



Shared Health Summary Structured Content Specification

10 April 2015 v1.2

Approved for external use

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Product or document version	Date	Release comments
1.0	13 May 2011	Initial draft.
1.1	30 Sep 2011	Final specification for submission to Standards Australia.
1.2	10 Apr 2015	This version implements changes authorised in September 2014 (by CCB- 0345).
1.2	22 May 2025	The document presentation has been enhanced to align with current branding guidelines; however the content has not been changed.
1.2	20 Apr 2026	This document has been updated to reflect rebranding from Digital Health Developer Portal to Digital Health Implementer Hub, including updates to referenced URL's.

Related documents

Name	Version/Release Date
NEHTA Acronyms, Abbreviations & Glossary of Terms	Version 1.2, Issued 25 May 2005
Participation Data Specification	Version 3.2, Issued 20 July 2011
Interoperability Framework	Version 2.0, Issued 17 August 2007
Shared Health Summary Information Requirements	Version 1.1, Issued 10 April 2015
Adverse Reaction Detailed Clinical Model Specification	Version 2.3, To be published
Medication Instruction and Action Detailed Clinical Model Specification	Version 2.3, To be published
Medical History Detailed Clinical Model Specification	Version 1.0, To be published

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)

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1 Introduction

This document is a Structured Content Specification (SCS) for a Shared Health Summary.

[Appendix C, Specification Guide for Use](#) provides definitional details on data type constraints applied to data elements defined in the SCS. It also provides important information on how to read and use the SCS. Therefore, it is an essential compendium for better understanding of the SCS.

NEHTA values your questions and comments about this document. Please direct your questions or feedback to help@nehta.gov.au.

1.1 Document Purpose

This document describes the structured content of Shared Health Summary documents that are added to the personally controlled electronic health record (PCEHR) system.

The content within this document provides reviewers (software development teams, architects, designers, clinicians and informatics researchers) with the necessary information (or references to information held outside this document) to evaluate and assess the clinical suitability of NEHTA-endorsed specifications for the electronic transfer of Shared Health Summaries.

It is also a key input to the [NEHTA Shared Health Summary CDA® Implementation Guide \[NEHT2015c\]](#), which describes how to implement NEHTA-compliant Shared Health Summaries using the [HL7 Clinical Document Architecture \[HL7CDAR2\]](#).

1.2 Intended Audience

This document is aimed at software development teams, architects, designers, clinicians and informatics researchers who are responsible for the delivery of clinical applications, infrastructure components and messaging interfaces and also for those who wish to evaluate the clinical suitability of NEHTA-endorsed specifications.

1.3 Document Scope

This document specifies the essential clinical data groups and elements to be captured in an exchange of Shared Health Summary documents and the constraints that should be applied. Its scope is aligned to the document [Concept of Operations: Relating to the introduction of a Personally Controlled Electronic Health Record System \[DHA2011b\]](#).

This is not a guide to implementing any specific messaging standard.

This document is not to be used as a guide to presentation (or rendering) of the data. It contains no information as to how the data described by it should be displayed and no such information should be inferred.

1.4 Known Issues

Known issues with this document are described in [Appendix B, Known Issues](#).

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2 Shared Health Summary Structured Document

2.1 SHARED HEALTH SUMMARY

Identification

Label	SHARED HEALTH SUMMARY
Metadata Type	Structured Document
Identifier	SD-16565
OID	1.2.36.1.2001.1001.101.100.16565

Definition

Definition	A clinical document written by the nominated provider, which contains key pieces of information about an individual's health status and is useful to a wide range of providers in assessing individuals and delivering care. (PCEHR Concept of Operations document)
Definition Source	NEHTA
Synonymous Names	







Data Hierarchy



















































Note


























Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. It is typically expected that such identifiers will be generated internally by systems and not displayed to users since they usually have no clinical significance.


























Items below whose background is grey and whose text is struck through are data components that are included in the relevant Detailed Clinical Model Specification, but whose use is prohibited in this particular scenario.


























	SHARED HEALTH SUMMARY		
CONTEXT			
		SUBJECT OF CARE	1..1
		DOCUMENT AUTHOR	1..1
		ENCOUNTER	0..0
		Document Instance Identifier	1..1
		RELATED INFORMATION	0..0


























		Document Type	1..1
		DateTime Attested	1..1
CONTENT			
		ADVERSE REACTIONS	1..1
		EXCLUSION STATEMENT - ADVERSE REACTIONS	0..1
		 Global Statement	1..1
		 No Known Adverse Reaction to	0..0
		 No Known Allergic Reaction to	0..0
		 No Known Hypersensitivity Reaction to	0..0
		 No Known Intolerance to	0..0
		 INFORMATION PROVIDER	0..0
		 SUBJECT	0..0
		 Exclusion Statement - Adverse Reactions Instance Identifier	0..0
		 RELATED INFORMATION	0..0
		 Detailed Clinical Model Identifier	1..1
		ADVERSE REACTION	0..*
		 Substance/Agent	1..1
		 Absolute Contraindication	0..0
		 Adverse Reaction Comment	0..0
		REACTION EVENT	0..1
		 Specific Substance/Agent	0..0
		 Manifestation	1..*
		 Reaction Type	0..1
		 Adverse Reaction Certainty	0..0
		 Reaction Description	0..0
		 Reaction Onset Date	0..0


























				Duration of Reaction	0..0
				Additional Reaction Detail (ANATOMICAL LOCATION)	0..0
				Exposure Description	0..0
				Earliest Exposure	0..0
				Duration of Exposure	0..0
				ADDITIONAL EXPOSURE DETAIL	0..0
				Clinical Management Description	0..0
				Multimedia	0..0
				Reporting Details	0..0
				Adverse Reaction Event Comment	0..0
				Reaction Reported	0..0
				Adverse Reaction Report	0..0
				Supporting Clinical Record Information	0..0
				INFORMATION PROVIDER	0..0
				SUBJECT	0..0
				Adverse Reaction Instance Identifier	1..1
				RELATED INFORMATION	0..0
				Detailed Clinical Model Identifier	1..1
			Adverse Reactions Instance Identifier		0..1
			RELATED INFORMATION		0..0
			Section Type		1..1
		Medications (MEDICATION ORDERS)			1..1
			EXCLUSION STATEMENT - MEDICATIONS		0..1
			Global Statement		1..1
			Not Currently Taking		0..0





















			Not Ever Taken	0..0
			INFORMATION PROVIDER	0..0
			SUBJECT	0..0
			Exclusion Statement – Medications Instance Identifier	0..0
			RELATED INFORMATION	0..0
			Detailed Clinical Model Identifier	1..1
			Known Medication (MEDICATION INSTRUCTION)	0..*
			Therapeutic Good Identification	1..1
			Additional Therapeutic Good Detail	0..0
			Directions	1..1
			Formula	0..0
			Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)	0..0
			Dose Description	0..0
			Structured Dose (AMOUNT OF MEDICATION)	0..0
			Timing (MEDICATION TIMING)	0..0
			Additional Instruction	0..0
			Clinical Indication	0..1
			Administration Details (MEDICATION ADMINISTRATION)	0..0
			Medication Instruction Comment	0..1
			DISPENSING	0..0
			Change Type	0..0
			Change Status	0..0
			Change Description	0..0
			Change or Recommendation Reason	0..0
			Indication for Authorised Use	0..0

			Medication Instruction ID	0..0
			Concession-Benefit	0..0
			DateTime Medication Instruction Written	0..0
			Administrative Manufacturer Code	0..0
			INFORMATION PROVIDER	0..0
			SUBJECT	0..0
			Medication Instruction Narrative	0..0
			DateTime Medication Instruction Expires	0..0
			Medication Instruction Instance Identifier	1..1
			RELATED INFORMATION	0..0
			Detailed Clinical Model Identifier	1..1
			Medication Orders Instance Identifier	0..1
			RELATED INFORMATION	0..0
			Section Type	1..1
		Past and Current Medical History (MEDICAL HISTORY)		1..1
			PROBLEM/DIAGNOSIS	0..*
			Problem/Diagnosis Identification	1..1
			Clinical Description	0..0
			Severity	0..0
			Date of Onset	0..1
			Age at Onset	0..0
			ANATOMICAL LOCATION	0..0
			Occurrence Summary (PROBLEM/DIAGNOSIS OCCURRENCE SUMMARY)	0..0
			RELATED ITEMS	0..0
			Date of Resolution/Remission	0..1

			Age at Resolution/Remission	0..0
			Diagnostic Criteria	0..0
			Clinical Stage/Grade	0..0
			Problem/Diagnosis Comment	0..1
			Link to Supporting Clinical Evidence	0..0
			Status	0..0
			INFORMATION PROVIDER	0..0
			SUBJECT	0..0
			Problem/Diagnosis Instance Identifier	1..1
			RELATED INFORMATION	0..0
			Detailed Clinical Model Identifier	1..1
			EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	0..1
			Global Statement	1..1
			No Previous History of	0..0
			No Evidence of	0..0
			INFORMATION PROVIDER	0..0
			SUBJECT	0..0
			Exclusion Statement - Problems and Diagnoses Instance Identifier	0..0
			RELATED INFORMATION	0..0
			Detailed Clinical Model Identifier	1..1
			PROCEDURE	0..*
			Procedure Name	1..1
			Procedure Description	0..0
			Procedure Reason	0..0
			ANATOMICAL LOCATION	0..0

				Procedure Detail	0..0	
				Multimedia	0..0	
				Procedure Comment	0..1	
				DEVICE	0..0	
				INFORMATION PROVIDER	0..0	
				SUBJECT	0..0	
				Procedure DateTime	1..1	
				Procedure Instance Identifier	1..1	
				RELATED INFORMATION	0..0	
				Detailed Clinical Model Identifier	1..1	
			EXCLUSION STATEMENT - PROCEDURES			0..1
				Global Statement	1..1	
				No Previous History of	0..0	
				INFORMATION PROVIDER	0..0	
				SUBJECT	0..0	
				Exclusion Statement – Procedures Instance Identifier	0..0	
				RELATED INFORMATION	0..0	
				Detailed Clinical Model Identifier	1..1	
			UNCATEGORISED MEDICAL HISTORY ITEM			0..*
				Medical History Item Description	1..1	
				Medical History Item TimeInterval	0..1	
				Medical History Item Comment	0..1	
				INFORMATION PROVIDER	0..0	
				SUBJECT	0..0	
				Uncategorised Medical History Item Instance Identifier	1..1	

			RELATED INFORMATION	0..0
			Detailed Clinical Model Identifier	1..1
			Medical History Instance Identifier	0..1
			RELATED INFORMATION	0..0
			Section Type	1..1
		IMMUNISATIONS		1..1
			Administered Immunisation (MEDICATION ACTION)	0..*
			Therapeutic Good Identification	1..1
			Additional Therapeutic Good Detail	0..0
			Medication Action Instructions	0..0
			Formula	0..0
			Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)	0..0
			Reason for Action	0..0
			Quantity of Medication (AMOUNT OF MEDICATION)	0..0
			Medication Action Comment	0..0
			Vaccine Sequence Number (Sequence Number)	0..1
			Administration (MEDICATION ADMINISTRATION)	0..0
			Brand Substitution Occurred	0..0
			Batch Identifier	0..0
			Expiry Date	0..0
			DISPENSED TO	0..0
			Number of this Dispense	0..0
			Maximum Number of Repeats	0..0
			Claim Category	0..0
			Administrative Item Code	0..0

			Administrative Manufacturer Code	0..0
			Administrative System Identifier	0..0
			INFORMATION PROVIDER	0..0
			SUBJECT	0..0
			Medication Action DateTime	1..1
			Medication Action Instance Identifier	1..1
			RELATED INFORMATION	0..0
			Detailed Clinical Model Identifier	1..1
			Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS)	0..1
			Global Statement	1..1
			Not Currently Taking	0..0
			Not Ever Taken	0..0
			INFORMATION PROVIDER	0..0
			SUBJECT	0..0
			Exclusion Statement - Medications Instance Identifier	0..0
			RELATED INFORMATION	0..0
			Detailed Clinical Model Identifier	1..1
			Immunisations Instance Identifier	0..1
			RELATED INFORMATION	0..0
			Section Type	1..1

2.2 SUBJECT OF CARE

Identification

Label	SUBJECT OF CARE
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	Person who receives healthcare services.
Definition Source	NEHTA
Synonymous Names	Patient Individual
Scope	The person who is the focus of this document.
Scope Source	NEHTA

Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <p>Obligation and occurrence constraints:</p> <ul style="list-style-type: none"> • Participation Period is PROHIBITED. • LOCATION OF PARTICIPATION is PROHIBITED. • Entity Identifier is ESSENTIAL. • ADDRESS is ESSENTIAL. • Relationship to Subject of Care is PROHIBITED. • EMPLOYMENT DETAIL is PROHIBITED. • DEMOGRAPHIC DATA is ESSENTIAL. • Sex is ESSENTIAL. • DATE OF BIRTH DETAIL is ESSENTIAL. • Indigenous Status is ESSENTIAL. • Qualifications is PROHIBITED. <p>Other constraints:</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to “Subject of Care”. • Role SHALL have an implementation-specific value equivalent to “Patient”.
--------------------------	---

**Conditions of
Use Source**


- The value of one Entity Identifier **SHALL** be an Australian IHI.
- PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.

Terms used in obligation and occurrence constraints are explained in [Appendix C, Specification Guide for Use](#).

NEHTA

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SHARED HEALTH SUMMARY	1..1

2.3 DOCUMENT AUTHOR

Identification

Label	DOCUMENT AUTHOR
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	Composer of the document.
Definition Source	NEHTA
Synonymous Names	Author
Scope	The healthcare provider nominated by the individual as being responsible for creating or managing their <i>Shared Health Summary</i> .
Scope Source	NEHTA
Notes	The date, or date and time, that the authoring of the document was completed is recorded in the <i>Participation Period</i> of the <i>Author</i> .


Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <p>Obligation and occurrence constraints:</p> <ul style="list-style-type: none"> • Participation Period is ESSENTIAL. • LOCATION OF PARTICIPATION is PROHIBITED. • Entity Identifier is ESSENTIAL. • Relationship to Subject of Care is PROHIBITED. • EMPLOYMENT DETAIL is ESSENTIAL. • EMPLOYER ORGANISATION is ESSENTIAL. • EMPLOYER ORGANISATION.Entity Identifier is ESSENTIAL. • EMPLOYER ORGANISATION.ADDRESS is ESSENTIAL. • EMPLOYER ORGANISATION.ELECTRONIC COMMUNICATION DETAIL is ESSENTIAL. • DEMOGRAPHIC DATA is PROHIBITED. <p>Other constraints:</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to "Document Author".
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<p>Conditions of Use Source</p>	<ul style="list-style-type: none"> • Role SHOULD have a value chosen from 1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 [ABS2009]. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7® and is publicly available MAY be used. • The value of one Entity Identifier SHALL be an Australian HPI-I. • The value of ADDRESS.Address Purpose SHALL be “B” (Business). • The value of ELECTRONIC COMMUNICATION DETAIL.Electronic Communication Usage Code SHALL be “B” (Business). • The value of one EMPLOYER ORGANISATION.Entity Identifier SHALL be an Australian HPI-O. • AUSTRALIAN OR INTERNATIONAL ADDRESS SHALL be instantiated as an AUSTRALIAN ADDRESS. • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON. <p>Terms used in obligation and occurrence constraints are explained in Appendix C, Specification Guide for Use.</p> <p>NEHTA</p>
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SHARED HEALTH SUMMARY	1..1

2.4 Document Instance Identifier

Identification

Label	Document Instance Identifier
Metadata Type	Data Element
Identifier	DE-20101
OID	1.2.36.1.2001.1001.101.103.20101

Definition


Definition	A globally unique identifier for each instance of a <i>Shared Health Summary</i> document.
Definition Source	NEHTA
Synonymous Names	
Context	A document can have multiple instances as it passes through its life cycle of creation, revisions before it is first sent, and revised versions thereafter. The value of this <code>data element</code> enables systems to identify all instances of a document uniquely, thus enabling efficient storage, query and audit trail of information about a subject of care.
Context Source	NEHTA
Notes	This <code>data element</code> is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for <code>UniquelIdentifier</code> .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SHARED HEALTH SUMMARY	1..1

2.5 Document Type

Identification

Label	Document Type
Metadata Type	Data Element
Identifier	DE-10335
OID	1.2.36.1.2001.1001.101.103.10335

Definition


Definition	Type of document.
Definition Source	NEHTA
Synonymous Names	
Notes	A document's type is identified by a unique identifier, not by a name.
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system, for example LOINC.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.100.16565

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SHARED HEALTH SUMMARY	1..1

2.6 DateTime Attested

Identification

Label	DateTime Attested
Metadata Type	Data Element
Identifier	DE-20106
OID	1.2.36.1.2001.1001.101.103.20106

Definition


Definition	The date and time that the document author or document authoriser or approver confirms that a document is complete and genuine.
Definition Source	NEHTA
Synonymous Names	Date Sent DateTime Document Sent DateTime Document Transmitted
Context	For use in a healthcare setting. The date and time value when the document author determines the document is complete and can be sent by the authoring provider to the document recipients. In an electronic environment, the date and time when the document is last saved by the document authoring application.
Context Source	NEHTA
Notes	Confirmation that a document is complete and genuine is usually by signature.
Data Type	DateTime

Usage

Conditions of Use	DateTime Attested SHALL include a date and a time component.
Conditions of Use Source	NEHTA
Examples	Please see DateTime in Appendix C, Specification Guide for Use for examples and usage information on specifying a date or time (or both).

