions	A reason for ordering the medicine, vaccine or othertherapeutic good.	Any additional information that may be needed to ensure the continuity of supply, rationale for current dose and timing, or safe and appropriate use.

Current and Past Medical History — 11 Items

Immunisations — 2 Items

Administered	Vaccine name	Sequence
2013-01-01	measles virus (Schwarz) live attenuated vaccine + mumps virus (Jeryl Lynn, strain RIT 4385) live attenuated vaccine + rubella virus (Wistar RA 27/3) live attenuated vaccine	1
2013-06-01	measles virus (Schwarz) live attenuated vaccine + mumps virus (Jeryl Lynn, strain RIT 4385) live attenuated vaccine + rubella virus (Wistar RA 27/3) live attenuated vaccine	

All Shared Health Summary documents — 22 Items

Documents available on the My Health Record in the last 12 months — 40 Items

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Example 2 **Prescription and Dispense View**

Summarises information about medication prescriptions and dispenses in a patient's record.

Prescription and Dispense View

Grouped by Prescription From 4-Feb-2013 To 19-Mar-2020

PEARL **DEMPSEY** DoB 6-Feb-1988 (32y) SEX Female IHI 8003 6088 3356 3950

START

This view is not a complete record of the individual's medicines information.

Prescribed	Medicine Details	First Dispense	Last Dispense	Dispensed
9-Jan-2020	A reason for ordering the medicine, vaccine or other therapeutic good	unavailable	unavailable	unavailable
9-Jan-2020	Prescribed	**A reason for ordering the medicine, vaccine or other therapeutic good** — A REASON FOR ORDERING THE MEDICINE, VACCINE OR OTHER THERAPEUTIC GOOD — A complete narrative description of how much, when and how to use the medicine, vaccine or other therapeutic good — The formulation or presentation of the overall substance — *Supply Quantity to Dispense (AMOUNT OF MEDICATION) - Quantity Description* — Dispense original and 6 repeats		
2-Dec-2013	LanZopran 30mg		3-Dec-2013	3-Dec-2013	1 of 2
3-Dec-2013	Dispensed	**Lansoprazole** — LANZOPRAN 30MG — 30 mg — Take ONE capsule In the evening — Capsule — Original dispense		
2-Dec-2013	Prescribed	**Lansoprazole** — LANZOPRAN 30MG — 30 mg — Take ONE capsule In the evening — Capsule — *Supply 28.* — Dispense original and 1 repeats		

