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**Discharge Summary - Acute Care to  
GP/Specialist**

**Structured Document Template**

Version 0.7 – 19/03/2009

Draft for Comment

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# Document Information

## Acknowledgements

This Structured Document Template draws on the significant work that resulted in the NEHTA *National Discharge Summary Data Content Specifications Version 1.0 – 21/12/2006* [NDS2006].

NEHTA would like to thank the following organisations for their contribution to these data specifications:

- Standards Australia
- Royal Australian College of General Practitioners
- Society of Hospital Pharmacists of Australia
- Members of the Australian DataTypes Project
- Australian Institute of Health and Welfare
- Ocean Informatics

## Change History

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0.3	10/11/2008	Don Stewart Robert L'Egan	Inclusion of CISR team feedback.
0.4	17/12/2008	Don Stewart Robert L'Egan	Inclusion of internal NEHTA feedback. Inclusion of full Medication details. Change to Diagnostic Imaging and Pathology data hierarchy.
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0.6	03/03/2009	Don Stewart	Inclusion of new data element "Additional Dose Instruction". Updates based on TSAG review feedback. Removal of sections covered by the NEHTA Data Specification and Structured Document Template Guide for Use. Inclusion of UML diagram.
0.7	19/03/2009	Don Stewart	Changes to Item Description DE-10194 for both Current and Ceased Medications.

## Authorisation History

Version	Date	Status	Comments

## List of Acronyms & Glossary

For a complete listing of all relevant Acronyms Abbreviations and a glossary of terms please refer to the NEHTA *Acronyms, Abbreviations & Glossary of Terms*, Version No.: 1.2, Issued: 25 May 2005 [[AGT-2005](#)].

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# 1 Introduction

## 1.1 Purpose and Scope

The role of Clinical Information Structured Reporting (CISR) within NEHTA packages is to specify the Logical Record Architecture to be used for clinical communication. For each package, CISR will be producing the following set of documents:

- a. Structured Document Templates (SDT) - organise the data elements from NEHTA Data Groups (see 1.5.4) into a logical model for clinical communication for a given purpose.
- b. Message Profiles - bind a single Structured Document Template to a particular messaging format, such as HL7 v2.5 or HL7 CDA- and provide instructions on how the messaging format should be implemented.

These documents are one component of the solution proposed for the purposes as specified by a NEHTA package. Other components, such as terminologies and web services, are covered in other documents within a package release.

The clinical information specifications for this release of the discharge summary package consist of the Structured Document Template – Discharge Summary – Acute Care to GP/Specialist (this document). It describes the logical information model proposed for use in communicating a discharge summary for an admitted inpatient encounter from an acute healthcare facility to a General Practitioner.

The SDT outlines the allowable content of the information to be exchanged for a Discharge Summary document and structures the content in a manner that delivers context and meaning. It provides an information framework on which to achieve semantic interoperability, independent of any messaging format, sending/receiving application or data store.

The specification is a template that divides the discharge summary into sections based upon topic-specific data groups such as medications, problems/ diagnoses, diagnostic investigations, etc. It is designed to facilitate the effective interchange of consistent clinical information regarding a subject of care's admitted hospital encounter within the following scope:

- A summary compiled on the discharge of the subject of care from acute care into the community, which is to be sent to a GP and limited specialists;
- A summary of the complete length of stay in acute care, from initial admission to final discharge into the community;
- A summary of any relevant pre-existing clinical details recorded during the acute care episode; and
- Demographic details of the subject of care, acute care facility and healthcare providers, as required to identify the participating parties.

