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Clinical Information System - General Practitioner Requirements

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1 Introduction

This document fits within a national program of work led by the Australian Digital Health Agency ('The Agency') that promotes use of digital health standards to enable safe, timely and accurate sharing of health information across the healthcare system. These requirements guide solution providers and implementers on the technical structures needed to support interoperability, data requirements, workflows and interfaces to be embedded within the technology we use in healthcare.

The Agency has created the General Practitioners (GP) Clinical Information Systems (CIS) Requirements (this document) to ensure digital health solutions are interoperable and support the safe, secure, accurate and timely exchange of high-quality health information among healthcare providers, services, and consumers.

This document outlines the software requirements with "must" and "should" statements providing guidance on the importance and priority of each requirement for those who choose to adopt it. While meeting the requirements in this document is voluntary, this document may become mandatory in the future at which point these "must" and "should" requirements would take on even greater significance and relevance.

1.1 Purpose

The purpose of this document is to describe the requirements recommended for implementation within Clinical Information Systems (CIS) in primary care with a focus on providing clinical care to an older person in a Residential Aged Care Home (RACH). These requirements are an extension of the Aged Care CIS requirements previously published (ADHA2024a).

The requirements are applicable to clinical information systems used by General Practitioners (GP) and collate existing requirements across many products and programs into this document for the primary care software sector. This will allow for interoperability, addressing barriers to GPs providing clinical support to residential aged care homes.

The Agency understands the term "patient management system" is used frequently. This document uses the more generic term of "clinical information system" to remain consistent with previous publications. In most cases, the terms are interchangeable.

The requirements reference technical standards, which collectively describe the recommended technical specifications a GP CIS needs to satisfy to move towards interoperability. The Australian Digital Health Agency (the Agency) will continue to work with software developers to enhance these requirements in future iterations to become more encompassing and further improve interoperability between clinical information systems.

1.2 Intended audience

The intended audience for this document is:

- GPs in the primary care and aged care sector.
- Clinical information system developers.
- Managers of GP clinics and clinicians.
- Peak bodies.
- Accrediting bodies (Australian Council on Health Standards, Australian General Practice Accreditation Limited).
- Standards developing organisations (SDO).
- Commonwealth bodies, especially the Department of Health, Disability and Ageing.

1.3 Scope

This document contains software requirements pertaining to clinical information systems for primary health care providers that provide clinical care to older persons in a RACH. The requirements in this document could also be applied to GP clinical information systems more broadly (not just those servicing older people) but that is not the focus of this document.

1.3.1 Out of scope

This document does not include:

- Requirements relating to clinical practices and workflows.
- Business practices and workflows relating to the operation of GP clinics.
- Requirements unrelated to the aged care sector.
- All matters relating to compliance or policy.
- Resident/relative/carer-facing information channels.

1.4 Overview

The development of the GP clinical information system requirements aligns with interoperability as a strategic priority in the Australian National Digital Health Strategy, as outlined in the National Healthcare Interoperability Plan 2023-2028, which states that interoperability of clinical information is essential to high-quality, sustainable health care in which clinical information is collected in a prescribed manner and can be shared in real time with patients and their providers.

GP clinical information system requirement development will support the level of software maturity and standardisation across Australia. The development of the requirements will support aged care sector interoperability and address barriers to GPs providing clinical support to residential aged care homes.

Standards create consistency and compatibility, support a single source of truth, and enable interoperability. This document describes the business requirements for the GP clinical information system, leveraging existing standards and infrastructure.

Efforts to standardise software systems aligns to the interoperability principles stated in the National Healthcare Interoperability Plan (ADHA2023a). The sections in this document align to the following interoperability principles:

- health information is discoverable and accessible,
- national healthcare identifiers are used across the healthcare sector,
- national digital health standards and specifications are agreed and adopted,
- core national healthcare digital infrastructure is used across the sector, and
- collaboration and stakeholder engagement underpin interoperability.