END

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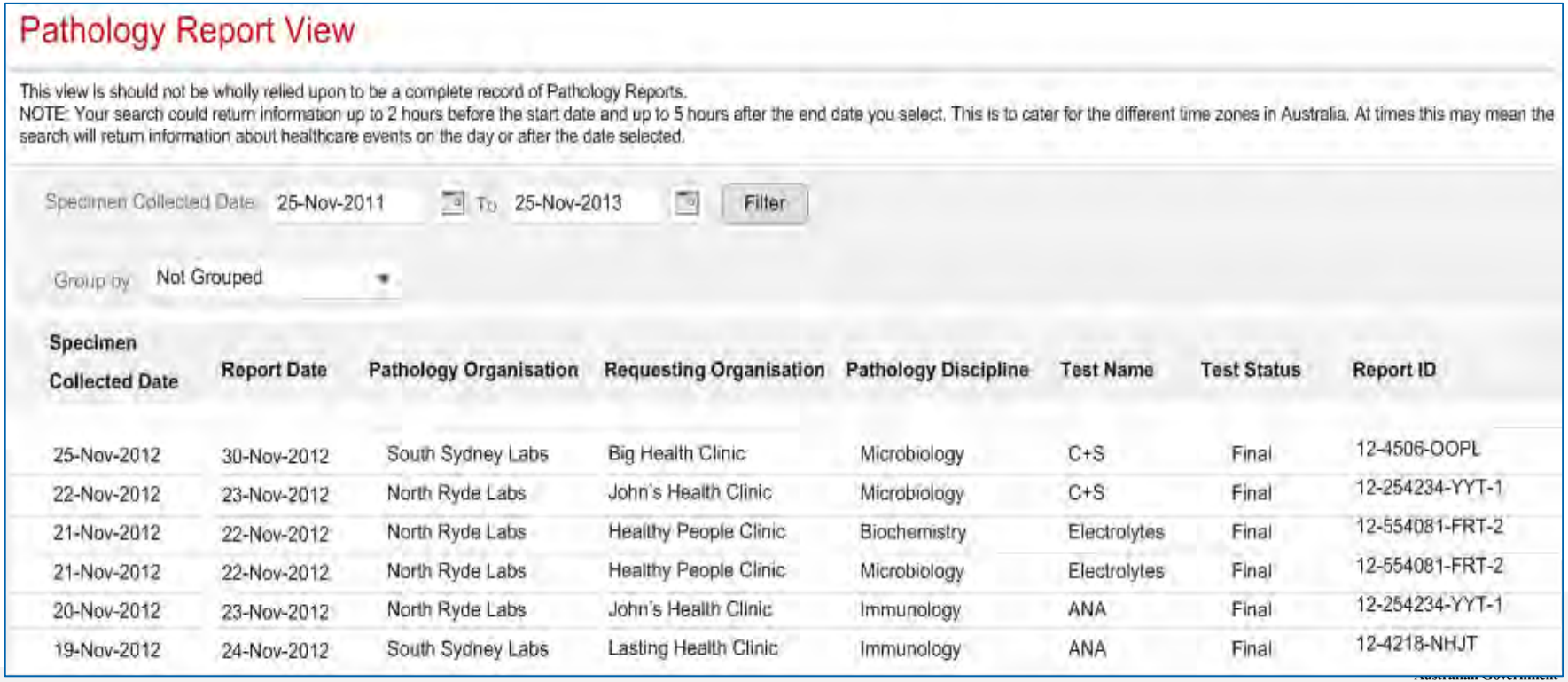
Example 3 **Pathology Report View**

Provides a mechanism to list, group and sort the reports in clinical software.



Pathology Report View

This view is should not be wholly relied upon to be a complete record of Pathology Reports.
NOTE: Your search could return information up to 2 hours before the start date and up to 5 hours after the end date you select. This is to cater for the different time zones in Australia. At times this may mean the search will return information about healthcare events on the day or after the date selected.

Specimen Collected Date 25-Nov-2011 To 25-Nov-2013 Filter

Group by Not Grouped

Specimen Collected Date	Report Date	Pathology Organisation	Requesting Organisation	Pathology Discipline	Test Name	Test Status	Report ID
25-Nov-2012	30-Nov-2012	South Sydney Labs	Big Health Clinic	Microbiology	C+S	Final	12-4506-OOPL
22-Nov-2012	23-Nov-2012	North Ryde Labs	John's Health Clinic	Microbiology	C+S	Final	12-254234-YYT-1
21-Nov-2012	22-Nov-2012	North Ryde Labs	Healthy People Clinic	Biochemistry	Electrolytes	Final	12-554081-FRT-2
21-Nov-2012	22-Nov-2012	North Ryde Labs	Healthy People Clinic	Microbiology	Electrolytes	Final	12-554081-FRT-2
20-Nov-2012	23-Nov-2012	North Ryde Labs	John's Health Clinic	Immunology	ANA	Final	12-254234-YYT-1
19-Nov-2012	24-Nov-2012	South Sydney Labs	Lasting Health Clinic	Immunology	ANA	Final	12-4218-NHJT

DocuViews

As with the View Service content these views are dynamically generated by the My Health Record system to provide a summary of information in a My Health Record at a point in time.

However unlike the View Service views these are not requested and are instead delivered in the document exchange service document list response when criteria are met.