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SHARED HEALTH SUMMARY	1..1

2.7 ADVERSE REACTIONS

Identification

Label	ADVERSE REACTIONS
Metadata Type	Section
Identifier	S-20113
OID	1.2.36.1.2001.1001.101.101.20113

Definition


Definition	Information about adverse reactions of the patient (including allergies and intolerances), and any relevant reaction details. This includes statements about adverse reactions that need to be positively recorded as absent or excluded.
Definition Source	NEHTA
Synonymous Names	
Scope	Includes allergies and adverse reaction to all substances which might include food allergies, bee sting allergies as well as prescription and nonprescription medicines.
Scope Source	NEHTA

Usage


Conditions of Use	This section SHALL contain either: <ul style="list-style-type: none">• exactly one instance of EXCLUSION STATEMENT - ADVERSE REACTIONS, or• at least one instance of ADVERSE REACTION.
Conditions of Use Source	This section SHALL NOT contain both an instance of EXCLUSION STATEMENT - ADVERSE REACTIONS and an instance of ADVERSE REACTION . NEHTA





Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SHARED HEALTH SUMMARY	1..1

Children

Data Type	Name	Occurrences
	EXCLUSION STATEMENT - ADVERSE REACTIONS	0..1

Data Type	Name	Occurrences
	ADVERSE REACTION	0..*
	Adverse Reactions Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Section Type	1..1

2.8 Adverse Reactions Instance Identifier

Identification

Label	Adverse Reactions Instance Identifier
Metadata Type	Data Element
Identifier	DE-16963
OID	1.2.36.1.2001.1001.101.103.16963

Definition


Definition	A globally unique identifier for each instance of an <i>Adverse Reactions</i> section.
Definition Source	NEHTA
Synonymous Names	
Notes	This <code>data element</code> is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for <code>UniquelIdentifier</code> .
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Relationships

Parents

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

2.9 Section Type

Identification

Label	Section Type
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Type of section.
Definition Source	NEHTA
Synonymous Names	
Notes	A section's type is identified by a unique identifier, not by a name.
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.101.20113

Relationships

Parents

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

2.10 MEDICATION ORDERS

Identification

Label	Medications
Metadata Type	Section
Identifier	S-16146
OID	1.2.36.1.2001.1001.101.101.16146

Definition


Definition	Medicines that the subject of care is using.
Definition Source	NEHTA
Synonymous Names	
Scope	Medicines includes prescribed and over-the-counter medicines.
Scope Source	NEHTA
Notes	Inclusion of medicines will be at the discretion of the clinician; it is likely that predominantly long-term medicines will be shared.

Usage






Conditions of Use	Each instance of this section SHALL contain either: <ul style="list-style-type: none"> • exactly one instance of EXCLUSION STATEMENT - MEDICATIONS, or • at least one instance of MEDICATION INSTRUCTION. This section SHALL NOT contain both an instance of EXCLUSION STATEMENT - MEDICATIONS and an instance of MEDICATION INSTRUCTION .
Conditions of Use Source	NEHTA
Misuse	Use to record vaccine administration record of the subject of care. The <i>Immunisations</i> section is used for this purpose.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SHARED HEALTH SUMMARY	1..1

Children

Data Type	Name	Occurrences
	EXCLUSION STATEMENT - MEDICATIONS	0..1
	Known Medication (MEDICATION INSTRUCTION)	0..*
	Medication Orders Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Section Type	1..1

2.11 Medication Orders Instance Identifier

Identification

Label	Medication Orders Instance Identifier
Metadata Type	Data Element
Identifier	DE-16964
OID	1.2.36.1.2001.1001.101.103.16964

Definition


Definition	A globally unique identifier for each instance of a <i>Medication Orders</i> section.
Definition Source	NEHTA
Synonymous Names	
Notes	This <code>data element</code> is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniqueIdentifier

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniqueIdentifier .
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Medications (MEDICATION ORDERS)	0..1

2.12 Section Type

Identification

Label	Section Type
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Type of section.
Definition Source	NEHTA
Synonymous Names	
Notes	A section's type is identified by a unique identifier, not by a name.
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.101.16146

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Medications (MEDICATION ORDERS)	1..1

2.13 MEDICAL HISTORY

Identification

Label	Past and Current Medical History
Metadata Type	Section
Identifier	S-16117
OID	1.2.36.1.2001.1001.101.101.16117

Definition


Definition	The history of the subject of care's problems, diagnoses and medical or surgical procedures.
Definition Source	NEHTA
Synonymous Names	
Assumptions	Every entry in a person's medical history is either a procedure or a problem/diagnosis.
Assumptions Source	NEHTA
Notes	<i>A Medical History section is allowed to contain Procedure, Problem/Diagnosis, and Uncategorized Medical History Item data groups. Having both categorised items (Procedure and Problem/Diagnosis) and uncategorised items (Uncategorised Medical History Item) would be unusual, because generally if a system is able to differentiate some items, it is able to differentiate them all. However a system may be able to categorise some, and not others – possibly because of legacy data, or partial classification in the underlying terminology. For this reason, the rules allow a mix of categorised and uncategorised items.</i>

Usage









Conditions of Use	<p>Each instance of this section with a child of type UNCATEGORISED MEDICAL HISTORY ITEM SHALL NOT contain a child of type:</p> <ul style="list-style-type: none"> • EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES, or • EXCLUSION STATEMENT - PROCEDURES. <p>Each instance of this section without a child of type UNCATEGORISED MEDICAL HISTORY ITEM SHALL contain:</p> <ul style="list-style-type: none"> • a child of type PROBLEM/DIAGNOSIS or EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES (but not both), and • a child of type PROCEDURE or EXCLUSION STATEMENT - PROCEDURES (but not both).
Conditions of Use Source	NEHTA

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SHARED HEALTH SUMMARY	1..1

Children

Data Type	Name	Occurrences
	PROBLEM/DIAGNOSIS	0..*
	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	0..1
	PROCEDURE	0..*
	EXCLUSION STATEMENT - PROCEDURES	0..1
	UNCATEGORISED MEDICAL HISTORY ITEM	0..*
	Medical History Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Section Type	1..1

2.14 Medical History Instance Identifier

Identification

Label	Medical History Instance Identifier
Metadata Type	Data Element
Identifier	DE-16965
OID	1.2.36.1.2001.1001.101.103.16965

Definition


Definition	A globally unique identifier for each instance of a <i>Medical History</i> section.
Definition Source	NEHTA
Synonymous Names	
Notes	This <code>data element</code> is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for <code>UniquelIdentifier</code> .
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Past and Current Medical History (MEDICAL HISTORY)	0..1

2.15 Section Type

Identification

Label	Section Type
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Type of section.
Definition Source	NEHTA
Synonymous Names	
Notes	A section's type is identified by a unique identifier, not by a name.
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.101.16117

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Past and Current Medical History (MEDICAL HISTORY)	1..1

2.16 IMMUNISATIONS

Identification

Label	IMMUNISATIONS
Metadata Type	Section
Identifier	S-16638
OID	1.2.36.1.2001.1001.101.101.16638

Definition


Definition	Information about vaccines given to the subject of care.
Definition Source	NEHTA
Synonymous Names	
Scope	Includes information about vaccines that have been administered.
Scope Source	NEHTA

Usage



Conditions of Use	Each instance of this section SHALL contain either: <ul style="list-style-type: none"> • exactly one instance of EXCLUSION STATEMENT - MEDICATIONS, or • at least one instance of MEDICATION ACTION. <p>This section SHALL NOT contain both an instance of EXCLUSION STATEMENT - MEDICATIONS and an instance of MEDICATION ACTION.</p>
Conditions of Use Source	NEHTA




Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SHARED HEALTH SUMMARY	1..1

Children

Data Type	Name	Occurrences
	Administered Immunisation (MEDICATION ACTION)	0..*
	Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS)	0..1

Data Type	Name	Occurrences
	Immunisations Instance Identifier	0..1
	RELATED INFORMATION	0..0
	Section Type	1..1

2.17 Immunisations Instance Identifier

Identification

Label	Immunisations Instance Identifier
Metadata Type	Data Element
Identifier	DE-16962
OID	1.2.36.1.2001.1001.101.103.16962

Definition


Definition	A globally unique identifier for each instance of an <i>Immunisations</i> section.
Definition Source	NEHTA
Synonymous Names	
Notes	This <code>data element</code> is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for <code>UniquelIdentifier</code> .
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Relationships

Parents

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

2.18 Section Type

Identification

Label	Section Type
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	Type of section.
Definition Source	NEHTA
Synonymous Names	
Notes	A section's type is identified by a unique identifier, not by a name.
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.101.16638

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	IMMUNISATIONS	1..1

3 Exclusion Statement - Adverse Reactions Detailed Clinical Model

This chapter describes a reuse of version 1.3 of the *Exclusion Statement - Adverse Reactions Detailed Clinical Model* (DCM).

See [Adverse Reaction Detailed Clinical Model Specification \[NEHT2015g\]](#) for more information.

3.1 Purpose

To positively record the absence or exclusion of any adverse reactions within the health record.

3.2 Use

Use to record the positive exclusion or absence of adverse reactions within the health record. This Detailed Clinical Model (DCM) avoids the need to use terminology to express negation about any item within the health record.

It is important to note that the Exclusion Statement information is time-specific. Its validity may not extend beyond the point in time when the information is recorded. The patient should always be asked to verify previous statements about adverse reactions to a substance.

3.3 EXCLUSION STATEMENT - ADVERSE REACTIONS

Identification


Label	EXCLUSION STATEMENT - ADVERSE REACTIONS
Metadata Type	Data Group
Identifier	DG-16137
OID	1.2.36.1.2001.1001.101.102.16137

Definition








Definition	Statements about adverse reactions that need to be positively recorded as absent or excluded.
Definition Source	openEHR Foundation
Scope	To positively record the absence or exclusion of any adverse reactions within the health record.
Scope Source	openEHR Foundation




Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Global Statement	1..1
	No Known Adverse Reaction to	0..0
	No Known Allergic Reaction to	0..0
	No Known Hypersensitivity Reaction to	0..0
	No Known Intolerance to	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0

Data Type	Name	Occurrences
	Exclusion Statement – Adverse Reactions Instance Identifier	0..0
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

3.4 Global Statement

Identification

Label	Global Statement
Metadata Type	Data Element
Identifier	DE-16302
OID	1.2.36.1.2001.1001.101.103.16302

Definition


Definition	The statement about the absence or exclusion.
Definition Source	openEHR Foundation
Synonymous Names	
Context	This can be used to capture any information that is needed to be explicitly recorded within the record as being absent or excluded.
Context Source	openEHR Foundation
Data Type	CodedText
Value Domain	Global Statement Values

Usage

Conditions of Use	The value SHALL NOT be 02 ("Not asked").
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for CodedText .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - ADVERSE REACTIONS	1..1

3.5 Global Statement Values

Identification

Label	Global Statement Values
Metadata Type	Value Domain
Identifier	VD-16299
OID	1.2.36.1.2001.1001.101.104.16299

Definition


Definition	The set of values for the global statements about the exclusion.
Definition Source	openEHR Foundation

Value Domain

Source	NEHTA
Permissible Values	<p>01, None known No information about adverse reactions to any substance is known.</p> <p>02, Not asked No information about adverse reactions to any substance is available because the patient was not asked or not able to be asked.</p> <p>03, None supplied No information about adverse reactions to any substance is supplied.</p> <p>Please see Appendix B, Known Issues.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Global Statement	1..1

3.6 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16137

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - ADVERSE REACTIONS	1..1

4 Adverse Reaction Detailed Clinical Model

This chapter describes a reuse of version 5.2 of the *Adverse Reaction Detailed Clinical Model* (DCM).

See [Adverse Reaction Detailed Clinical Model Specification \[NEHT2015g\]](#) for more information.

4.1 Purpose

To record health information that will inform a clinical assessment of the propensity of an individual for a future reaction to a substance, class of substance or agent.

To record information about exposure events to a substance, building up a persisting and evolving summary over time.

To record information about any adverse reaction, including:

- immune mediated reactions Types I-IV (including allergic reactions and hypersensitivities), and
- non-immune mediated reactions (including pseudoallergic reactions, side effects, intolerances, drug toxicities (e.g. Gentamicin), drug-drug interactions, food-drug interactions, drug-disease interactions and idiosyncratic reactions).

4.2 Use

Use to record all information about adverse reactions (including allergic reactions) that are required to support direct clinical care of an individual, safe exchange of information about adverse reactions and to enable computerised knowledge-based activities such as clinical decision support and alerts.

Use to provide a single place within the health record to record a range of clinical statements about adverse reactions, including:

- recording cumulative information about each exposure to a known substance, class of substance or agent; and
- recording a clinician's opinion that administration of, or exposure to, a substance or agent is absolutely contraindicated.

It can also be used to record an individual's reflections on their adverse reactions.

Use to record the information about an adverse reaction that might be exchanged with other systems, including as part of an adverse reaction report sent to statutory authorities. It is likely that a formal adverse reaction report will require additional information that will be captured in the health record using other data groups, for example medication and problem/diagnosis etc.

This data group has been designed to allow recording of information about a more generic substance, class of substance or agent, and then allow more specific details to be recorded including identification of the specific substance on a per exposure basis, including links to other parts of the health record where further details may be located. Note: it is possible on second or subsequent exposures to a previously identified substance for a reaction not to occur; this data group allows for these events to be closely linked in a way that will assist in determining if the adverse reaction has been incorrectly identified.

In addition, it is anticipated that in some very specific clinical situations, such as immunologist assessment or for use in clinical trials, more information about the adverse reaction may be required.

The act of recording an adverse reaction in the health record implies there is a potential hazard for the individual if they are exposed to the same substance or agent in the future - a relative contraindication. If a clinician considers that it is not safe for the individual to be deliberately re-exposed to the substance or agent again, for example, following a manifestation of anaphylaxis, the Absolute Contraindication data flag should be recorded as "true". Note: Conversely, a statement about severity of propensity (with possible values such as mild, moderate and severe) has deliberately not been modelled explicitly. Predicting or estimating the grade of possible severity of a future reaction is not safe to record and persist in data, except where it is absolutely clear that the risk of deliberate re-exposure is unacceptable and highly likely to cause significant harm, such as a previous manifestation of anaphylaxis, and in this case the Absolute Contraindication data flag should be used.

Valuable first-level information that could be presented to the clinician when they need to assess propensity for future reactions are:

- statements about previous clinical manifestations following exposure,
- source of the information or reporter, and
- a flag for absolute contraindication.

Second-level information can be drawn from each exposure event and links to additional detailed information such as history, examination and diagnoses stored elsewhere in the record, if available.

4.3 Misuse

- 1) Not to be used for recording the absence (or negative presence) of a reaction to 'any substances' or to identified substances – use the EVALUATION.exclusion family of data groups to express a positive statement of exclusion.
- 2) Not to be used for recording that no information was able to be obtained about the adverse reaction status of a patient. Use the EVALUATION.absent_information family of data group to record a positive statement of absent information about adverse reactions was able to be obtained, for example, if a non-cooperative patient refuses to answer questions.
- 3) Not to be used to record adverse events, including failures of clinical process, interventions or products. For example: abnormal use or mistakes or errors made in administration of an agent or substance; mislabelling; harm or injury caused by an intervention or procedure; overdose, etc.
- 4) Not to be used for recording alerts.

4.4 ADVERSE REACTION

Identification


Label	ADVERSE REACTION
Metadata Type	Data Group
Identifier	DG-15517
OID	1.2.36.1.2001.1001.101.102.15517

Definition









Definition	A harmful or undesirable effect associated with exposure to any substance or agent.
Definition Source	NEHTA
Scope	Substances and agents include medication at therapeutic or sub-therapeutic doses, food, plants, animals, venom from insect stings and glycoprotein from animals such as cats.
Scope Source	NEHTA





Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Substance/Agent	1..1
	Absolute Contraindication	0..0
	Adverse Reaction Comment	0..0
	REACTION EVENT	0..1
	Reaction Reported	0..0
	Adverse Reaction Report	0..0
	Supporting Clinical Record Information	0..0
	INFORMATION PROVIDER	0..0

Data Type	Name	Occurrences
	SUBJECT	0..0
	Adverse Reaction Instance Identifier	1..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

4.5 Substance/Agent

Identification

Label	Substance/Agent
Metadata Type	Data Element
Identifier	DE-15521
OID	1.2.36.1.2001.1001.101.103.15521

Definition


Definition	Identification of a substance, agent, or a class of substance, that is considered to be responsible for the adverse reaction.
Definition Source	NEHTA
Synonymous Names	Agent Substance
Notes	An agent can be a substance such as food, drug or an environmental allergen.
Data Type	CodeableText
Value Domain	Substance/Agent Values

Usage

Examples	1) Animal protein 2) Latex 3) Peanut 4) Penicillin 5) Bee venom
-----------------	---

Relationships

Parents

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

4.6 Substance/Agent Values

Identification

Label	Substance/Agent Values
Metadata Type	Value Domain
Identifier	VD-15521
OID	1.2.36.1.2001.1001.101.104.15521

Definition


Definition	The set of values for the agent or substance causing the adverse reaction experienced by the subject of care.
Definition Source	NEHTA

Value Domain

Source	NEHTA
Permissible Values	<p>The permissible values are the members of the following 9 reference sets.</p> <p>From SNOMED CT-AU:</p> <ul style="list-style-type: none"> • 142321000036106 <i>Adverse reaction agent reference set</i> • 32570211000036100 <i>Substance foundation reference set</i> <p>From AMT:</p> <ul style="list-style-type: none"> • 929360061000036106 <i>Medicinal product reference set</i> • 929360081000036101 <i>Medicinal product pack reference set</i> • 929360071000036103 <i>Medicinal product unit of use reference set</i> • 929360021000036102 <i>Trade product reference set</i> • 929360041000036105 <i>Trade product pack reference set</i> • 929360031000036100 <i>Trade product unit of use reference set</i> • 929360051000036108 <i>Containerized trade product pack reference set</i>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Substance/Agent	1..1

4.7 REACTION EVENT

Identification


Label	REACTION EVENT
Metadata Type	Data Group
Identifier	DG-16474
OID	1.2.36.1.2001.1001.101.102.16474

Definition










Definition	Details about each adverse reaction event.
Definition Source	NEHTA
Synonymous Names	








Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Specific Substance/Agent	0..0
	Manifestation	1..*
	Reaction Type	0..1
	Adverse Reaction Certainty	0..0
	Reaction Description	0..0
	Reaction Onset Date	0..0
	Duration of Reaction	0..0
	Additional Reaction Detail (ANATOMICAL LOCATION)	0..0
	Exposure Description	0..0