The standardising of software systems needs to reflect the above interoperability principles.

1.5 How to use this document with other CIS requirements documents

This document should be read and used alongside with the Common CIS Requirements and Aged Care CIS Requirements. The Common CIS Requirements provide a national baseline for all clinical information systems, defining core capabilities such as interoperability, security and connection to Australia's digital health infrastructure. These common requirements should be implemented as a baseline for all GP CIS solutions, with the GP CIS requirements then applied to address general practice specific clinical and operational needs. Where information is shared between aged care services and general practitioners, the GP CIS requirements are used alongside these documents to ensure GP clinical software supports consistent and interoperable exchange of information for residents of aged care homes. Together the CIS Requirement documents form a cohesive, layered approach that supports coordinated care across aged care and general practices while aligning with national digital health infrastructure.

2 Connections to national systems

This section describes the business requirements for implementation of clinical information systems in primary care when connecting to national systems. In a primary care setting a GP may use a clinical information system to prescribe, whereas in a RACH the GP would likely use Electronic Medication Management (EMM) systems and medication charts.

Agency design documents have traditionally used terms such as “consumer”, “patient”, “individual”, “healthcare recipient”, “resident”, and “healthcare individual” to refer to the person receiving healthcare. For simplicity, this document uses the generic term “patient”, while acknowledging in some circumstances other terms like “older person” are more appropriate, especially in a residential aged care home setting.

GPCS-005

Uploading documents to My Health Record

The software must have the capability to author, upload, download and render the shared health summary to My Health Record.

Applicable to:

GP clinical information system

Notes:

The software will need to be conformant to the HI service conformance assessment scheme (ADHA2025c) prior to gaining production access to the My Health Record system. Onboarding processes to the My Health Record system are publicly available.

This requirement supports the Royal Australian College of General Practitioners (RACGP) publication “Minimum requirements for general practice clinical information systems to improve usability” (RACGP2022a).

Also see the My Health Record System – Conformance Assessment Scheme (ADHA2025a).

GPCS-010

Download and render documents in My Health Record

The software should have the capability to download and render the following My Health Record document types:

- Discharge Summary,
- Advance Care Planning Information,
- Goals of Care, and
- Pharmacist Shared Medicines List.
- Pathology Report
- Diagnostic Imaging Reports

Applicable to: GP clinical information system

Notes: The clinical information system should be able to download and render clinical documents to enable quality continuity of care. The Australian Digital Health Agency has technical specifications that describe these clinical documents (ADHA2026a). Onboarding processes to the My Health Record system is publicly available.

This requirement supports the Royal Australian College of General Practitioners (RACGP) publication “Minimum requirements for general practice clinical information systems to improve usability” (RACGP2022a).

GPCS-025 Send prescriptions to the National Prescription Delivery Service

The software should have the capability to send prescriptions to the National Prescription Delivery Service.

Applicable to: GP clinical information system

Notes: Software supporting chart-based electronic prescriptions simplifies the dispensing workflow and contributes to positive clinical outcomes.

See the Electronic Prescribing - Technical Framework Documents v3.7 (ADHA2025b) for more information.

GPCS-030 National Real Time Prescription Monitoring

The software should allow seamless integration with the Real Time Prescription Monitoring (RTPM) system.

Applicable to: GP clinical information system

Notes: Prescribers have a legal obligation (in some States and Territories) to view the RTPM system before prescribing a monitored medicine during prescribing events (including when creating charts). Understanding recent prescribing and dispensing events, including events that may not be detailed on the current RACH chart, contributes to positive clinical outcomes.

Some State/Territory RTPM systems are web portals so seamless integration might be a link to the RTPM portal for the relevant State/Territory or other mechanism to facilitate the viewing of the RTPM system.

3 Requirements for terminology code sets

This section describes the requirements to implement terminology code set requirements that reflect important health concepts.

GPCS-055 Native Support for Australian Medicines Terminology (AMT)

The software should implement native support for AMT.