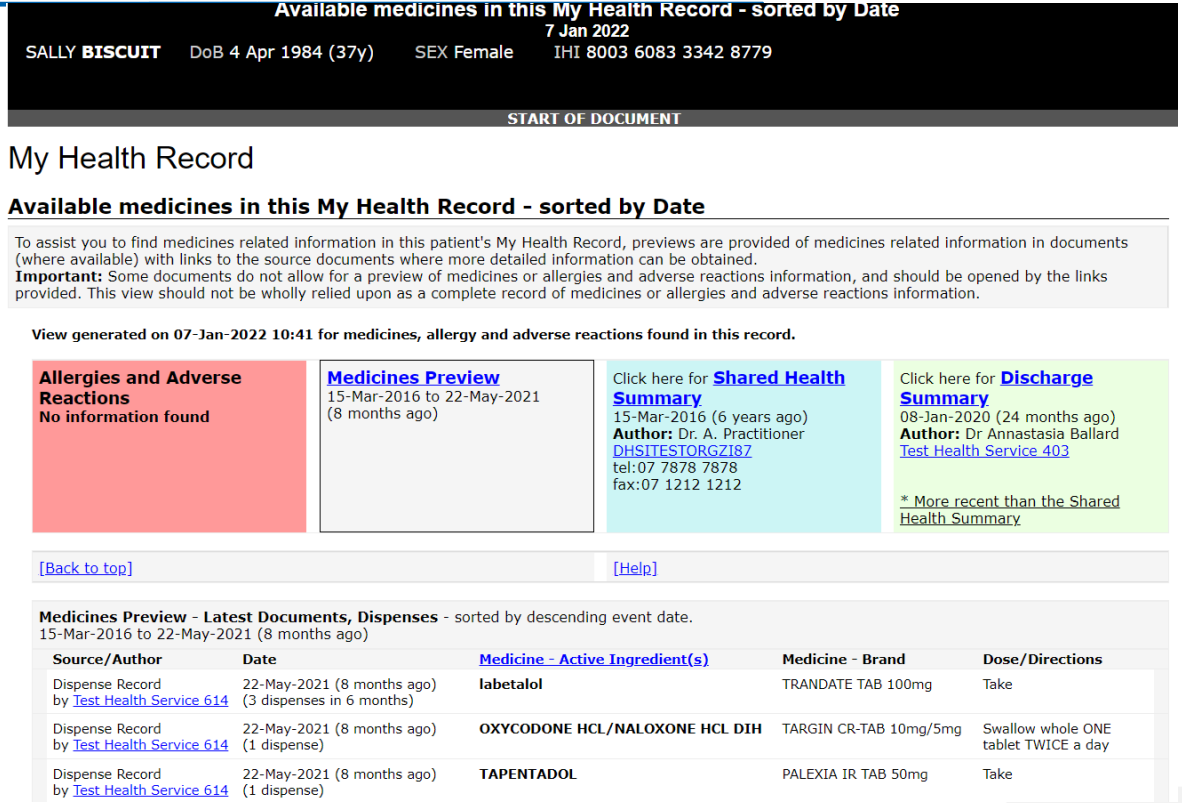
- Medicines View
- Immunisation Consolidated View
- Medicare Overview (Last 12 Months and All)
- Pathology Overview
- Diagnostic Imaging Overview

Example **Medicines View**

Summarises information about medications in a patient's record.

Returned when search criteria includes documents which may contain medicined information.

(Discharge Summaries, Shared Health Summaries, Event Summaries, Specialist Letters etc)



Available medicines in this My Health Record - sorted by Date
7 Jan 2022
SALLY **BISCUIT** DoB 4 Apr 1984 (37y) SEX Female IHI 8003 6083 3342 8779

START OF DOCUMENT

My Health Record

Available medicines in this My Health Record - sorted by Date

To assist you to find medicines related information in this patient's My Health Record, previews are provided of medicines related information in documents (where available) with links to the source documents where more detailed information can be obtained.
Important: Some documents do not allow for a preview of medicines or allergies and adverse reactions information, and should be opened by the links provided. This view should not be wholly relied upon as a complete record of medicines or allergies and adverse reactions information.