Data Type	Name	Occurrences
	Earliest Exposure	0..0
	Duration of Exposure	0..0
	ADDITIONAL EXPOSURE DETAIL	0..0
	Clinical Management Description	0..0
	Multimedia	0..0
	Reporting Details	0..0
	Adverse Reaction Event Comment	0..0

4.8 Manifestation

Identification

Label	Manifestation
Metadata Type	Data Element
Identifier	DE-15564
OID	1.2.36.1.2001.1001.101.103.15564

Definition


Definition	Presentation or exhibition of signs and symptoms of the adverse reaction expressed as a single word, phrase or brief description.
Definition Source	NEHTA
Synonymous Names	Reaction
Notes	<p>The clinical manifestation (signs, symptoms, severity or certainty) of the adverse reaction are relevant as they contribute towards the decision as to the immediacy and extent of treatment to be provided, as determined by a healthcare provider.</p> <p>Given that an adverse reaction has occurred, it is important to determine the manifestations of that reaction.</p>
Data Type	CodeableText
Value Domain	Clinical Manifestation Values

Usage

Examples	<ol style="list-style-type: none">1) Itchy eyes2) Dysphagia3) Tinnitus4) Nausea5) Rash
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REACTION EVENT	1..*

4.9 Clinical Manifestation Values

Identification

Label	Clinical Manifestation Values
Metadata Type	Value Domain
Identifier	VD-15564
OID	1.2.36.1.2001.1001.101.104.15564

Definition


Definition	The set of values for recording clinical manifestation of an adverse reaction.
Definition Source	NEHTA

Value Domain

Source	SNOMED CT-AU
Permissible Values	<p>The permissible values are the members of the following SNOMED CT reference sets:</p> <ul style="list-style-type: none"> 142341000036103 <i>Clinical manifestation reference set</i> 32570071000036102 <i>Clinical finding foundation reference set</i>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Manifestation	1..1

4.10 Reaction Type

Identification

Label	Reaction Type
Metadata Type	Data Element
Identifier	DE-15554
OID	1.2.36.1.2001.1001.101.103.15554

Definition


Definition	The type of reaction, as determined by the clinician.
Definition Source	NEHTA
Synonymous Names	
Context	<p>This field is used to identify the type of adverse reaction as determined by:</p> <ul style="list-style-type: none">• the signs and symptoms experienced by the subject of care;• information provided by a relevant individual;• previously documented history; and• clinical assessment by a healthcare provider.
Context Source	NEHTA
Data Type	CodedText
Value Domain	Adverse Reaction Type Values

Usage

Examples	<ol style="list-style-type: none">1) Allergic reaction2) Drug interaction3) Food intolerance4) Hypersensitivity reaction5) Medication side-effect
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	REACTION EVENT	0..1

4.11 Adverse Reaction Type Values

Identification

Label	Adverse Reaction Type Values
Metadata Type	Value Domain
Identifier	VD-15554
OID	1.2.36.1.2001.1001.101.104.15554
External Identifier	SNOMED CT-AU Concept Id: 11000036103 [<i>Adverse reaction type reference set</i>]

Definition


Definition	The set of values for the type of adverse reaction.
Definition Source	NEHTA

Value Domain

Source	SNOMED CT-AU
---------------	--------------

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Reaction Type	1..1

4.12 Adverse Reaction Instance Identifier

Identification

Label	Adverse Reaction Instance Identifier
Metadata Type	Data Element
Identifier	DE-16697
OID	1.2.36.1.2001.1001.101.103.16697

Definition


Definition	A globally unique identifier for each instance of an <i>Adverse Reaction</i> evaluation.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

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

4.13 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.15517

Relationships

Parents

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

5 Exclusion Statement - Medications Detailed Clinical Model

This chapter describes a reuse of version 1.3 of the *Exclusion Statement - Medications* Detailed Clinical Model (DCM).

See [Medication Instruction and Action Detailed Clinical Model Specification \[NEHT2015h\]](#) for more information.

5.1 Purpose

To positively record the absence or exclusion of any medication use within the health record.

5.2 Use

Use to record the positive exclusion or absence of medication use within the health record. This Detailed Clinical Model (DCM) avoids the need to use terminology to express negation about any item within the health record.

This DCM is only to be used to record 'point in time' or event-based information. It is not to be used for a persistent storage of information as the patient should always be questioned about current or past medication use prior to initiation of any treatment or management plan.

5.3 EXCLUSION STATEMENT - MEDICATIONS

Identification


Label	EXCLUSION STATEMENT - MEDICATIONS
Metadata Type	Data Group
Identifier	DG-16136
OID	1.2.36.1.2001.1001.101.102.16136

Definition








Definition	Statement to positively assert that the patient has not been prescribed or is not taking certain medication.
Definition Source	openEHR Foundation
Scope	To positively record the absence or exclusion of any medication use within the health record.
Scope Source	openEHR Foundation


Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Medications (MEDICATION ORDERS)	0..1

Children

Data Type	Name	Occurrences
	Global Statement	1..1
	Not Currently Taking	0..0
	Not Ever Taken	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Exclusion Statement - Medications Instance Identifier	0..0
	RELATED INFORMATION	0..0

Data Type	Name	Occurrences
	Detailed Clinical Model Identifier	1..1

5.4 Global Statement

Identification

Label	Global Statement
Metadata Type	Data Element
Identifier	DE-16302
OID	1.2.36.1.2001.1001.101.103.16302

Definition


Definition	The statement about the absence or exclusion of certain medication.
Definition Source	openEHR Foundation
Synonymous Names	
Context	This can be used to capture any information that is needed to be explicitly recorded within the record as being absent or excluded.
Context Source	openEHR Foundation
Data Type	CodedText
Value Domain	Global Statement Values

Usage

Conditions of Use	The value SHALL NOT be 02 ("Not asked").
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for CodedText .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - MEDICATIONS	1..1

5.5 Global Statement Values

Identification

Label	Global Statement Values
Metadata Type	Value Domain
Identifier	VD-16299
OID	1.2.36.1.2001.1001.101.104.16299

Definition


Definition	The set of values for the statement about the absence or exclusion.
Definition Source	openEHR Foundation

Value Domain

Source	NEHTA
Permissible Values	<p>01, None known No information about taking any medication is known.</p> <p>02, Not asked No information about taking any medication is available because the patient was not asked or not able to be asked.</p> <p>03, None supplied No information about taking any medication is supplied.</p> <p>Please see Appendix B, Known Issues.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Global Statement	1..1

5.6 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16136

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - MEDICATIONS	1..1

6 Known Medication Detailed Clinical Model

This chapter describes a reuse of version 3.3 of the *Medication Instruction Detailed Clinical Model* (DCM).

See [Medication Instruction and Action Detailed Clinical Model Specification \[NEHT2015h\]](#) for more information.

6.1 Purpose

To record the intent to use or to continue to use a medicine, vaccine, or other therapeutic good, including instructions on use, dispensing, and administration, where necessary.

6.2 Use

For recording instructions to dispense, administer or use a medicine, vaccine or other therapeutic good. This medication instruction can be used in many circumstances including: a record in a progress note; an item in a medication list, prescription or drug chart (to be dispensed or administered); or in a summary document such as a discharge summary or a referral for care. The instruction may be complex and involve more than one activity, such as in the case of a Prednisolone reducing dose regimen, or multiple medications as components of the same order. This would include a written order by a physician, dentist, nurse practitioner, or other designated health professional for a medication to be dispensed and administered to a patient.

This instruction will generally apply to things that can be prescribed or are available “over the counter”.

Use for orders for vaccinations or other therapeutic goods. These may be presented differently in different applications but require the same structure.

Use for the consistent representation of an item in a medication list comprising the medicines that clinicians collectively expect the individual to be taking.

The information recorded may separate dose, route and timing to achieve a computable and shareable specification but also allows for narrative instructions for orders like "Frusemide 40mg two tablets in the morning and one at lunch" to ensure compatibility with existing systems. To achieve a structured statement for such compound orders, two items are required: "Frusemide 40mg two tablets in the morning" and "Frusemide 40mg one tablet at lunch". The instruction will usually include information about the timing and dose (which may be structured) and in some settings will include the route of administration. The amount of the medicines will usually be given in terms of a number and a dose unit but may be a textual statement to ensure compatibility with existing systems and also coverage of all scenarios.

Use to represent a prescription item for a medicine, vaccine or other therapeutic good within a document such as an electronic prescription or a medication chart.

The content is potentially complex. Where the content is reusable in other contexts, especially the paired Medication Action (for recording dispensing, administration etc.) the content has been specified in reusable data groups. For example: the AMOUNT OF MEDICATION data group contains detail about medication dose; the TIMING data group contains detail about structured dose timing; the MEDICATION ADMINISTRATION data group contains structure around administration for both the order and the action; and the CHEMICAL DESCRIPTION OF MEDICATION data group describes the specific ingredients within a medicine. All of these data groups together are required to make up the total maximal dataset for a reusable medication instruction.

6.3 Misuse

Not to be used to record administration, use or dispensing. (For those use Medication Action.)

Not to be used to record ordering of blood products, implants or major devices such as pacemakers and defibrillators, etc.

6.4 MEDICATION INSTRUCTION

Identification


Label	Known Medication
Metadata Type	Data Group
Identifier	DG-16211
OID	1.2.36.1.2001.1001.101.102.16211

Definition



Definition	Information pertaining to one or more therapeutic goods that is represented to achieve, or is likely to achieve, its principal intended action by pharmacological, chemical, immunological or metabolic means in or on the body of a human.
Definition Source	NEHTA
Synonymous Names	Drug Medicine Potion Prescribed Item Therapeutic
Scope	<p>For use in the healthcare setting. Captures detailed information on the medication being used by or prescribed for the subject of care for their personal healthcare. This only includes legal substances.</p> <p>Such information covers not only aspects of the medication itself, but information relating to the ordering, dispensing, administration and review of medications. The specifications herein are presented grouped according to these process states.</p> <p>Recording legal substances such as over-the-counter medications, complementary and alternative medications, and prescribed medications.</p>
Scope Source	NEHTA

























Relationships




Parents

Data Type	Name	Occurrences (child within parent)
	Medications (MEDICATION ORDERS)	0..*

Children

Data Type	Name	Occurrences
	Therapeutic Good Identification	1..1
	Additional Therapeutic Good Detail	0..0

Data Type	Name	Occurrences
	Directions	1..1
	Formula	0..0
	Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)	0..0
	Dose Description	0..0
	Structured Dose (AMOUNT OF MEDICATION)	0..0
	Timing (MEDICATION TIMING)	0..0
	Additional Instruction	0..0
	Clinical Indication	0..1
	Administration Details (MEDICATION ADMINISTRATION)	0..0
	Medication Instruction Comment	0..1
	DISPENSING	0..0
	Change Type	0..0
	Change Status	0..0
	Change Description	0..0
	Change or Recommendation Reason	0..0
	Indication for Authorised Use	0..0
	Medication Instruction ID	0..0
	Concession Benefit	0..0
	DateTime Medication Instruction Written	0..0
	Administrative Manufacturer Code	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Medication Instruction Narrative	0..0
	DateTime Medication Instruction Expires	0..0

Data Type	Name	Occurrences
	Medication Instruction Instance Identifier	1..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

6.5 Therapeutic Good Identification

Identification

Label	Therapeutic Good Identification
Metadata Type	Data Element
Identifier	DE-10194
OID	1.2.36.1.2001.1001.101.103.10194

Definition

Definition	The medicine, vaccine or other therapeutic good being ordered for, administered to or used by the subject of care.
Definition Source	NEHTA
Synonymous Names	Item Name
Context	This includes medications and medical devices. It includes drugs, appliances, dressings, and reagents.
Context Source	NEHTA
Notes	<p>Identifies a therapeutic good, which is broadly defined as a good which is represented in any way to be, or is likely to be taken to be, for therapeutic use (unless specifically excluded or included under Section 7 of the <i>Therapeutic Goods Act 1989</i>).</p> <p>Therapeutic use means use in or in connection with:</p> <ul style="list-style-type: none"> • preventing, diagnosing, curing or alleviating a disease, ailment, defect or injury; or • influencing, inhibiting or modifying a physiological process; or • testing the susceptibility of persons to a disease or ailment; or • influencing, controlling or preventing conception; or • testing for pregnancy; or • replacement or modification of parts of the anatomy. <p>From the <i>Therapeutic Goods Act 1989</i> [TGA1989a].</p> <p>The formal definition of a therapeutic good is given in Section 3 of the <i>Therapeutic Goods Act 1989</i>.</p>
Data Type	CodeableText
Value Domain	Medicines Terminology


Usage

Conditions of Use	<p>Where the therapeutic good can be identified by an Australian Medicines Terminology (AMT) concept, the value of this data element SHALL be the AMT ConceptID and Preferred Term. For details see Medicines Terminology.</p> <p>For items without an AMT code (including some extemporaneous preparations), a text description is suitable. For a medication, this SHALL include the name of the medication</p>
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Conditions of Use Source	(brand name or generic name equivalent), the strength and, where appropriate, the dose form.
Examples	<p>NEHTA</p> <p>Some examples of AMT ConceptIDs and their AMT Preferred Terms are:</p> <ol style="list-style-type: none"> 1) 23641011000036102 <i>paracetamol 500 mg + codeine phosphate 30 mg tablet</i> 2) 28329011000036108 <i>paracetamol 500 mg + codeine phosphate 30 mg tablet, 20</i> 3) 13362011000036106 <i>Panadeine Forte tablet: uncoated, 20</i> 4) 6647011000036101 <i>Panadeine Forte tablet: uncoated</i> 5) 20138011000036107 <i>Panadeine Forte tablet: uncoated, 20, blister pack</i> 6) 51295011000036108 <i>bandage compression 10 cm x 3.5 m bandage: high stretch</i> 7) 48667011000036100 <i>Eloflex (2480) 10 cm x 3.5 m bandage: high stretch</i> 8) 926706011000036104 <i>Engerix-B Paediatric 10 microgram/0.5 mL injection: suspension, 0.5 mL syringe</i>
Misuse	Detailing the formula of a compounded (extemporaneous) medication.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	1..1

6.6 Medicines Terminology

Identification

Label	Medicines Terminology
Metadata Type	Value Domain
Identifier	VD-16115
OID	1.2.36.1.2001.1001.101.104.16115

Definition


Definition	A set of values used to refer to medicines and other therapeutic goods.
Definition Source	NEHTA
Notes	An explanation of AMT concepts can be found in Australian Medicines Terminology v3 Model - Editorial Rules v2.0 [NEHT2014ag] .

Value Domain

Source	Australian Medicines Terminology
Permissible Values	<p>The permissible values are the members of the following seven AMT reference sets:</p> <ul style="list-style-type: none"> 929360061000036106 <i>Medicinal product reference set</i> 929360081000036101 <i>Medicinal product pack reference set</i> 929360071000036103 <i>Medicinal product unit of use reference set</i> 929360021000036102 <i>Trade product reference set</i> 929360041000036105 <i>Trade product pack reference set</i> 929360031000036100 <i>Trade product unit of use reference set</i> 929360051000036108 <i>Containerised trade product pack reference set</i>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Therapeutic Good Identification	1..1

6.7 Directions

Identification

Label	Directions
Metadata Type	Data Element
Identifier	DE-16429
OID	1.2.36.1.2001.1001.101.103.16429

Definition


Definition	A complete narrative description of how much, when and how to use the medicine, vaccine or other therapeutic good.
Definition Source	NEHTA
Synonymous Names	
Notes	It is essential that when the <i>Directions</i> data element is used together with structured information components such as <i>Ingredients and Form</i> and <i>Structured Dose</i> in clinical records or prescriptions, the contents of <i>Directions</i> not contradict the contents of these structured information components.
Data Type	Text

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	1..1

6.8 Clinical Indication

Identification

Label	Clinical Indication
Metadata Type	Data Element
Identifier	DE-10141
OID	1.2.36.1.2001.1001.101.103.10141

Definition


Definition	A reason for ordering the medicine, vaccine or other therapeutic good.
Definition Source	NEHTA
Synonymous Names	Reason for Prescribing
Notes	The clinical justification (e.g. specific therapeutic effect intended) for this subject of care's use of the therapeutic good.
Data Type	Text

Usage

Examples	1) Long-term maintenance treatment of bronchospasm and dyspnoea.
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	0..1

6.9 Medication Instruction Comment

Identification

Label	Medication Instruction Comment
Metadata Type	Data Element
Identifier	DE-16044
OID	1.2.36.1.2001.1001.101.103.16044

Definition


Definition	Any additional information that may be needed to ensure the continuity of supply, rationale for current dose and timing, or safe and appropriate use.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	<ol style="list-style-type: none">1) Patient requires an administration aid.2) Portable Pulse Oximeter measurement to be taken by clipping the sensor onto the tip of a finger.3) Consulted prescriber concerning dose.
Misuse	Use for information that could be recorded as structured data.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	0..1

6.10 Medication Instruction Instance Identifier

Identification

Label	Medication Instruction Instance Identifier
Metadata Type	Data Element
Identifier	DE-16713
OID	1.2.36.1.2001.1001.101.103.16713

Definition


Definition	A globally unique object identifier for each instance of a <i>Medication Instruction</i> instruction.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	1..1

6.11 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16211

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Known Medication (MEDICATION INSTRUCTION)	1..1

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7 Problem/Diagnosis Detailed Clinical Model

This chapter describes a reuse of version 5.2 of the *Problem/Diagnosis Detailed Clinical Model* (DCM).

See [Medical History Detailed Clinical Model Specification \[NEHT2015j\]](#) for more information.

7.1 Purpose

To record details about a problem or diagnosis by a clinician.

7.2 Use

Use to record detailed information about problems or diagnoses recognised by a clinician. There are many uses including: recording a diagnosis during an encounter; populating a problem list or a summary statement, such as a discharge summary.

Use to record all problems or diagnoses, including those with context-specific qualifiers such as past or present, primary or secondary, active or inactive etc. These qualifiers can be documented separately and included in the Status data group, because their use varies in different settings.

7.3 Misuse

Not to be used to record differential diagnoses - use the Differential Diagnosis archetype (to be published).

Not to be used to record reason for encounter - use the Reason for Encounter archetype.

Not to be used to record presenting complaint - which is information captured early in the encounter, usually prior to full assessment and will be represented using a separate archetype.