Applicable to: GP clinical information system

Notes: Native adoption of AMT prevents complications caused by mapping data between reference sets.

Due to some medicines not having AMT codes, it is important for software to not enforce an AMT code for every medicine.

This requirement supports the Royal Australian College of General Practitioners (RACGP) publication “Minimum requirements for general practice clinical information systems to improve usability” (RACGP2022a).

GPCS-060 Authoring with Australian Medicines Terminology (AMT)

When authoring medicine information for transfer to other healthcare organisations, the software should be able to author that clinical information using AMT terms where clinically and technically appropriate.

Applicable to: GP clinical information system

Notes: Ensuring medicine information is expressed in AMT terms at the point of information transfer increases the chance of data interoperability. In some contexts, the use of AMT is not clinically advisable or technically possible.

This requirement supports the Royal Australian College of General Practitioners (RACGP) publication “Minimum requirements for general practice clinical information systems to improve usability” (RACGP2022a).

4 Requirements for the point-to-point exchange of information

This section describes the requirements for the implementation of the clinical note document previously published by the Agency (ADHA2026b). The clinical note document provides a record of clinical information relevant to the care of a patient. In the context of aged care, a clinical note document is a record of clinical information relevant to the care of an aged care patient or resident. The clinical note document can be safely and securely exchanged between healthcare organisations using existing point-to-point transfer mechanisms.

GPCS-065 Author and send clinical note document

The software should author the clinical note document (ADHA2026b) in the GP clinical information system and send the clinical note document to another healthcare organisation.

Applicable to: GP clinical information system

Notes: Ensuring healthcare providers can author the clinical note document using information from the patient record and send to the desired healthcare organisation.

This requirement supports the Royal Australian College of General Practitioners (RACGP) Proposition statement, Seamless exchange of information between aged care and general practice. (RACGP2025a)

GPCS-070 Receive and render clinical note document

The software should receive and render the clinical note document in the GP clinical information system.

Applicable to: GP clinical information system

Notes: Ensuring healthcare providers can receive and render the information included in the clinical note document.

This requirement supports the Royal Australian College of General Practitioners (RACGP) Proposition statement, Seamless exchange of information between aged care and general practice. (RACGP2025a)

Acronyms

Acronym	Description
ACCIS	Aged Care Clinical Information System
AMT	Australian Medicines Terminology
CIS	Clinical Information System
EMM	Electronic Medication Management
GP	General Practitioner
HI Service	Healthcare Identifiers Service
RACGP	Royal Australian College of General Practitioners
RACH	Residential Aged Care Home
RTPM	Real Time Prescription Monitoring
SDO	Standards developing organisations
SNOMED	Systematized Nomenclature of Medicine
SNOMED-CT AU	Systematized Nomenclature of Medicine, Clinical Terminology Australian Release AU

Glossary

Term	Meaning
Clinical Information System	A system that deals with the collection, storage, retrieval, communication and optimal use of health-related data, information, and knowledge. A clinical information system may provide access to information contained in an electronic health record, but it may also provide other functions such as workflow, order entry, and results reporting. A CIS may also serve the role, or have similar features to, an electronic medicines management system.
Discharge Summary	A record of a patient's hospital visit.
Electronic Medicines Management System	The utilisation of electronic systems to facilitate and enhance the communication of a prescription or medicine order, aiding the choice, administration and supply of a medicine through knowledge and decision support and providing a robust audit trail for the entire medicines use process. Also see Clinical Information System.
Must	The solution design is expected to enable, support or make the stated requirement technically possible.
Should	It is desirable for the solution design to enable, support or make the stated requirement technically possible.
Shared health summary	A clinical document summarising an individual's health status and includes important information such as allergies/adverse reactions, medicines, medical history and immunisations. Only a nominated provider can create or update the shared health summary.
Standard	Standards are voluntary documents that set out specifications, procedures and guidelines that aim to ensure products, services, and systems are safe, consistent and reliable.

References

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