View generated on 07-Jan-2022 10:41 for medicines, allergy and adverse reactions found in this record.

Allergies and Adverse Reactions
No information found

Medicines Preview
15-Mar-2016 to 22-May-2021
(8 months ago)

Click here for **Shared Health Summary**
15-Mar-2016 (6 years ago)
Author: Dr. A. Practitioner
DHSITESTORGZI87
tel:07 7878 7878
fax:07 1212 1212

Click here for **Discharge Summary**
08-Jan-2020 (24 months ago)
Author: Dr Annastasia Ballard
Test Health Service 403

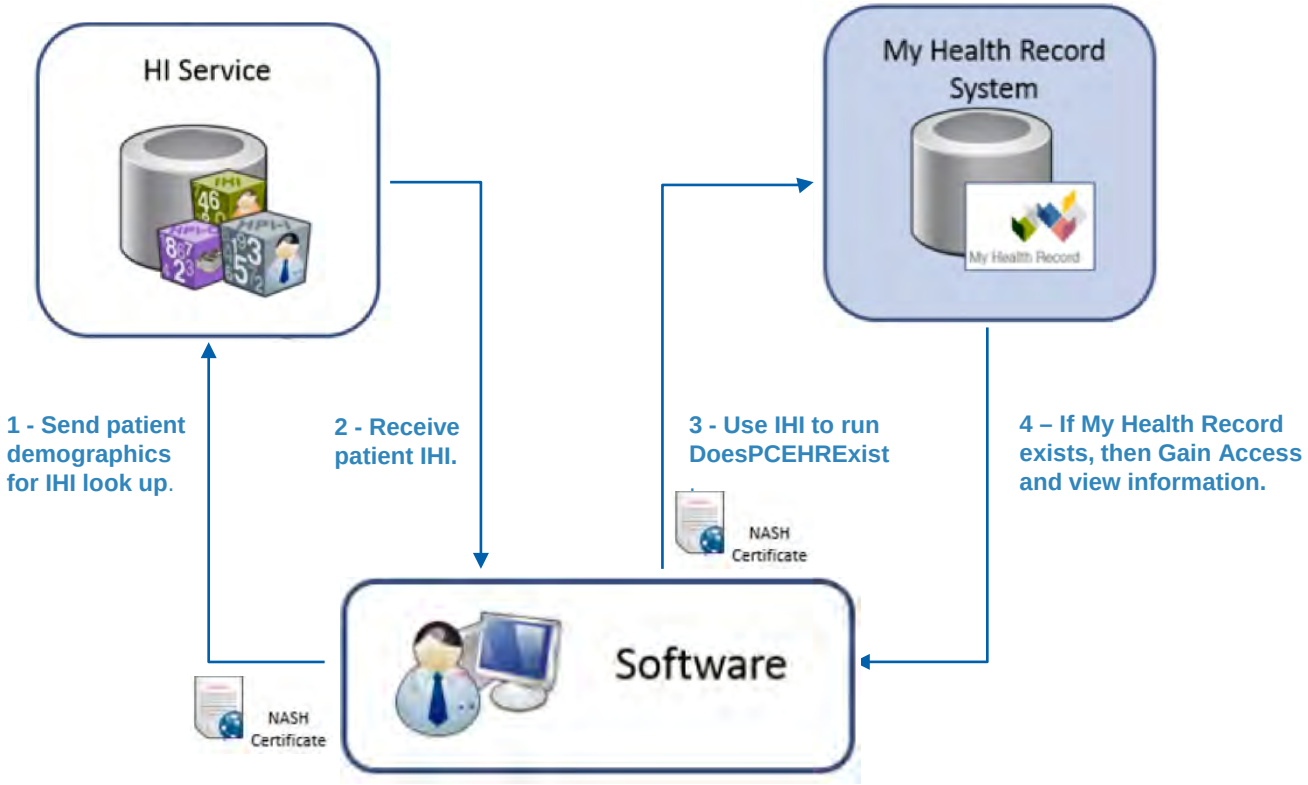
* More recent than the Shared Health Summary