Not to be used to record procedures - use the Procedure archetype.

Not to be used to record symptoms or signs - these should be recorded as part of a patient story or history. A problem such as chest pain may masquerade as a symptom, however in this context we are recording it as a problem the person has.

7.4 PROBLEM/DIAGNOSIS

Identification


Label	PROBLEM/DIAGNOSIS
Metadata Type	Data Group
Identifier	DG-15530
OID	1.2.36.1.2001.1001.101.102.15530

Definition





Definition	A health condition that, as determined by a clinician, may have impact on the physical, mental or social well-being of a person. A diagnosis is determined by scientific evaluation of pathological and pathophysiological findings identified from the patient's clinical history, family history, physical examination and diagnostic investigations.
Definition Source	NEHTA
Synonymous Names	
Scope	The problems and diagnoses that form part of the past and current medical history of the subject of care.
Scope Source	NEHTA
Notes	An account of relevant identified health related problems as reported by a healthcare provider. This can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status as assessed by a healthcare provider.

















Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Past and Current Medical History (MEDICAL HISTORY)	0..*

Children

Data Type	Name	Occurrences
	Problem/Diagnosis Identification	1..1
	Clinical Description	0..0
	Severity	0..0
	Date of Onset	0..1

Data Type	Name	Occurrences
	Age at Onset	0..0
	ANATOMICAL LOCATION	0..0
	Occurrence Summary (PROBLEM/DIAGNOSIS OCCURRENCE SUMMARY)	0..0
	RELATED ITEMS	0..0
	Date of Resolution/Remission	0..1
	Age at Resolution/Remission	0..0
	Diagnostic Criteria	0..0
	Clinical Stage/Grade	0..0
	Problem/Diagnosis Comment	0..1
	Link to Supporting Clinical Evidence	0..0
	Status	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Problem/Diagnosis Instance Identifier	1..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

7.5 Problem/Diagnosis Identification

Identification

Label	Problem/Diagnosis Identification
Metadata Type	Data Element
Identifier	DE-15514
OID	1.2.36.1.2001.1001.101.103.15514

Definition


Definition	Identification of the problem or diagnosis.
Definition Source	NEHTA
Synonymous Names	
Notes	This item denotes the name of the condition used by the healthcare provider, after assessment, to describe the health problem or diagnosis experienced by the subject of care.
Data Type	CodeableText
Value Domain	Problem/Diagnosis Reference Set

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	1..1

7.6 Problem/Diagnosis Reference Set

Identification

Label	Problem/Diagnosis Reference Set
Metadata Type	Value Domain
Identifier	VD-16617
OID	1.2.36.1.2001.1001.101.104.16617
External Identifier	SNOMED CT-AU Concept Id: 32570581000036105 <i>Problem/Diagnosis reference set</i>

Definition


Definition	The <i>Problem/Diagnosis reference set</i> provides terminology to support the recording of a subject of care problem or diagnosis for medical records within Australia.
Definition Source	NEHTA

Value Domain

Source	SNOMED CT-AU
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Problem/Diagnosis Identification	1..1

7.7 Date of Onset

Identification

Label	Date of Onset
Metadata Type	Data Element
Identifier	DE-15507
OID	1.2.36.1.2001.1001.101.103.15507

Definition


Definition	Estimated or actual date the problem or diagnosis began, as indicated or identified by the clinician.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

Conditions of Use	<i>Date of Onset</i> SHALL NOT include a time component.
Conditions of Use Source	NEHTA
Examples	Please see DateTime in Appendix C, Specification Guide for Use for examples and usage information on specifying a date or time (or both).

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

7.8 Date of Resolution/Remission

Identification

Label	Date of Resolution/Remission
Metadata Type	Data Element
Identifier	DE-15510
OID	1.2.36.1.2001.1001.101.103.15510

Definition


Definition	Estimated or actual date the problem or diagnosis resolved or went into remission, as indicated or identified by the clinician.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

Conditions of Use	<i>Date of Resolution/Remission</i> SHALL NOT include a time component.
Conditions of Use Source	NEHTA
Examples	Please see DateTime in Appendix C, Specification Guide for Use for examples and usage information on specifying a date.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

7.9 Problem/Diagnosis Comment

Identification

Label	Problem/Diagnosis Comment
Metadata Type	Data Element
Identifier	DE-16545
OID	1.2.36.1.2001.1001.101.103.16545

Definition


Definition	Additional narrative about the problem or diagnosis not captured in other fields.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

7.10 Problem/Diagnosis Instance Identifier

Identification

Label	Problem/Diagnosis Instance Identifier
Metadata Type	Data Element
Identifier	DE-16702
OID	1.2.36.1.2001.1001.101.103.16702

Definition


Definition	A globally unique object identifier for each instance of a <i>Problem/Diagnosis</i> evaluation.
Definition Source	NEHTA
Synonymous Names	
Notes	This <code>data element</code> is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for <code>UniquelIdentifier</code> .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	1..1

7.11 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.15530

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	1..1

8 Exclusion Statement - Problems and Diagnoses Detailed Clinical Model

This chapter describes a reuse of version 1.3 of the *Exclusion Statement - Problems and Diagnoses Detailed Clinical Model* (DCM).

See [Medical History Detailed Clinical Model Specification \[NEHT2015i\]](#) for more information.

8.1 Purpose

To positively record the absence or exclusion of any problems or diagnoses within the health record.

8.2 Use

Use to record the positive exclusion or absence of problems or diagnoses within the health record. This Detailed Clinical Model (DCM) avoids the need to use terminology to express negation about any problem or diagnoses within the health record.

This DCM is only to be used to record 'point in time' information. It is not to be used for a persistent storage of information as the patient should always be questioned about past or existing problems and diagnoses; diagnosis should always be undertaken prior to initiation of any treatment or management plan.

8.3 EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES

Identification

Label	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES
Metadata Type	Data Group
Identifier	DG-16138
OID	1.2.36.1.2001.1001.101.102.16138

Definition


Definition	Statements which positively assert that the patient does not have the problem or diagnosis.
Definition Source	openEHR Foundation
Scope	To positively record the absence or exclusion of any problems or diagnoses within the health record.
Scope Source	openEHR Foundation

Usage



Conditions of Use	Use to record the positive exclusion or absence of problems or diagnoses within the health record. This data group avoids the need to use terminology to express negation about any problem or diagnosis within the health record. The positive assertion and persistence of absence of problem or diagnosis is time-specific. It is important to note that the patient's condition should be reviewed and required to validate such statement at each encounter.
Conditions of Use Source	openEHR Foundation







Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Past and Current Medical History (MEDICAL HISTORY)	0..1

Children

Data Type	Name	Occurrences
	Global Statement	1..1
	No Previous History of	0..0

Data Type	Name	Occurrences
	No Evidence of	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Exclusion Statement – Problems and Diagnoses Instance Identifier	0..0
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

8.4 Global Statement

Identification

Label	Global Statement
Metadata Type	Data Element
Identifier	DE-16302
OID	1.2.36.1.2001.1001.101.103.16302

Definition


Definition	The statement about the absence or exclusion.
Definition Source	openEHR Foundation
Synonymous Names	
Context	This can be used to capture any information that is needed to be explicitly recorded within the record as being absent or excluded.
Context Source	openEHR Foundation
Data Type	CodedText
Value Domain	Global Statement Values

Usage

Conditions of Use	The value SHALL NOT be 02 ("Not asked").
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for CodedText .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	1..1

8.5 Global Statement Values

Identification

Label	Global Statement Values
Metadata Type	Value Domain
Identifier	VD-16299
OID	1.2.36.1.2001.1001.101.104.16299

Definition


Definition	The set of values for the global statements about the exclusion of problems or diagnoses.
Definition Source	openEHR Foundation

Value Domain

Source	NEHTA
Permissible Values	<p>01, None known No information about any problem or diagnosis is known.</p> <p>02, Not asked No information about any problem or diagnosis is available because the patient was not asked or not able to be asked.</p> <p>03, None supplied No information about any problem or diagnosis is supplied.</p> <p>Please see Appendix B, Known Issues.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Global Statement	1..1

8.6 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16138

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	1..1

9 Procedure Detailed Clinical Model

This chapter describes a reuse of version 4.2 of the *Procedure (Action)* Detailed Clinical Model (DCM).

See [Medical History Detailed Clinical Model Specification \[NEHT2015i\]](#) for more information.

9.1 Purpose

To record information about the activities required to carry out a procedure, including the planning, scheduling, performance, suspension, cancellation, documentation and completion.

9.2 Use

Use to record information about the activities required to carry out a procedure, including the planning, scheduling, performance, suspension, cancellation, documentation and completion.

The scope of this archetype encompasses activities for a broad range of clinical procedures performed for therapeutic, evaluative, investigative, screening or diagnostic purposes. Examples range from the relatively simple activities, such as insertion of an intravenous cannula, through to complex surgical operations.

Additional structured and detailed information about the procedure can be captured using purpose-specific data groups inserted into the *Procedure Detail* slot, where required.

Within the context of an operation report, this DCM will be used to record only what was done during the procedure. Separate DCMs will be used to record the other required components of the operation report, including the taking of tissue specimen samples, use of imaging guidance, operation findings, post-operative instructions and plans for follow-up.

Within the context of a problem list or summary, this DCM may be used to represent procedures that have been performed. The *Problem/Diagnosis* archetype will be used to represent the patient's problems and diagnoses.

Recording information using this *Procedure* DCM indicates that some sort of activity has actually occurred; this will usually be the procedure itself but may be a failed attempt or another activity such as postponing the procedure.

9.3 Misuse

Not to be used to record details about related DCMs, such as use of imaging guidance during the procedure or collection of tissue samples for analysis - use a specific DCM for this purpose.

Not to be used to record a whole operation or procedure report.

Not to be used to record an observation such as a pathology test result or an imaging test.

9.4 PROCEDURE

Identification

Label	PROCEDURE
Metadata Type	Data Group
Identifier	DG-15514
OID	1.2.36.1.2001.1001.101.102.15514

Definition


Definition	A clinical activity carried out for therapeutic, evaluative, investigative, screening or diagnostic purposes.
Definition Source	NEHTA
Synonymous Names	Clinical Intervention
Scope	The procedures that form part of the past and current medical history of the subject of care.
Scope Source	NEHTA

Usage



Misuse	Recording details about related activities such as use of imaging guidance during the procedure or collection of tissue samples for analysis - use specific DCMs for these purposes.
	Recording a whole operation or procedure report.
	Recording an observation such as a pathology test result or an imaging test.













Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Past and Current Medical History (MEDICAL HISTORY)	0..*

Children

Data Type	Name	Occurrences
	Procedure Name	1..1
	Procedure Description	0..0

Data Type	Name	Occurrences
	Procedure Reason	0..0
	ANATOMICAL LOCATION	0..0
	Procedure Detail	0..0
	Multimedia	0..0
	Procedure Comment	0..1
	DEVICE	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Procedure DateTime	1..1
	Procedure Instance Identifier	1..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

9.5 Procedure Name

Identification

Label	Procedure Name
Metadata Type	Data Element
Identifier	DE-15579
OID	1.2.36.1.2001.1001.101.103.15579

Definition


Definition	The name of the procedure (to be) performed.
Definition Source	NEHTA
Synonymous Names	
Data Type	CodeableText
Value Domain	Procedure Foundation Reference Set

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	1..1

9.6 Procedure Foundation Reference Set

Identification

Label	Procedure Foundation Reference Set
Metadata Type	Value Domain
Identifier	VD-16580
OID	1.2.36.1.2001.1001.101.104.16580
External Identifier	SNOMED CT-AU Concept Id: 32570141000036105 <i>Procedure foundation reference set</i>

Definition


Definition	The <i>Procedure foundation reference set</i> provides the broadest possible terminology to support the recording of clinical interventions in Australian eHealth implementations.
Definition Source	NEHTA

Value Domain

Source	SNOMED CT-AU
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Procedure Name	1..1

9.7 Procedure Comment

Identification

Label	Procedure Comment
Metadata Type	Data Element
Identifier	DE-15595
OID	1.2.36.1.2001.1001.101.103.15595

Definition


Definition	Additional narrative about the procedure not captured in other fields.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

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

9.8 Procedure DateTime

Identification

Label	Procedure DateTime
Metadata Type	Data Element
Identifier	DE-16475
OID	1.2.36.1.2001.1001.101.103.16475

Definition


Definition	The date range during which the <i>Procedure</i> action occurred.
Definition Source	NEHTA
Synonymous Names	
Data Type	TimeInterval

Usage

Examples	Please see DateTime in Appendix C, Specification Guide for Use for examples and usage information on specifying a date or time (or both).
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	1..1

9.9 Procedure Instance Identifier

Identification

Label	Procedure Instance Identifier
Metadata Type	Data Element
Identifier	DE-16561
OID	1.2.36.1.2001.1001.101.103.16561

Definition


Definition	A globally unique identifier for each instance of a <i>Procedure</i> action.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for <i>UniquelIdentifier</i> .
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	1..1

9.10 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.15514

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	1..1

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10 Exclusion Statement - Procedures Detailed Clinical Model

This chapter describes a reuse of version 1.2 of the *Exclusion Statement - Procedures Detailed Clinical Model* (DCM).

See [Medical History Detailed Clinical Model Specification \[NEHT2015i\]](#) for more information.

10.1 Purpose

To positively record the non-performance or exclusion of general groups of procedures (e.g. "never had a surgical procedure") or specific procedures ("no history of appendectomy") within the health record.

10.2 Use

Use to record the positive non-performance or exclusion of general groups of procedures (e.g. "never had a surgical procedure") or specific procedures ("no history of appendectomy") within the health record. This Detailed Clinical Model (DCM) avoids the need to use terminology to express negation about any item within the health record.

10.3 EXCLUSION STATEMENT - PROCEDURES

Identification


Label	EXCLUSION STATEMENT - PROCEDURES
Metadata Type	Data Group
Identifier	DG-16603
OID	1.2.36.1.2001.1001.101.102.16603

Definition








Definition	Statements to positively assert that a certain procedure has not been performed on the patient.
Definition Source	NEHTA
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Past and Current Medical History (MEDICAL HISTORY)	0..1

Children

Data Type	Name	Occurrences
	Global Statement	1..1
	No Previous History of	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Exclusion Statement – Procedures Instance Identifier	0..0
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

10.4 Global Statement

Identification

Label	Global Statement
Metadata Type	Data Element
Identifier	DE-16302
OID	1.2.36.1.2001.1001.101.103.16302

Definition


Definition	The statement about the absence or exclusion of procedure performed on the patient.
Definition Source	openEHR Foundation
Synonymous Names	
Context	This can be used to capture any information that is needed to be explicitly recorded within the record as being absent or excluded.
Context Source	openEHR Foundation
Data Type	CodedText
Value Domain	Global Statement Values

Usage

Conditions of Use	The value SHALL NOT be 02 ("Not asked").
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for CodedText .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROCEDURES	1..1

10.5 Global Statement Values

Identification

Label	Global Statement Values
Metadata Type	Value Domain
Identifier	VD-16299
OID	1.2.36.1.2001.1001.101.104.16299

Definition


Definition	The set of values for the statement about the absence or exclusion.
Definition Source	openEHR Foundation

Value Domain

Source	NEHTA
Permissible Values	01, None known No information about past procedures is known.
	02, Not asked No information about past procedures is available because the patient was not asked or not able to be asked.
	03, None supplied No information about past procedures is supplied.
	Please see Appendix B, Known Issues .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Global Statement	1..1

10.6 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16603

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROCEDURES	1..1

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11 Uncategorised Medical History Item Detailed Clinical Model

This chapter describes a reuse of version 2.0 of the *Uncategorised Medical History Item* Detailed Clinical Model (DCM).

See [Medical History Detailed Clinical Model Specification \[NEHT2015i\]](#) for more information.

11.1 Purpose

To record an entry in a medical history when it cannot be determined whether the entry is a *Procedure* or is a *Problem/Diagnosis*.

11.2 Use

Use to record an item that is known to be a Procedure or a Problem/Diagnosis but that cannot be explicitly categorised as one or the other. This covers cases where the source system cannot automatically classify an entry as a Problem/Diagnosis or a Procedure, including cases where:

- the coding system used for medical history item cannot structurally support adequate concept classification; and
- the medical history item is maintained as free text and thus has never been classified.

Since it is not known whether an *Uncategorised Medical History Item* entry is conceptually a procedure or a problem/diagnosis, exclusion statements cannot be used when an *Uncategorised Medical History Item* entry is present, as the entry may, in fact, be a procedure or a problem/diagnosis.

11.3 Misuse

Misuses of this DCM include:

- using it when the item is known to be neither a Procedure nor a Problem/Diagnosis; and
- using it when the item can be identified as either a Procedure or a Problem/Diagnosis.

11.4 UNCATEGORISED MEDICAL HISTORY ITEM

Identification

Label	UNCATEGORISED MEDICAL HISTORY ITEM
Metadata Type	Data Group
Identifier	DG-16627
OID	1.2.36.1.2001.1001.101.102.16627

Definition


Definition	A medical history entry that has not been categorised as either <i>Procedure</i> or <i>Problem/Diagnosis</i> .
Definition Source	NEHTA
Synonymous Names	
Scope	For exchanging medical history items from clinical information systems that do not separate procedure and problem/diagnosis data in their data store.
Scope Source	NEHTA
Assumptions	Every entry in a person's medical history is either a procedure or a problem/diagnosis.
Assumptions Source	NEHTA

Usage









Misuse	<p>Misuses of this data group include:</p> <ul style="list-style-type: none"> • using it when the item is known to be neither a <i>Procedure</i> nor <i>Problem/Diagnosis</i>; and • using it when the item can be identified as either a <i>Procedure</i> or <i>Problem/Diagnosis</i>.
---------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Past and Current Medical History (MEDICAL HISTORY)	0..*

Children

Data Type	Name	Occurrences
	Medical History Item Description	1..1
	Medical History Item TimeInterval	0..1
	Medical History Item Comment	0..1
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Uncategorised Medical History Item Instance Identifier	1..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

11.5 Medical History Item Description

Identification

Label	Medical History Item Description
Metadata Type	Data Element
Identifier	DE-16628
OID	1.2.36.1.2001.1001.101.103.16628

Definition


Definition	A description of the problem, diagnosis or procedure as a medical history item.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	1) Hypercholesterolaemia 2) Left total knee replacement 3) RLL pneumonia
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	1..1

11.6 Medical History Item TimeInterval

Identification

Label	Medical History Item TimeInterval
Metadata Type	Data Element
Identifier	DE-16629
OID	1.2.36.1.2001.1001.101.103.16629

Definition


Definition	The date range during which the problem or diagnosis applied or the procedure occurred.
Definition Source	NEHTA
Synonymous Names	
Data Type	TimeInterval

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for TimeInterval .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	0..1

11.7 Medical History Item Comment

Identification

Label	Medical History Item Comment
Metadata Type	Data Element
Identifier	DE-16630
OID	1.2.36.1.2001.1001.101.103.16630

Definition


Definition	Additional narrative about the problem, diagnosis or procedure.
Definition Source	NEHTA
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	0..1

11.8 Uncategorized Medical History Item Instance Identifier

Identification

Label	Uncategorised Medical History Item Instance Identifier
Metadata Type	Data Element
Identifier	DE-16479
OID	1.2.36.1.2001.1001.101.103.16479

Definition


Definition	A globally unique identifier for each instance of an Uncategorized Medical History Item evaluation.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	1..1

11.9 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16627

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	1..1

12 Administered Immunisation

Detailed Clinical Model

This chapter describes a reuse of version 4.1 of the *Medication Action* Detailed Clinical Model (DCM).

See [Medication Instruction and Action Detailed Clinical Model Specification \[NEHT2015h\]](#) for more information.

12.1 Purpose

To record activities undertaken with regard to a medicine, vaccine or other therapeutic good, and link to the instruction if appropriate.

12.2 Use

Use to record the planning, issuing of a prescription, dispensing, administration, cessation, suspension, completion of a medicine, vaccine or other therapeutic good. This will usually be in response to a medication order but may be administered immediately without an order at times, thus requiring recording of the administration alone (e.g. in an emergency). Such a record may be made to indicate the administration of a dose, dispensing of a certain quantity or as a record of ceasing a medication. The state of the medication instruction is altered by the action taken, as indicated in the pathway definition.

There is a date and time at which this action took place (as there is for all actions) and use of this DCM indicates that some action has actually occurred.

12.3 Misuse

Not to be used for recording an instruction or order (use *Medication Instruction* DCM).

12.4 MEDICATION ACTION

Identification


Label	Administered Immunisation
Metadata Type	Data Group
Identifier	DG-16210
OID	1.2.36.1.2001.1001.101.102.16210

Definition








Definition	The act of administering a dose of a vaccine to a person for the purpose of preventing or minimising the effects of a disease by producing immunity or to counter the effects of an infectious organism.
Definition Source	NEHTA
Synonymous Names	Medication Item
Scope	It is specifically used for the vaccine administration record and is intended to enable recording of the vaccine administered to the subject of care.
Scope Source	NEHTA






















Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Therapeutic Good Identification	1..1
	Additional Therapeutic Good Detail	0..0
	Medication Action Instructions	0..0
	Formula	0..0
	Ingredients and Form (CHEMICAL DESCRIPTION OF MEDICATION)	0..0
	Reason for Action	0..0
	Quantity of Medication (AMOUNT OF MEDICATION)	0..0

Data Type	Name	Occurrences
	Medication Action Comment	0..0
	Vaccine Sequence Number (Sequence Number)	0..1
	Administration (MEDICATION ADMINISTRATION)	0..0
	Brand Substitution Occurred	0..0
	Batch Identifier	0..0
	Expiry Date	0..0
	DISPENSED TO	0..0
	Number of this Dispense	0..0
	Maximum Number of Repeats	0..0
	Claim Category	0..0
	Administrative Item Code	0..0
	Administrative Manufacturer Code	0..0
  	Administrative System Identifier	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Medication Action DateTime	1..1
	Medication Action Instance Identifier	1..1
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

12.5 Therapeutic Good Identification

Identification

Label	Therapeutic Good Identification
Metadata Type	Data Element
Identifier	DE-10194
OID	1.2.36.1.2001.1001.101.103.10194

Definition

Definition	The vaccine that was administered to or used by the subject of care.
Definition Source	NEHTA
Synonymous Names	Item Name
Notes	<p>Identifies a therapeutic good, which is broadly defined as a good which is represented in any way to be, or is likely to be taken to be, for therapeutic use (unless specifically excluded or included under Section 7 of the <i>Therapeutic Goods Act 1989</i>).</p> <p>Therapeutic use means use in or in connection with:</p> <ul style="list-style-type: none"> • preventing, diagnosing, curing or alleviating a disease, ailment, defect or injury; or • influencing, inhibiting or modifying a physiological process; or • testing the susceptibility of persons to a disease or ailment; or • influencing, controlling or preventing conception; or • testing for pregnancy; or • replacement or modification of parts of the anatomy. <p>From the <i>Therapeutic Goods Act 1989</i> [TGA1989a].</p> <p>The formal definition of a therapeutic good is given in Section 3 of the <i>Therapeutic Goods Act 1989</i>.</p>
Data Type	CodeableText
Value Domain	Medicines Terminology


Usage

Conditions of Use	<p>Where the therapeutic good can be identified by an Australian Medicines Terminology (AMT) concept, the value of this data element SHALL be the AMT ConceptID and Preferred Term. For details see Medicines Terminology.</p> <p>For items without an AMT code (including some extemporaneous preparations), a text description is suitable. For a medication, this SHALL include the name of the medication (brand name or generic name equivalent), the strength and, where appropriate, the dose form.</p>
Conditions of Use Source	NEHTA

Examples	<p>Some examples of AMT ConceptIDs and their AMT Preferred Terms are:</p> <ol style="list-style-type: none"> 1) 73810011000036102 <i>Polio Sabin Multidose oral liquid: solution, 1 vial</i> 2) 73802011000036101 <i>Twinrix injection: suspension, 1 mL syringe</i> 3) 923052011000036100 <i>Prevenar-13 30.8 microgram/0.5 mL injection: suspension, 0.5 mL syringe</i>
Misuse	Detailing the formula of a compounded (extemporaneous) medication.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Administered Immunisation (MEDICATION ACTION)	1..1

12.6 Medicines Terminology

Identification

Label	Medicines Terminology
Metadata Type	Value Domain
Identifier	VD-16115
OID	1.2.36.1.2001.1001.101.104.16115

Definition


Definition	A set of values used to refer to medicines and other therapeutic goods.
Definition Source	NEHTA
Notes	An explanation of AMT concepts can be found in Australian Medicines Terminology v3 Model - Editorial Rules v2.0 [NEHT2014ag] .

Value Domain

Source	Australian Medicines Terminology
Permissible Values	<p>The permissible values are the members of the following seven AMT reference sets:</p> <ul style="list-style-type: none"> 929360061000036106 <i>Medicinal product reference set</i> 929360081000036101 <i>Medicinal product pack reference set</i> 929360071000036103 <i>Medicinal product unit of use reference set</i> 929360021000036102 <i>Trade product reference set</i> 929360041000036105 <i>Trade product pack reference set</i> 929360031000036100 <i>Trade product unit of use reference set</i> 929360051000036108 <i>Containerized trade product pack reference set</i>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Therapeutic Good Identification	1..1

12.7 Sequence Number

Identification

Label	Vaccine Sequence Number
Metadata Type	Data Element
Identifier	DE-16424
OID	1.2.36.1.2001.1001.101.103.16424

Definition


Definition	The sequence number specific to the action being recorded.
Definition Source	NEHTA
Synonymous Names	
Notes	Used to specify the sequence number of the vaccine that has been administered or reported to be administered.
Data Type	Integer

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for Integer .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Administered Immunisation (MEDICATION ACTION)	0..1

12.8 Medication Action DateTime

Identification

Label	Medication Action DateTime
Metadata Type	Data Element
Identifier	DE-16591
OID	1.2.36.1.2001.1001.101.103.16591

Definition


Definition	Date, and optionally time, that the medication action is completed.
Definition Source	NEHTA
Synonymous Names	
Data Type	DateTime

Usage

Examples	Please see DateTime in Appendix C, Specification Guide for Use for examples and usage information on specifying a date or time (or both).
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Administered Immunisation (MEDICATION ACTION)	1..1

12.9 Medication Action Instance Identifier

Identification

Label	Medication Action Instance Identifier
Metadata Type	Data Element
Identifier	DE-16637
OID	1.2.36.1.2001.1001.101.103.16637

Definition


Definition	A globally unique identifier for each instance of <i>Medication Action</i> action.
Definition Source	NEHTA
Synonymous Names	
Notes	This <code>data element</code> is intended for machine or system use only and hence need not be displayed on documents.
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Administered Immunisation (MEDICATION ACTION)	1..1

12.10 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16210

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Administered Immunisation (MEDICATION ACTION)	1..1

13 Exclusion Statement - Immunisations Detailed Clinical Model

This chapter describes a reuse of version 1.3 of the *Exclusion Statement - Medications* Detailed Clinical Model (DCM).

See [Medication Instruction and Action Detailed Clinical Model Specification \[NEHT2015h\]](#) for more information.

13.1 Purpose

To positively record the absence or exclusion of any medication use within the health record.

13.2 Use

Use to record the positive exclusion or absence of medication use within the health record. This Detailed Clinical Model (DCM) avoids the need to use terminology to express negation about any item within the health record.

This DCM is only to be used to record 'point in time' or event-based information. It is not to be used for a persistent storage of information as the patient should always be questioned about current or past medication use prior to initiation of any treatment or management plan.

13.3 EXCLUSION STATEMENT - MEDICATIONS

Identification

Label	Exclusion Statement - Immunisations
Metadata Type	Data Group
Identifier	DG-16136
OID	1.2.36.1.2001.1001.101.102.16136

Definition


Definition	Statements that positively assert that the patient has not received immunisations.
Definition Source	openEHR Foundation
Synonymous Names	
Scope	To positively record the absence or exclusion of any vaccine administration within the health record.
Scope Source	openEHR Foundation
Notes	This Detailed Clinical Model (DCM) avoids the need to use terminology to express negation about any item within the health record. It is important to note that exclusion statement information is time-specific. Its validity may not extend beyond the point in time that information is recorded. The patient should always be asked to verify previous statements on any exclusion statement about medications.

Usage


Conditions of Use	Use to record the positive exclusion or absence of medication use within the health record.
Conditions of Use Source	NEHTA








Relationships

Parents

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

Children

Data Type	Name	Occurrences
	Global Statement	1..1

Data Type	Name	Occurrences
	Not Currently Taking	0..0
	Not Ever Taken	0..0
	INFORMATION PROVIDER	0..0
	SUBJECT	0..0
	Exclusion Statement – Medications Instance Identifier	0..0
	RELATED INFORMATION	0..0
	Detailed Clinical Model Identifier	1..1

13.4 Global Statement

Identification

Label	Global Statement
Metadata Type	Data Element
Identifier	DE-16302
OID	1.2.36.1.2001.1001.101.103.16302

Definition


Definition	The statement about the absence or exclusion of certain medication.
Definition Source	openEHR Foundation
Synonymous Names	
Context	This can be used to capture any information that is needed to be explicitly recorded within the record as being absent or excluded.
Context Source	openEHR Foundation
Data Type	CodedText
Value Domain	Global Statement Values

Usage

Conditions of Use	The value SHALL NOT be 02 ("Not asked").
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for CodedText .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS)	1..1

13.5 Global Statement Values

Identification

Label	Global Statement Values
Metadata Type	Value Domain
Identifier	VD-16299
OID	1.2.36.1.2001.1001.101.104.16299

Definition


Definition	The set of values for the statement about the absence or exclusion.
Definition Source	openEHR Foundation

Value Domain

Source	NEHTA						
Permissible Values	<table><tr><td>01, None known</td><td>No information about taking any medication is known.</td></tr><tr><td>02, Not asked</td><td>No information about taking any medication is available because the patient was not asked or not able to be asked.</td></tr><tr><td>03, None supplied</td><td>No information about taking any medication is supplied.</td></tr></table>	01, None known	No information about taking any medication is known.	02, Not asked	No information about taking any medication is available because the patient was not asked or not able to be asked.	03, None supplied	No information about taking any medication is supplied.
01, None known	No information about taking any medication is known.						
02, Not asked	No information about taking any medication is available because the patient was not asked or not able to be asked.						
03, None supplied	No information about taking any medication is supplied.						
	Please see Appendix B, Known Issues .						

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Global Statement	1..1

13.6 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this Detailed Clinical Model.
Definition Source	NEHTA
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	NEHTA
Examples	Please see Appendix C, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16136

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Exclusion Statement - Immunisations (EXCLUSION STATEMENT - MEDICATIONS)	1..1

14 UML Class Diagrams

The following figures represent the data hierarchy using UML 2.0 class diagrams. The diagrams display data groups, sections, structured documents and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes; data groups, sections and structured documents are displayed as classes; their label names are represented as association role names. Association role names are only displayed if they differ from the associated class name. When a data element has a choice of data types, the data type of the attribute that represents it is an abstract interface class generalised from the individual data types. The diagrams show the data hierarchy excluding the details of participation. The default multiplicity is 1..1.

If a data element's label differs from its name, the label is the attribute name and the name is a stereotype of the attribute. If a data group's or section's label differs from its name, the label is the class name and the name is a stereotype of the class.