[Back to top] [Help]

Medicines Preview - Latest Documents, Dispenses - sorted by descending event date.
15-Mar-2016 to 22-May-2021 (8 months ago)

Source/Author	Date	Medicine - Active Ingredient(s)	Medicine - Brand	Dose/Directions
Dispense Record by Test Health Service 614	22-May-2021 (8 months ago) (3 dispenses in 6 months)	**labetalol**	TRANDATE TAB 100mg	Take
Dispense Record by Test Health Service 614	22-May-2021 (8 months ago) (1 dispense)	**OXYCODONE HCL/NALOXONE HCL DIH**	TARGIN CR-TAB 10mg/5mg	Swallow whole ONE tablet TWICE a day
Dispense Record by Test Health Service 614	22-May-2021 (8 months ago) (1 dispense)	**TAPENTADOL**	PALEXIA IR TAB 50mg	Take

Interaction flows



Australian Government
Australian Digital Health Agency

How we will support you

Conformance

Conformance	Tests System's	**Performed by**	**Process**
HI Notice of Connection (HI NOC)	Interaction	Services Australia	Web service request and responses sent to and from the HI Service
HI Conformance (HI CCA)	Behaviour	Australian Digital Health Agency	Self-assessment and observed assessment
My Health Record Notice of Connection (MHR NOC)	Interaction	National Infrastructure Operator	Self-assessment and observed assessment.
My Health Record Conformance, Compliance and Declaration (MHR CCD)	Behaviour	Australian Digital Health Agency	Self-assessment and signed declaration form

Key organisations supporting you, their roles and responsibilities

Australian Digital Health Agency Contact	
The Agency's Digital Health Help Centre First level support and escalation to Agency subject matter experts, product and partnership teams	1300 901 001 (Mon-Fri, 8:00-17:00 AEST/AEDT) help@digitalhealth.gov.au

Services Australia Contacts	
Developer Support (Services Australia) First level support and escalation to technical support and product integration teams	1300 550 115 (Mon-Fri, 8:30-17:00 AEST) DevSupport@servicesaustralia.gov.au
Test Kit Support	DevSupport@servicesaustralia.gov.au
Online technical support HI service	HI.OTS.HELPDESK@servicesaustralia.gov.au
Online technical support My Health Record system	Myhealthrecord.otshelpdesk@servicesaustralia.gov.au
Other questions	help@digitalhealth.gov.au

For further information please visit the Agency's Developer Centre, alternatively, please the list of resources.

Aged Care Resources

Aged Care Industry Offer - eMail
AgedCareIndustryOffer@digitalhealth.gov.au

My Health Record Developer Guides
https://developer.digitalhealth.gov.au/developer-guide/introduction-my-health-record-b2b-developer-guides

My Health Record in aged care
https://www.myhealthrecord.gov.au/for-healthcare-professionals/aged-care

Healthcare Identifiers Service
https://developer.digitalhealth.gov.au/healthcare-identifiers-service

HI Test and Go Live
https://developer.digitalhealth.gov.au/resources/faqs/hi-test-and-go-live

My Health Record
https://developer.digitalhealth.gov.au/my-health-record

Introduction - My Health Record B2B Developer Guides
https://developer.digitalhealth.gov.au/developer-guide/introduction-my-health-record-b2b-developer-guides

NASH SHA-2 Certificates - Developer Guide
https://developer.digitalhealth.gov.au/developer-guide/transition-nash-sha-2-certificates-developer-guide

Questions

Further information and support

My Health Record

Web: www.myhealthrecord.gov.au

Help line: 1800 723 471 (select 2 for providers)

Australian Digital Health Agency

Web: www.digitalhealth.gov.au

Email: help@digitalhealth.gov.au

Help line: 1300 901 001

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