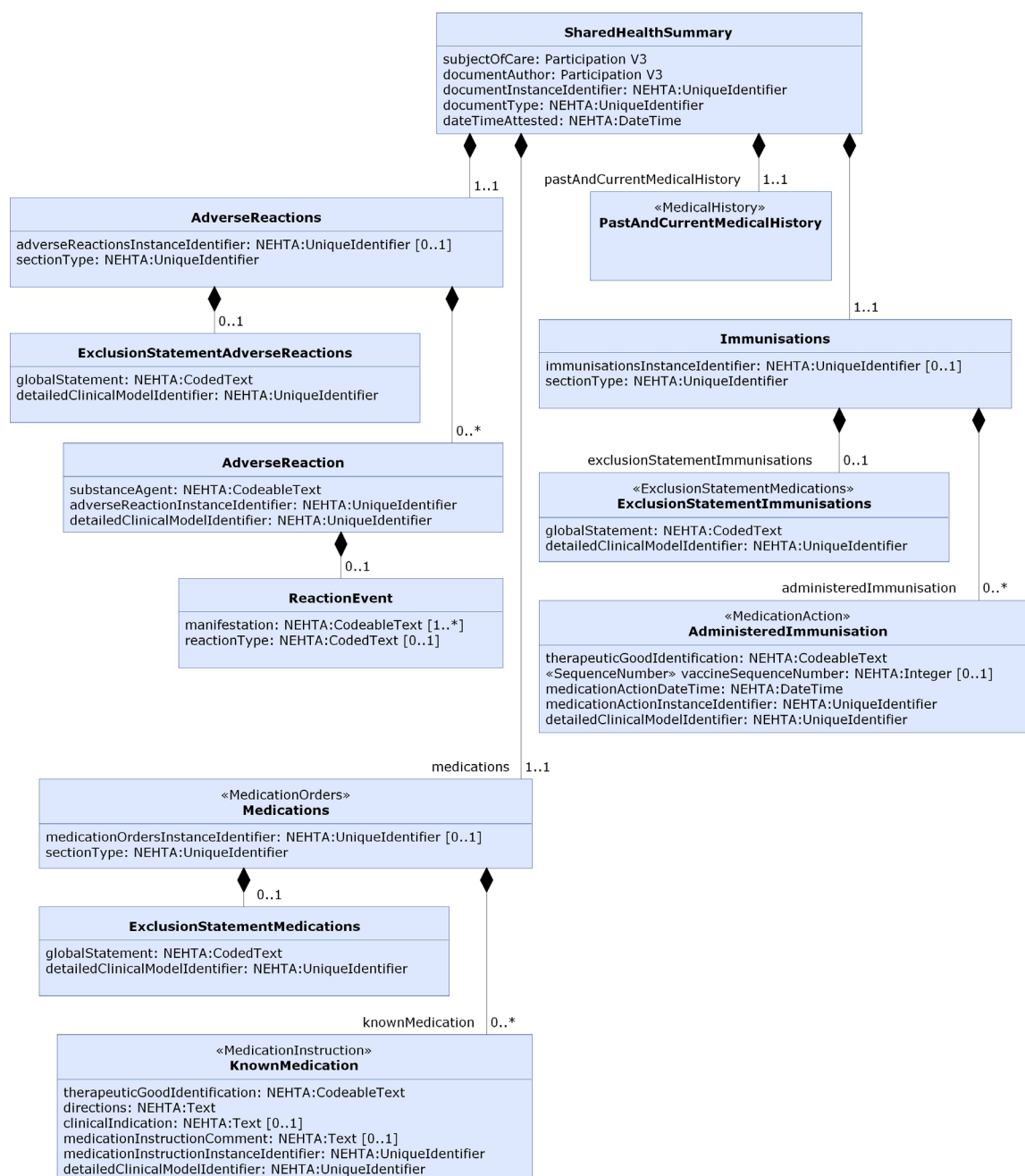


Figure 14.1. Shared Health Summary

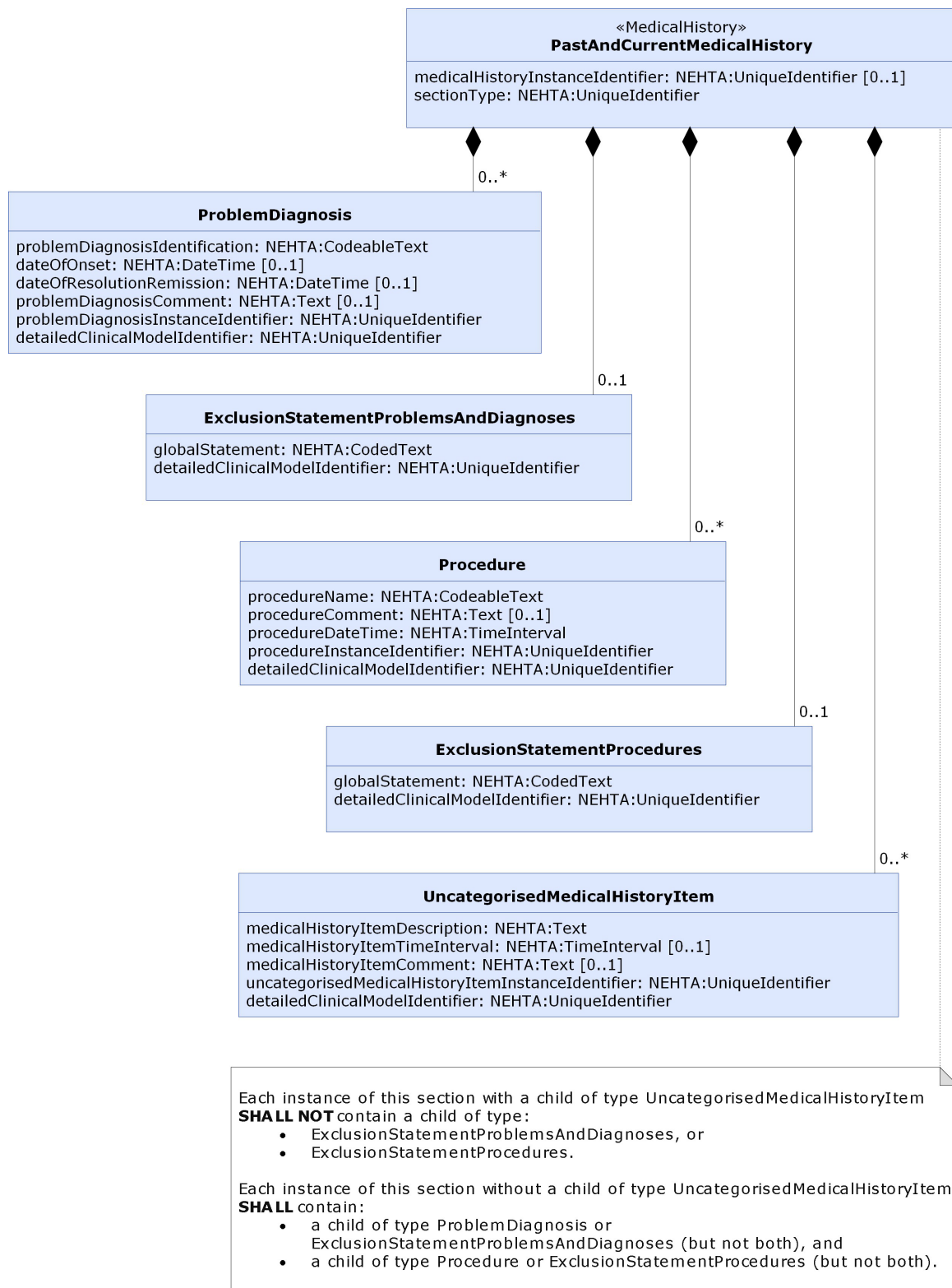


Figure 14.2. Past and Current Medical History

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Appendix A. Mappings from Requirements

This appendix lists data elements from the [NEHTA Shared Health Summary Information Requirements \[NEHT2015e\]](#) document and matches them to their associated data elements in this Structured Content Specification (SCS) augmented with [NEHTA Participation Data Specification \[NEHT2011v\]](#).

Data components are identified by their label, e.g. *Known Medication*, rather than by their name, e.g. *Medication Instruction*.

The mappings table below includes links to the SCS data elements that are described in this document.

Some cells in the mapping table are empty. This is used to indicate that the cell has the same value as the cell immediately above it.

Requirement Section	Data Item	Req No.	SCS Data Element
Individual	N/A	N/A	Subject of Care [SOC] [SOC] > Participant > Person or Organisation or Device > Person [SOC > P > POD > P]
Individual (Core)	N/A	N/A	N/A
	Individual Healthcare Identifier (mandatory)	022082	[SOC] > Participant > Entity Identifier
	Individual's Title (optional)	022081	[SOC > P > POD > P] > Person Name > Name Title
	Individual's Given Name (optional)	023056	[SOC > P > POD > P] > Person Name > Given Name
	Individual's family name (mandatory)	023058	[SOC > P > POD > P] > Person Name > Family Name
	Individual's Name Suffix (optional)	023059	[SOC > P > POD > P] > Person Name > Name Suffix
	Individual's Sex (mandatory)	024032	[SOC > P > POD > P] > Demographic Data > Sex
	Individual's Date of Birth (mandatory)	023060	[SOC > P > POD > P] > Demographic Data > Date of Birth Detail > Date of Birth
	Date of Birth accuracy indicator (optional)	024026	[SOC > P > POD > P] > Demographic Data > Date of Birth Detail > Date of Birth Accuracy Indicator
Individual (extension)	N/A	N/A	N/A
	Individual's Address (mandatory)	024041	[SOC] > Participant > Address
	Individual's Electronic Communication Details (optional)	024042	[SOC] > Participant > Electronic Communication Detail

Requirement Section	Data Item	Req No.	SCS Data Element
	Indigenous Status (mandatory)	024033	[SOC > P > POD > P] > Demographic Data > Indigenous Status
Shared health summary author	N/A	N/A	Document Author [DA] [DA] > Participant > Person or Organisation or Device > Person [DA > P > POD > P]
	Healthcare Provider Professional Role (mandatory)	024040	[DA] > Role
	Healthcare provider organisation name (mandatory)	023070	[DA > P > POD > P] > Employment Detail > Employer Organisation > Person or Organisation or Device > Organisation > Organisation Name
	Healthcare Provider Employer Organisation Address	025064	[DA > P > POD > P] > Employment Detail > Employer Organisation > Address
	Healthcare Provider Employer Organisation Electronic Communication Detail	025063	[DA > P > POD > P] > Employment Detail > Employer Organisation > Electronic Communication Detail
PCEHR participating Healthcare Provider (core)	N/A	N/A	N/A
	Healthcare Provider Identifier-Individual (mandatory)	023066	[DA] > Participant > Entity Identifier
	Healthcare Provider Identifier-Organisation (mandatory)	023071	[DA > P > POD > P] > Employment Detail > Employer Organisation > Entity Identifier
	Healthcare Provider's Title (optional)	023061	[DA > P > POD > P] > Person Name > Name Title
	Healthcare Provider Given Name (optional)	023062	[DA > P > POD > P] > Person Name > Given Name
	Healthcare Provider Family Name (mandatory)	023064	[DA > P > POD > P] > Person Name > Family Name
	Healthcare provider name suffix (optional)	023065	[DA > P > POD > P] > Person Name > Name Suffix
Healthcare Provider (extension)	N/A	N/A	N/A

Requirement Section	Data Item	Req No.	SCS Data Element
	Healthcare Provider Individual's Workplace Address (optional)	024035	[DA] > Participant > Address
	Healthcare Provider Individual's Workplace Electronic Communication Details (optional)	024036	[DA] > Participant > Electronic Communication Detail
Allergies and adverse reactions	N/A	N/A	Adverse Reactions [AR]
	Component	022870	[AR]
		024962	[AR] > Exclusion Statement - Adverse Reactions > Global Statement
	Agent Description	022871	[AR] > Adverse Reaction > Substance/Agent
		023235	
	Reaction Type	024963	[AR] > Adverse Reaction > Reaction Event > Reaction Type
		024964	
	Reaction Description	023239	[AR] > Adverse Reaction > Reaction Event > Manifestation
		022887	
		023240	
		023241	
Medicines	N/A	N/A	Medications [M]
	Component	022746	[M]
		024965	[M] > Exclusion Statement - Medications > Global Statement
	Item Description	023242	[M] > Known Medication > Therapeutic Good Identification
		023243	
		023244	
	Dose Instructions	023245	[M] > Known Medication > Directions
	Reason for Medicine	023246	[M] > Known Medication > Clinical Indication
		023247	
	Additional comments	023248	[M] > Known Medication > Medication Instruction Comment
		023249	
Current and past medical history	N/A	N/A	Past and Current Medical History [PCMH]
	Component	023250	[PCMH]
		023251	

Requirement Section	Data Item	Req No.	SCS Data Element
		024966	[PCMH] > Exclusion Statement - Problems and Diagnoses > Global Statement [PCMH] > Exclusion Statement - Procedures > Global Statement
	Medical History Description	023252	[PCMH] > Problem/Diagnosis > Problem/Diagnosis Identification [PCMH] > Procedure > Procedure Name [PCMH] > Uncategorized Medical History Item > Medical History Item Description
		023253	
		023236	
	Medical History DateTime Range	024947	[PCMH] > Problem/Diagnosis > Date of Onset [PCMH] > Procedure > Procedure DateTime [PCMH] > Uncategorized Medical History Item > Medical History Item TimeInterval
		024948	[PCMH] > Problem/Diagnosis > Date of Resolution/Remission [PCMH] > Procedure > Procedure DateTime [PCMH] > Uncategorized Medical History Item > Medical History Item TimeInterval
		024949	<i>All DateTime data elements allow partial dates, unless explicitly prohibited.</i>
		024991	[PCMH] > Problem/Diagnosis > Date of Onset [PCMH] > Problem/Diagnosis > Date of Resolution/Remission
	Medical History comments	024950	[PCMH] > Problem/Diagnosis > Problem/Diagnosis Comment [PCMH] > Procedure > Procedure Comment [PCMH] > Uncategorized Medical History Item > Medical History Item Comment
Immunisations	N/A	N/A	Immunisations [I]
	Component	023254	[I]
		024924	
		024967	[I] > Exclusion Statement - Immunisations
	Vaccine Name	024925	[I] > Administered Immunisation > Therapeutic Good Identification
		024926	
		024927	
	DateTime Administration	024928	[I] > Administered Immunisation > Medication Action DateTime
		024929	
	Sequence Number	024930	[I] > Administered Immunisation > Vaccine Sequence Number (Sequence Number)
		024931	

Requirement Section	Data Item	Req No.	SCS Data Element
Document control	N/A	N/A	N/A
	Date/Time Attested (mandatory)	024038	DateTime Attested

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Appendix B. Known Issues

This appendix lists known issues with this specification at the time of publishing. NEHTA is working on solutions to these issues, and we encourage comments to further assist with the development of these solutions.

Reference	Description
Links to external resources	If a link (usually in references section) spans across several lines, certain PDF readers have problems opening it.
Procedure DateTime	In the previous version of the SCS the data element Start Date/Time (DateTime Started) was used to capture the date and time the procedure ended. The new data element is suitable for that. There is no change to the implementation in HL7® CDA®.
Exclusion Statement detailed clinical models	<p>The Exclusion Statement detailed clinical models:</p> <ul style="list-style-type: none"> • EXCLUSION STATEMENT - ADVERSE REACTIONS • EXCLUSION STATEMENT - MEDICATIONS • EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES • EXCLUSION STATEMENT - PROCEDURES • EXCLUSION STATEMENT - MEDICATIONS <p>are the subject of on-going development and review. They will change in the future.</p> <p>This includes the values of <i>Global Statement Values</i>.</p>
Medicines Terminology	The described use of TPUU for administration of therapeutic goods does not work for vaccines where two or more components need to be combined prior to administration.
PROBLEM/DIAGNOSIS	The requirements for the PROBLEM/DIAGNOSIS data group do not distinguish between a clinical description of the problem/diagnosis and a comment on the problem/diagnosis. An issue has been raised as to whether this SCS should include PROBLEM/DIAGNOSIS.Clinical Description as well as or instead of the Problem/Diagnosis Comment data element.
DateTime Attested	Many other documents do not have this data element, they record the date and time authored. The definition and exact intent of this data element need clarification.
UML Class Diagrams	The representation of data component names and labels with stereotypes and names is not good UML practice. It will be changed when a diagramming tool that supports an appropriate representation is adopted by NEHTA.
Date of Onset Date of Resolution/Remission	It is possible that Date of Onset and Date of Resolution/Remission should be considered as the start and end of a period. Resolution depends upon whether a recurrent problem should be recorded as a single Problem/Diagnosis, or as a series of them.

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Appendix C. Specification Guide for Use

C.1 Overview

Each Detailed Clinical Model (DCM) and Structured Content Specification (SCS) is designed to be a shared basis for data interpretation. It specifies rigorous business and technical definitions of data which systems may need to share. It is intended to be a logical specification of the data to be persisted within or communicated between systems. It is also the foundation for conformance, compliance and accreditation testing of implemented systems. NEHTA's CDA[®] implementation guides are guides to the implementation of HL7[®] CDA[®] R2 messages based upon these DCMs and SCSs.

Each DCM specifies all of the data components required for any use of a clinical concept, for instance an entry in a medical record such as a procedure or an imaging test. As such, they are maximal data sets. DCMs are building blocks which are trimmed to size for use in the construction of SCSs.

Each SCS specifies the data for a single type of clinical document or information exchange, such as a discharge summary. It is assembled using DCMs that have been constrained to eliminate data components not relevant to the particular context. For example, *Procedure* in a discharge summary uses only some of the data components required by *Procedure* in a specialist report.

C.2 The Structured Content Specification Metamodel

The NEHTA Structured Content Specification Metamodel (see Figure 1) is used to specify the overall structure of a Structured Content Specification.

A DCM can be regarded as a data group with no parent.

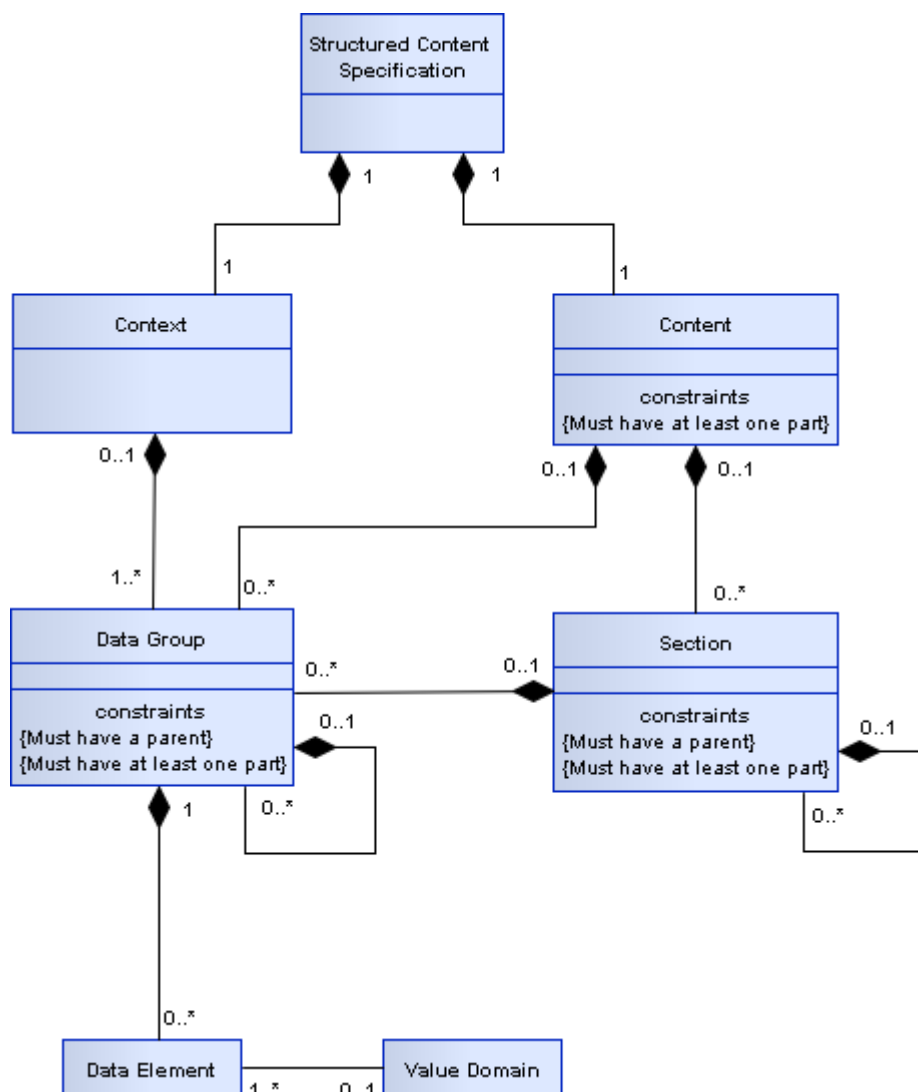


Figure 1: SCS Metamodel

There are two main components used to organise information within an SCS as follows:

Context: This contains information related to the overall context of the document.

Content: This contains information that changes between different SCSs, but is always structured as shown, and consists of the following components:

- Section
- Data Group
- Data Element
- Value Domain

These components are described in more detail below.

Context

The purpose of the context is to identify and classify the document and to provide subjects of care and involved healthcare providers with the information related to the relevant healthcare events.

Content

Content contains a collection of personal information and health information pertinent to a subject of care which is derived from the healthcare event described in the document. The detail is organised into one or more data groups which are optionally grouped into sections.

Section

A section is composed of other sections, data groups, or both. It is an organising container that gives the reader a clue as to the expected content. The primary purpose of a section is to organise information in a manner that is suitable for the primary purpose for which it is collected, and to provide a way to navigate through the data components within the document, thereby enabling more efficient querying. It is recommended that the section support safe reuse for secondary purposes, e.g. clinical coding or inclusion in a summarised form in an electronic health record. A section is context-specific to the document in which it resides.

Data Group

Each data group is used to represent one concept. A data group consists of other data groups or data elements (or both). Some data groups are reused across DCMs.

Every instance of a data group **SHALL** have at least one child data component instantiated.

Participation

Participation is a special case of a data group that is based on a data group template, which is reused throughout the DCMs and SCSs. Participations are an amalgam of the Actors (see below) operating within a defined healthcare domain and the Roles they are playing within that domain.

A Participant has been defined to align with the concepts of the NEHTA interoperability framework [\[NEHT2007b\]](#). It equates to an *Entity* that is related to the action described in an SCS as an *Actor*. A Participant can be a human, an organisation or an IT system.

[\[NEHT2011v\]](#) defines the full Participation specification.

Choice

Choice represents a decision to be made at run-time between a disjunctive mandatory set of data groups defined at design-time, i.e. one and only one member of the set is chosen for each instance of the choice.

For example, at design-time a Healthcare Provider provides a service but it is not until run-time that a decision can be made as to whether the provider is a person or an organisation. Hence when a Healthcare Provider Participant is instantiated, it will contain either an instance of the *Person* data group or an instance of the *Organisation* data group.

Data Element

A data element is the smallest named unit of information in the model that can be assigned a value. For example, *DateTime of Observation* and *Observation Note*. Data elements are bound to data types (see [Data Types Legend](#)). Some data elements are reused in different data groups.

While all data elements are constrained by their data type, some data elements are further constrained by value domains (see [Value Domain](#) below).

Value Domain

A value domain constrains the permissible values for a data element. The values are often a subset of values based on a generic data type.

Value domains are reusable components and therefore, the same value domain can be referred to by different data elements in different contexts. Value domains are often specified as a reference set. A reference set (or a subset) is a constrained list of SNOMED CT-AU, AMT or LOINC concepts that are appropriate to a particular context. It is noted that many of these reference sets have been developed specifically for the context in which they appear. It is recommended that an assessment of fitness for purpose be undertaken before using any of the reference sets in another context.

Value domains constrain by either specifying a lower or upper bound (or both) on the range of permissible values or else by specifying a finite set of prescribed values. Such a set of prescribed values can be specified directly within the definition of the data element, or in a separate but associated specification or else by reference to one or more vocabulary/terminology reference sets. The table below provides some examples of value domains.

Table 1: Value Domain Examples

Data Element	Data Type	Example of Value Domain										
Sex	CodedText	<p>[SA2006a] and [SA2006b] derive their values from METeOR 287316 which includes values such as:</p> <table><tr><th>Value</th><th>Meaning</th></tr><tr><td>1</td><td>Male</td></tr><tr><td>2</td><td>Female</td></tr><tr><td>3</td><td>Intersex or Indeterminate</td></tr><tr><td>9</td><td>Not Stated/Inadequately Described</td></tr></table>	Value	Meaning	1	Male	2	Female	3	Intersex or Indeterminate	9	Not Stated/Inadequately Described
Value	Meaning											
1	Male											
2	Female											
3	Intersex or Indeterminate											
9	Not Stated/Inadequately Described											
Diagnosis	CodeableText	A SNOMED CT-AU reference set which references concepts such as “Bronchitis” (Concept ID: 32398004).										
Therapeutic Good Identification	CodeableText	An AMT reference set which references concepts such as “Ibuprofen Blue (Herron) (ibuprofen 200 mg) tablet: film-coated, 1 tablet” (Concept ID: 54363011000036107).										
Individual Pathology Test Result Name	CodeableText	A LOINC subset which references concepts such as “Cholesterol [Moles/volume] in Serum or Plasma” (ID: 14647-2).										


C.3 Icon Legend




These legends describe all icons that are used within the various NEHTA information specifications.

Metadata Types Legend

The following table explains each of the icons used to represent the metadata types within DCMs and SCSs.

Table 2: Metadata Types Legend




Icon	Metadata Types
	Structured Document

	Section
	Data Group
	Participation
	Choice

Data Types Legend

The following table explains each of the icons used to represent the data types bound to each data element in the SCSs. These data types are a profile of the **ISO 21090-2011** data types as specified in [\[NEHT2010c\]](#).

Table 3: Data Types Legend

Icon	Data type	Explanation
	Boolean (ISO 21090: BL)	<p>A primitive data type, sometimes called the logical data type, having one of two values: <i>true</i> and <i>false</i>. Many systems represent true as <i>non-zero</i> (often 1, or -1) and false as <i>zero</i>.</p> <p>Usage/Examples</p> <ul style="list-style-type: none"> An actual value entered by a user might be “yes” or could be chosen by a mouse click on an icon such as .
	CodeableText (ISO 21090: CD)	<p>Coded text <i>with</i> exceptions; a flexible data type to support various ways of holding text, both free text and coded text. Commonly used to support compliance for early adopters of the Structured Content Specifications. While it is recommended that the values in this data type come from the bound value domain, it allows other value domains to also be used (with or without translations to the bound value domain) or free text alternatives. This is in recognition that it may not be possible to define an entire value domain for a complex concept (e.g. <i>Diagnosis</i>) or that there may be competing code sets in existence. Note that within exchange specifications or message profiles this data type MAY be constrained to mandate compliance with the bound value domain.</p> <p>Usage/Examples</p> <ul style="list-style-type: none"> AIHW Separation Mode specifies the status at separation of a person from an organisation. An early adopter MAY have a similar concept (coded or otherwise) that maps to this data element but does not strictly comply with the AIHW values. A SNOMED CT-AU coded/complex expression that embodies single or multiple concepts. The SNOMED CT-AU concepts behind these CodeableText components are specified in the Structured Content Specification value domains.



CodedText
(ISO 21090: CD)

Coded text *without* exceptions; text with code mappings. Values in this data type **SHALL** come from the bound value domain, with no exceptions. Often used for reference sets with only a small number of applicable values, e.g. Gender and Document Status.

Usage/Examples

[SA2006b] specifies the following value domain representing a type of address:

Value	Meaning
1	Business
2	Mailing or Postal
3	Temporary Accommodation
4	Residential (permanent)
9	Not Stated/Unknown/Inadequately Described



DateTime
(ISO 21090: TS)

Used for specifying a single date or time (or both). Has the ability to indicate a level of precision, but not whether the date or time is estimated. String representations of known dates **SHALL** conform to the nonextended format within the **ISO 21090-2011** standard, i.e. YYYY[MM[DD[HH[MM[SS[.U[U[U[U]]]]]]]]][+|-ZZzz].

Usage/Examples

- Partial dates: 2008, 20081001.
- To indicate 1:20 pm on May the 31st, 1999 for a time zone which is 5 hours behind Coordinated Universal Time (UTC): 19990531132000-0500.



Duration
(ISO 21090: PQ.TIME)

The period of time during which something continues. Consists of a value and a unit which represents the time value, e.g. hours, months. Compound durations are not allowed, e.g. 10 days 3 weeks 5 hours.

Usage/Examples

- 3 hours
- 6 months
- 1 year



Any
(ISO 21090: ANY)

Represents a data element where the data type to be used is conditional on another data component. The values that can be required will vary considerably depending on the context. Note that this is an abstract data type that is the basis for all data types and **SHOULD NOT** be used in an actual implementation.






EncapsulatedData
(ISO 21090: ED)

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).

Usage/Examples

- JPEG images
- HTML documents
- [RFC1521] MIME types

	Integer (ISO 21090: INT)	The mathematical data type comprising the exact integral values (according to [NEHT2010c]). Usage/Examples <ul style="list-style-type: none">• 1• -50• 125
	Link (ISO 21090: TEL)	This is a general link, reference or pointer to an object, data or application that exists logically or is stored electronically in a computer system. Usage/Examples <ul style="list-style-type: none">• URL (Uniform Resource Locator) – the World Wide Web address of a site on the internet, such as the URL for the Google internet search engine – <i>http://www.google.com</i>.• An absolute or relative path within a file or directory structure – e.g. in the Windows® operating system, the “link” or absolute path to a particular letter could be <i>C:\Documents and Settings\GuestUser\MyDocuments\letter.doc</i>
	Quantity (ISO 21090: PQ)	Used for recording many real world measurements and observations. Includes the magnitude value and the units. Usage/Examples <ul style="list-style-type: none">• 100 centimetres• 25.5 grams
	QuantityRatio (ISO 21090: RTO)	The relative magnitudes of two <i>Quantity</i> values (usually expressed as a quotient). Usage/Examples <ul style="list-style-type: none">• 25 mg/500 ml• 200 mmol per litre
	QuantityRange (ISO 21090: IVL)	Two <i>Quantity</i> 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. Usage/Examples <ul style="list-style-type: none">• -20 to 100 Celsius• 30-50 mg• >10 kg

	Real (ISO 21090: REAL)	<p>A computational approximation to the standard mathematical concept of real numbers. These are often called floating-point numbers.</p> <p>Usage/Examples</p> <ul style="list-style-type: none">• 1.075• -325.1• 3.14157
	Text (ISO 21090: ST)	<p>Character strings (with optional language). Unless otherwise constrained by an implementation, can be any combination of alpha, numeric or symbols from the Unicode character set. This is sometimes referred to as free text.</p> <p>Usage/Examples</p> <p>“The patient is a 37 year old man who was referred for cardiac evaluation after complaining of occasional palpitations, racing heart beats and occasional dizziness.”</p>
	TimeInterval (ISO 21090: TS)	<p>An interval in time, with (optionally) a start date/time and (optionally) an end date/time and/or a duration/width.</p> <p>Usage/Examples</p> <ul style="list-style-type: none">• 01/01/2008 – 31/12/2008• 1:30 a.m. – 6:00 p.m., duration/width = 16.5 hours



UniquelIdentifier (ISO 21090: II)

A general unique value to identify a physical or virtual object or concept.

In using this data type, the attributes of the UniquelIdentifier data type **SHOULD** be populated from the identifiers as defined in AS 4846 (2006) [SA2006a] and AS 5017 (2006) [SA2006b] as follows:

- *root*: a globally unique object identifier that identifies the combination of geographic area, issuer and type. If no such globally unique object identifier exists, it **SHALL** be created.
- *extension*: a unique identifier within the scope of the root that is directly equivalent to the identifier designation element.
- *identifierName*: a human readable name for the namespace represented by the root that is populated with the issuer or identifier type values, or a concatenation of both, as appropriate. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used for that purpose.
- *identifierScope*: the geographic span or coverage that applies to or constrains the identifier. It is directly equivalent to the geographic area element. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used as such.

Also, the following constraints apply on the UniquelIdentifier data type:

- 1) The *root* attribute **SHALL** be used.
- 2) For an entity identifier, the *root* attribute **SHALL** be an OID that consists of a node in a hierarchically-assigned namespace, formally defined using the ITU-T's ASN.1 standard.
- 3) For an entity identifier, the *root* attribute **SHALL NOT** be a UUID.
- 4) The *extension* attribute **SHALL** be used.

Usage/Examples

IHIs, HPI-Is, HPI-Os and patient hospital medical record numbers are examples of identifiers that **MAY** be carried by this data type.

Keywords Legend

Where used in this document and in DCMs and SCSs, the keywords **SHALL**, **SHOULD**, **MAY**, **SHALL NOT** and **SHOULD NOT** are to be interpreted as described in [RFC2119].

The following table defines these keywords.

Table 4: Keywords Legend

Keyword	Interpretation
SHALL	This word, or the term “required”, means that the statement is an absolute requirement of the specification.
SHOULD	This word, or the adjective “recommended”, means that there MAY exist valid reasons in particular circumstances to ignore a particular component, but the full implications SHALL be understood and carefully weighed before choosing a different course.

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

Obligation Legend

Obligation in DCMs or SCSs specifies whether or not a data component **SHALL** be populated in the logical record architecture of a message. NEHTA intends that all data components will be implemented.

Implementation guides specify the rules and formats for implementing and populating data components in specific messaging formats.

The following table defines the obligations.

Table 5: Obligations Legend

Keyword	Interpretation
ESSENTIAL	<p>Indicates that the data component is considered a mandatory component of information and SHALL be populated.</p> <p>Usage/Examples:</p> <p>The Participant component for a Subject of Care SHALL include an Entity Identifier data component in order to hold the IHI.</p>
OPTIONAL	<p>Indicates that the data component is not considered a mandatory component of information and MAY be populated.</p> <p>Usage/Examples:</p> <p>This is only needed when a DCM incorrectly asserts that a data component is ESSENTIAL. It will be used with a note stating that the DCM needs revision.</p>
PROHIBITED	<p>Indicates that the data component is considered a forbidden component of information and SHALL NOT be populated.</p> <p>Usage/Examples:</p> <p>Within a Participation data group depicting a Subject of Care, the Participation Healthcare Role SHALL NOT be completed.</p>

CONDITIONAL	<p>Indicates that a data component is considered ESSENTIAL only on satisfaction of a given condition. Individual data components specify the obligation of the data component when the condition is not met.</p> <p>When a condition is met, the data component is considered to be ESSENTIAL and SHALL be populated.</p> <p>When a condition is not met, the data component may be considered as PROHIBITED, or the data component may be considered OPTIONAL.</p> <p>Usage/Examples:</p> <p>Within a Pathology Result Report, the <i>Specimen Detail</i> data group is ESSENTIAL if the requested test is to be performed on a specimen, otherwise it SHALL NOT be populated.</p>
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Where **ESSENTIAL** child data components are contained within **OPTIONAL** parent data components, the child data components only need to be populated when the parent is populated.

C.4 Information Model Specification Parts Legends

This section illustrates the format and parts used to define each section, data group and data element within NEHTA's information model specifications and identifies when each part is applicable.

Data Hierarchy

The top-level component contains a data hierarchy. Each row contains information about a single data component. The entries are nested to represent inclusion of one component in another. Each entry contains at least three occupied cells. The left-most cell contains an icon to indicate the entry's data type. The next cell to the right contains the label and description of the component (if the label is different from the name, the name is displayed in brackets after the label). The next cell to the right contains the multiplicity range for the data component.

The right-hand side of the data hierarchy may contain one or more columns under the heading "Core Requirement". Each column contains information for one document exchange scenario. A cell that is empty indicates that the data component on that row is **OPTIONAL** to implement. That is, software that creates documents made in conformance with this specification **MAY** exclude the data component; and software that reads documents made in conformance with this specification **MAY** ignore the data component. All other components **SHALL** be implemented.

In an SCS, a component may be prohibited, that is, it occurs in the referenced DCM but it **SHALL NOT** be included in documents created according to the SCS. This is represented by a multiplicity range of 0..0. The text of the entry is also in a ~~strike through~~ font and it has a grey background.

Chapter Name

Each section, data group, data element, value domain or choice has its own eponymous chapter. The chapter name is used in all data hierarchies.

Identification Section Legend

The following table illustrates the layout of the Identification section and describes the various parts of the section.

Table 6: Identification Section Legend

Label	A suggested display name for the component. (Source NEHTA.)
Metadata Type	The type of the component, e.g. section, data group or data element. (Source NEHTA.)
Identifier	A NEHTA assigned internal identifier of the concept represented by the component. (Source NEHTA.)
OID	An object identifier that uniquely identifies the concept represented by the data component. (Source NEHTA.)
External Identifier	An identifier of the concept represented by the data component that is assigned by an organisation other than NEHTA. (Source NEHTA.)

Definition Section Legend

The following table illustrates the layout of the Definition section and describes the various parts of the section.

Table 7: Definition Section Legend

Definition	The meaning, description or explanation of the data component. (Source NEHTA.) For data groups used in a particular context, the definition MAY be a refinement of the generic data group definition.
Definition Source	The authoritative source for the Definition statement.
Synonymous Names	A list of any names the data component MAY also be known as. (Source NEHTA.) Implementers MAY prefer to use synonymous names to refer to the component in specific contexts.
Scope	Situations in which the data component may be used, i.e. the extent and capacity within which this data component may be used, including the circumstances under which the collection of specified data is required or recommended. For example, Medication Instruction (data group) has a scope which includes all prescribable therapeutic goods, both medicines and non-medicines. This attribute is not relevant to data elements or value domains. (Source NEHTA.)
Scope Source	The authoritative source for the Scope statement.
Context	The environment in which the data component is meaningful, i.e. the circumstance, purpose and perspective under which this data component is defined or used. For example, Street Name has a context of Address. (Source NEHTA.)
Assumptions	Suppositions and notions used in defining the data component. (Source NEHTA.)
Assumptions Source	The authoritative source for the Assumptions statement.
Notes	Informative text that further describes the data component, or assists in the understanding of how the data component can be used. (Source NEHTA.)
Notes Source	The authoritative source for the Notes statement.
Data Type	The data type of the data element, e.g. DateTime or Text. (Source NEHTA.) The data type is applicable only to data elements. The valid data types are specified in the Data Types Legend .

Value Domain	<p>The name and identifier of the terminologies, code sets and classifications to define the data element value range, or a statement describing what values to use in the absence of a defined value domain for the related data element.</p> <p>In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7® code set registration procedure with an appropriate object identifier (OID), and SHALL be publicly available.</p> <p>When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated. (Source NEHTA.)</p> <p>The Value Domain is applicable only to CodedText and CodeableText data elements.</p>
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Value Domain Section Legend

The following table illustrates the layout of the Value Domain section and describes the various parts of the section.

Table 8: Value Domain Section Legend

Source	The name of the terminology or vocabulary from which the value domain's permissible values are sourced, e.g. SNOMED CT-AU, LOINC.
Version Number	Version number of the value domain source.
Permissible Values	List of permissible values in the value domain.

Usage Section Legend

The following table illustrates the layout of the Usage section and describes the various parts of the section.

Table 9: Usage Section Legend

Examples	<p>One or more demonstrations of the data that is catered for by the data element. (Source NEHTA.)</p> <p>Where a data element has an associated value domain, examples representative of that domain are used where possible. Where the value domain is yet to be determined, an indicative example is provided.</p> <p>Implementation guides MAY contain specific examples for how data elements SHALL be populated and how they relate to each other.</p> <p>The Value Domain is applicable only to CodedText and CodeableText data elements.</p>
Conditions of Use	Prerequisites, provisos or restrictions for use of the component. (Source NEHTA.)
Conditions of Use Source	The authoritative source for the Conditions of Use statement.
Misuse	Incorrect, inappropriate or wrong uses of the component. (Source NEHTA.)
Default Value	A common denomination, or at least a usable denomination, from the Value Domain where available or applicable, typically assigned at the creation of an instance of the component. (Source NEHTA.)

Relationships Section Legend

The Relationships section specifies the cardinality between parent and child data components.

The following table illustrates the layout of the Parent relationships table. Note that the occurrences in the relationships described by this table are from the parent to the child component, i.e. from the component listed in the table to the component described by the section.

Table 10: Parent Legend

Data Type	Name	Occurrences (child within parent)
The icon illustrating the metadata type or data type.	Parent Component Name	The minimum and maximum number of instances of the component described on this page that SHALL occur.

The following table illustrates the layout of the Children relationships table.

Table 11: Children Legend

Data Type	Name	Occurrences
The icon illustrating the metadata type or data type.	Child Component Name	The minimum and maximum number of instances of the component described on this page that SHALL occur.

Appendix D. Change History

A summary of changes from one document version to the next. Changes to the change history are excluded.

D.1 Changes Since Version 1.1 - 30 November 2011

Significant changes

Significant changes are listed here as well as in the next section. Significant changes are additions, deletions and substitutions of clinical data elements and changes of cardinality range, data type or conditions of use of clinical data elements. Significant changes do not include rewording of definitions, notes or conditions of use where the intended meaning has not changed. Reworded definitions, notes and conditions of use should be reviewed, as the previous wording may have been misunderstood.

Data Hierarchy changes

The following data components were added, deleted or substituted:

- data element *DateTime Attested* has been added;
- data group *ADVERSE REACTIONS* > *ADVERSE REACTION*, the data element *Reaction Type* has been added;
- data group *Past and Current Medical History* > *PROCEDURE*, the data element *Start Date/Time (DateTime Started)* has been replaced with the new data element *Procedure DateTime*;
- section *Past and Current Medical History*, the data group *Other Medical History Item* has been renamed to *UNCATEGORISED MEDICAL HISTORY ITEM*;

Chapter 2 Shared Health Summary Structured Document

In 2.2 SUBJECT OF CARE, the following Conditions of Use have been changed:

- “Source of Death Notification is PROHIBITED” has been deleted; and
- “Mothers Original Family Name is PROHIBITED” has been deleted.

In 2.3 DOCUMENT AUTHOR, the following Conditions of Use have been changed:

- “Participation Period is ESSENTIAL” has been added;
- “ADDRESS is ESSENTIAL” has been deleted;
- “ELECTRONIC COMMUNICATION DETAIL is ESSENTIAL” has been deleted;
- “EMPLOYER ORGANISATION.ADDRESS is ESSENTIAL” has been added;
- “EMPLOYER ORGANISATION.ELECTRONIC COMMUNICATION DETAIL is ESSENTIAL” has been added;
- “Qualifications is PROHIBITED” has been deleted;
- “The value of ADDRESS.Address Purpose SHALL be ‘B’ (Business)” has been added; and

- “The value of ELECTRONIC COMMUNICATION DETAIL.Electronic Communication Usage Code SHALL be ‘B’ (Business)” has been added.

In 2.6 DateTime Attested, Condition of Use has been added.

In 2.13 MEDICAL HISTORY, Conditions of Use have changed.

Chapter 3 Exclusion Statement - Adverse Reactions Detailed Clinical Model

In 3.4 Global Statement Conditions of Use, a new condition of use has been added.

Chapter 4 Adverse Reaction Detailed Clinical Model

In 4.6 Substance/Agent Values Permissible Values, the set of values has been widened.

In 4.9 Clinical Manifestation Values Permissible Values, the set of values has been widened.

Chapter 5 Exclusion Statement - Medications Detailed Clinical Model

In 5.4 Global Statement Conditions of Use, a new condition of use has been added.

Chapter 6 Known Medication Detailed Clinical Model

No significant changes.

Chapter 7 Problem/Diagnosis Detailed Clinical Model

In 7.7 Date of Onset Conditions of Use, a condition prohibiting time has been added.

Chapter 8 Exclusion Statement - Problems and Diagnoses Detailed Clinical Model

In 8.4 Global Statement Conditions of Use, a new condition of use has been added.

Chapter 9 Procedure Detailed Clinical Model

No significant changes additional to those listed in the Data Hierarchy changes.

Chapter 10 Exclusion Statement - Procedures Detailed Clinical Model

In 10.4 Global Statement Conditions of Use, a new condition of use has been added.

Chapter 11 Uncategorized Medical History Item Detailed Clinical Model

11.4 UNCATEGORISED MEDICAL HISTORY ITEM has a new Name, Label, Definition and Usage. The Identifier is the same as the meaning has not changed.

Chapter 12 Administered Immunisation Detailed Clinical Model

In 12.6 Medicines Terminology Conditions of Use, the set of values has been widened.

Chapter 13 Exclusion Statement - Immunisations Detailed Clinical Model

In 13.4 Global Statement Conditions of Use, a new condition of use has been added.

Changes

This includes those changes listed in the previous section.

The presentation format has changed between version 1.1 and version 1.2. Changes that result from the change in presentation format are not listed below.

Changes to prohibited data components are not described.

Changes to the appendices are not described.

Data Hierarchy changes

The following data components were added, deleted or substituted:

- data element *DateTime Attested* has been added;
- data group *ADVERSE REACTIONS* > *ADVERSE REACTION*, the data element *Reaction Type* has been added;
- in data group *Past and Current Medical History* > *PROCEDURE*, the data element *Start Date/Time (DateTime Started)* has been replaced with the new data element *Procedure DateTime*; and
- in section *Past and Current Medical History*, the data group *Other Medical History Item (MEDICAL HISTORY ITEM)* has been renamed to *UNCATEGORISED MEDICAL HISTORY ITEM*

The following technical identifiers have been added:

- *Document Instance Identifier*
- *Document Type*
- *Adverse Reactions* > *Exclusion Statement - Adverse Reactions* > *Detailed Clinical Model Identifier*
- *Adverse Reactions* > *Adverse Reaction* > *Adverse Reaction Instance Identifier*
- *Adverse Reactions* > *Adverse Reaction* > *Detailed Clinical Model Identifier*
- *Adverse Reactions* > *Adverse Reactions Instance Identifier*
- *Adverse Reactions* > *Section Type*
- *Medications* > *Exclusion Statement - Medications* > *Detailed Clinical Model Identifier*
- *Medications* > *Known Medication* > *Medication Instruction Instance Identifier*
- *Medications* > *Known Medication* > *Detailed Clinical Model Identifier*
- *Medications* > *Medication Orders Instance Identifier*

- *Medications > Section Type*
- *Past and Current Medical History > Problem/Diagnosis > Problem/Diagnosis Instance Identifier*
- *Past and Current Medical History > Problem/Diagnosis > Detailed Clinical Model Identifier*
- *Past and Current Medical History > Exclusion Statement - Problems and Diagnoses > Detailed Clinical Model Identifier*
- *Past and Current Medical History > Procedure > Procedure Instance Identifier*
- *Past and Current Medical History > Procedure > Detailed Clinical Model Identifier*
- *Past and Current Medical History > Exclusion Statement - Procedures > Detailed Clinical Model Identifier*
- *Past and Current Medical History > Uncategorized Medical History Item > Uncategorized Medical History Item Instance Identifier*
- *Past and Current Medical History > Uncategorized Medical History Item > Detailed Clinical Model Identifier*
- *Past and Current Medical History > Medical History Instance Identifier*
- *Past and Current Medical History > Section Type*
- *Immunisations > Administered Immunisation > Medication Action Identifier*
- *Immunisations > Administered Immunisation > Detailed Clinical Model Identifier*
- *Immunisations > Exclusion Statement - Immunisations > Detailed Clinical Model Identifier*
- *Immunisations > Immunisations Instance Identifier*
- *Immunisations > Section Type*

The following data elements have had their labels changed to match their names:

- *Medications > Known Medication > Medicine (Therapeutic Good Identification)*
- *Medications > Known Medication > Comment (Medication Instruction Comment)*
- *Past and Current Medical History > Problem/Diagnosis > Problem/Diagnosis (Problem/Diagnosis Identification)*
- *Past and Current Medical History > Problem/Diagnosis > Comment (Problem/Diagnosis Comment)*
- *Past and Current Medical History > Procedure > Comment (Procedure Comment)*
- *Immunisations > Administered Immunisation > Medicine (Therapeutic Good Identification)*

Chapter 2 Shared Health Summary Structured Document

In 2.2 SUBJECT OF CARE the following changes have been made:

- External Identifier has been deleted;
- in Definition, Synonymous Names and Scope, the text has changed; and
- in Conditions of Use, the condition:
 - “Source of Death Notification is PROHIBITED” has been deleted;
 - “Mothers Original Family Name is PROHIBITED” has been deleted;
 - “Participation Type SHALL have an implementation-specific fixed value equivalent to ‘Subject of Care’ ” has been reworded, the word “fixed” has been deleted;

- “Role SHALL have a fixed value of ‘Patient’ ” has been reworded; and
- “The value of Entity Identifier SHALL be an Australian IHI” has been reworded.

In 2.3 DOCUMENT AUTHOR the following changes have been made:

- in Definition and Scope, the text has changed;
- in Notes, the note has been replaced;
- in Conditions of Use, the condition :
 - “Participation Period is ESSENTIAL” has been added;
 - “ADDRESS is ESSENTIAL” has been deleted;
 - “ELECTRONIC COMMUNICATION DETAIL is ESSENTIAL” has been deleted;
 - “EMPLOYER ORGANISATION.ADDRESS is ESSENTIAL” has been added;
 - “EMPLOYER ORGANISATION.ELECTRONIC COMMUNICATION DETAIL is ESSENTIAL” has been added;
 - “ENTITLEMENT is PROHIBITED” has been deleted;
 - “Qualifications is PROHIBITED” has been deleted;
 - “Participation Type SHALL have an implementation-specific fixed value equivalent to ‘Document Author’ ” has been reworded, the word “fixed” has been deleted;
 - “The value of Entity Identifier SHALL be an Australian HPI-I” has been reworded;
 - “The value of ADDRESS.Address Purpose SHALL be ‘B’ (Business)” has been added;
 - “The value of ELECTRONIC COMMUNICATION DETAIL.Electronic Communication Usage Code SHALL be ‘B’ (Business)” has been added; and
 - “The value of EMPLOYER ORGANISATION.Entity Identifier SHALL be an Australian HPI-O” has been reworded.

2.4 Document Instance Identifier has been added.

2.5 Document Type has been added.

In 2.6 DateTime Attested:

- Definition has been reworded and a Note has been added; and
- Condition of Use has been added.

In 2.7 ADVERSE REACTIONS, Definition, Scope and Conditions of Use have been reworded.

2.8 Adverse Reactions Instance Identifier has been added.

2.9 Section Type has been added.

In 2.10 MEDICATION ORDERS

- Definition, Scope, Notes and Conditions of Use have been reworded; and
- Misuse has been added.

2.11 Medication Orders Instance Identifier has been added.

2.12 Section Type has been added.

In 2.13 MEDICAL HISTORY

- Definition, Scope and Notes have been reworded; and
- Conditions of Use have changed.

2.14 Medical History Instance Identifier has been added.

2.15 Section Type has been added.

In 2.16 IMMUNISATIONS, Definition, Scope and Conditions of Use have been reworded.

2.17 Immunisations Instance Identifier has been added.

2.18 Section Type has been added.

Chapter 3 Exclusion Statement - Adverse Reactions Detailed Clinical Model

The version of the DCM used has changed from 1.2 to 1.3.

In 3.3 EXCLUSION STATEMENT - ADVERSE REACTIONS:

- Definition has been reworded; and
- Synonymous Names has been deleted; and
- Conditions of Use and Conditions of Use Source have been removed.

In 3.4 Global Statement Conditions of Use:

- Context has been reworded; and
- Conditions of Use and Conditions of Use Source have been removed and new ones added.

In 3.5 Global Statement Values, the Permissible Values have been changed.

3.6 Detailed Clinical Model Identifier has been added.

Chapter 4 Adverse Reaction Detailed Clinical Model

The version of the DCM used has changed from 5.1 to 5.2.

In 4.4 ADVERSE REACTION:

- Definition has been reworded;
- Scope and Scope Source have been added; and
- Conditions of Use and Conditions of Use Source have been removed.

In 4.6 Substance/Agent Values:

- Definition has been reworded; and
- in Permissible Values, the set of values has been widened.

In 4.8 Manifestation, Definition and Notes have been reworded.

In 4.9 Clinical Manifestation Values:

- External Identifier has been deleted;

- Definition has been reworded; and
- in Value Domain, Permissible Values have been added.

4.10 Reaction Type has been added.

4.11 Adverse Reaction Type Values has been added.

4.12 Adverse Reaction Instance Identifier has been added.

4.13 Detailed Clinical Model Identifier has been added.

Chapter 5 Exclusion Statement - Medications Detailed Clinical Model

The version of the DCM used has changed from 1.2 to 1.3.

In 5.3 EXCLUSION STATEMENT - MEDICATIONS:

- Definition has been reworded; and
- Conditions of Use and Conditions of Use Source have been removed.

In 5.4 Global Statement Conditions of Use:

- Context has been reworded; and
- Conditions of Use and Conditions of Use Source have been removed and new ones added.

In 5.5 Global Statement Values, the Permissible Values have been changed.

5.6 Detailed Clinical Model Identifier has been added.

Chapter 6 Known Medication Detailed Clinical Model

The version of the DCM used has changed from 3.2 to 3.3.

In 6.4 MEDICATION INSTRUCTION:

- Synonymous Names has been updated; and
- Conditions of Use has been removed.

In 6.5 Therapeutic Good Identification:

- the label has changed from *Medicine* to match the name; and
- Definition, Context, Notes, Conditions of Use and Examples have been reworded.

In 6.6 Medicines Terminology, Notes and Permissible Values have been reworded.

In 6.7 Directions, Conditions of Use has been moved to Notes.

In 6.8 Clinical Indication, Conditions of Use has been removed.

In 6.9 Medication Instruction Comment, the label has changed from *Comment* to match the name.

6.10 Medication Instruction Instance Identifier has been added.

6.11 Detailed Clinical Model Identifier has been added.

Chapter 7 Problem/Diagnosis Detailed Clinical Model

The version of the DCM used has changed from 5.1 to 5.2.

In 7.4 PROBLEM/DIAGNOSIS:

- Definition and Notes have been reworded;
- Scope has been added; and
- Conditions of Use has been removed.

In 7.5 Problem/Diagnosis Identification, the label has changed from *Problem/Diagnosis* to match the name.

In 7.6 Problem/Diagnosis Reference Set, External Identifier and Definition have been reworded.

In 7.7 Date of Onset:

- Definition has been reworded; and
- in Conditions of Use, a condition prohibiting time has been added.

In 7.8 Date of Resolution/Remission:

- Definition has been reworded; and
- Conditions of Use has been reworded.

In 7.9 Problem/Diagnosis Comment, the label has changed from *Comment* to match the name.

6.9 Problem/Diagnosis Instance Identifier has been added.

6.10 Detailed Clinical Model Identifier has been added.

Chapter 8 Exclusion Statement - Problems and Diagnoses Detailed Clinical Model

The version of the DCM used has changed from 1.2 to 1.3.

In 8.3 EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES:

- Definition has been reworded; and
- Conditions of Use have been changed.

In 8.4 Global Statement Conditions of Use:

- Context has been reworded; and
- Conditions of Use and Conditions of Use Source have been removed and new ones added.

In 8.5 Global Statement Values, the Permissible Values have been changed.

8.6 Detailed Clinical Model Identifier has been added.

Chapter 9 Procedure Detailed Clinical Model

The version of the DCM used has changed from 4.1 to 4.2.

In 9.4 PROCEDURE:

- Scope, Scope Source and Misuse have been added; and

- Conditions of Use has been removed.

In 9.6 Procedure Foundation Reference Set, External Identifier has been updated with the name of reference set.

In 9.7 Procedure Comment, the label has changed from *Comment* to match the name.

9.8 DateTime Started has been deleted.

9.8 Procedure DateTime has been added.

9.9 Procedure Instance Identifier has been added.

9.10 Detailed Clinical Model Identifier has been added.

Chapter 10 Exclusion Statement - Procedures Detailed Clinical Model

The version of the DCM used has changed from 1.1 to 1.2.

In 10.3 EXCLUSION STATEMENT - PROCEDURES:

- Notes has been removed; and
- Conditions of Use have been changed.

In 10.4 Global Statement Conditions of Use:

- Context has been reworded;
- Conditions of Use and Conditions of Use Source have been removed and new ones added.

In 10.5 Global Statement Values, the Permissible Values have been changed.

10.6 Detailed Clinical Model Identifier has been added.

Chapter 11 Uncategorised Medical History Item Detailed Clinical Model

The version of the DCM used has changed from 1.1 to 2.0.

11.4 UNCATEGORISED MEDICAL HISTORY ITEM has a new Name, Label, Definition and Usage. The Identifier is the same as the meaning has not changed.

11.5 Medical History Item Description, Definition has been reworded.

11.6 Medical History TimeInterval has been renamed to *Medical History TimeInterval*.

11.6 Medical History TimeInterval, Definition has been reworded.

11.7 Medical History Comment, Definition has been reworded.

11.8 Uncategorised Medical History Item Instance Identifier has been added.

11.9 Detailed Clinical Model Identifier has been added.

Chapter 12 Administered Immunisation Detailed Clinical Model

The version of the DCM used has changed from 4.0 to 4.1.

In 12.4 MEDICATION ACTION:

- Definition has been reworded; and
- Conditions of Use has been deleted.

In 12.5 Therapeutic Good Identification:

- the label has changed from *Medicine* to match the name; and
- Definition, Notes, Conditions of Use and Examples have been reworded.

In 12.6 Medicines Terminology Conditions of Use, the set of values has been widened.

In 12.8 Medication Action DateTime, Definition has been reworded.

12.9 Medication Action Instance Identifier has been added.

12.10 Detailed Clinical Model Identifier has been added.

Chapter 13 Exclusion Statement - Immunisations Detailed Clinical Model

The version of the DCM used has changed from 1.2 to 1.3.

In 13.3 EXCLUSION STATEMENT - MEDICATIONS:

- Scope has been reworded;
- Notes has been added;; and
- Conditions of Use and Conditions of Use Source have been changed.

In 13.4 Global Statement Conditions of Use:

- Context has been reworded; and
- Conditions of Use and Conditions of Use Source have been removed and new ones added.

In 13.5 Global Statement Values, the Permissible Values have been changed.

13.6 Detailed Clinical Model Identifier has been added.

Chapter 14 UML Class Diagrams

The diagram has been updated to include all changes to the data hierarchy and use current NEHTA data component modelling conventions.

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