This document excludes discharge summaries within the following scope:

- Summaries that include an attached 'Summary Health Profile', or consider their future implementation;
- Transfer summaries, compiled upon the transfer of a subject of care between units within the acute care setting;
- Summaries to be sent to non-GP recipients (except where the recipient is cc-ed on a discharge summary sent to a GP);
- Medication lists that include a structured solution for variable dosing, and medicinal formulations;

- Ambulatory visits, outpatients, Emergency Department encounters and courses of treatment over multiple visits.
- Specialised summaries relating to mental health subjects of care; and
- Details specific to the transfer of care, as required by a 'Referral';

## 1.2 Intended Audience

This document is intended to be read and understood by:

1. Software development teams -
  - a. To plan, architect or implement:
    - clinical applications, infrastructure components or messaging interfaces
    - facilitating semantic interoperability
  - b. To support NEHTA-defined terminology in:
    - clinical interfaces and messaging interfaces
    - generating value domains for data elements
    - creating or receiving electronic information exchanges containing clinical content
    - writing queries over clinical Electronic Health Record (EHR) data
    - implementing data constraint checks
    - designing term mappings
2. IT-aware clinicians to evaluate the clinical suitability of NEHTA-endorsed standards.
3. Researchers to explore certain aspects of NEHTA-endorsed standards.

The documents are reasonably technical in nature and expect the audience to be familiar with the language of health data specifications and have some familiarity with health information standards and specifications such as HL7 v2.4, and [\[AS4700.6-2007\]](#).

## 1.3 Related Documents

The following documents are companion documents to this SDT:

1. Data Specifications – Guide for Use [\[DS-GUIDE\]](#) - this guide describes the generic data structures, data types, keywords and icons used within this Structured Document Template.
2. Document Header Data Specification [\[DS-DH\]](#) – contains the full specification of the standardised header used across all NEHTA Structured Document Templates
3. Participation Data Specification [\[DS-PART\]](#) – contains the full specification which forms the basis of all participants contained in NEHTA Structured Document Templates.

These documents are currently undergoing internal review and will be published to the NEHTA external website in the near future.

## 1.4 Definition of Discharge Summary

A Discharge Summary is defined in [\[AS4700.6-2007\]](#) as;

A collection of information about events during care by a provider or organisation.

NOTE: A Discharge Summary does not necessarily represent or enable transfer of care, nor is it necessarily intended for any particular provider or organisation. Such a summary may form part of a Discharge Referral. If a Discharge Summary is intended to take on the role of discharge referral then additional constraints are applicable on content, and the full referral information and encapsulating message should be used.

The *Discharge Summary* is a document produced during a subject of care's admitted inpatient episode in hospital and issued when or after a subject of care leaves the care of the hospital. Its primary function is to support the continuity of care as the subject of care returns to the care of their community health care provider(s). The primary recipients of the Discharge Summary are health care providers for the subject of care who were providing care prior to the hospital admission and have (implicitly) accepted ongoing responsibility for the ongoing care. As such, the primary recipients include;

- The subject of care's usual community GP (or primary health service such as an Aboriginal Community Controlled Health Service);
- The referring clinician e.g. private specialist; and
- Residential Aged Care Facility where the subject of care usually resides or will newly reside.

The secondary functions of the Discharge Summary include;

- Attached with a referral letter when a subject of care is referred for other care;
- Use by clinical coders / Health Information Managers (HIMs) when coding a subject of care record;
- Providing summary information regarding an admission to assist subsequent care (be that further admissions at the same hospital or a different hospital, or outpatient follow up); and
- Inclusion in a Shared Electronic Health Record (which could include a national IEHR or a local repository, for example to support coordinated care).

## 1.5 Discharge Summary Generation and Life-Cycle

A discharge summary is expected to be commenced by the clinician(s) involved in the care of the subject during the admitted event and completed at discharge (or soon after the discharge) of the subject of care. In the processes of generating a Discharge Summary, clinical information recorded during the healthcare event which is considered important for safe and effective continual management of the subject is included in the summary. It is expected to contain clinical content conforming to various NEHTA data groups depending on the investigations, findings, assessments, interventions and planned services recorded during the healthcare event.

The specific content (i.e. the NEHTA data groups) to be included in a discharge summary will depend upon the nature of the health problems/diagnoses, diagnostic tests done, assessments, medications prescribed, and interventions performed and/or planned. To cater for an optimal level of flexibility, a number of clinical data groups that are considered by the consultation processes as

critical have been given the “essential” obligation (refer to section 3.3 for obligation definitions). These core data groups which appear in all discharge summaries include:

- Principal Problem/Diagnosis;
- Adverse Reactions;
- Clinical Synopsis; and
- Medication.

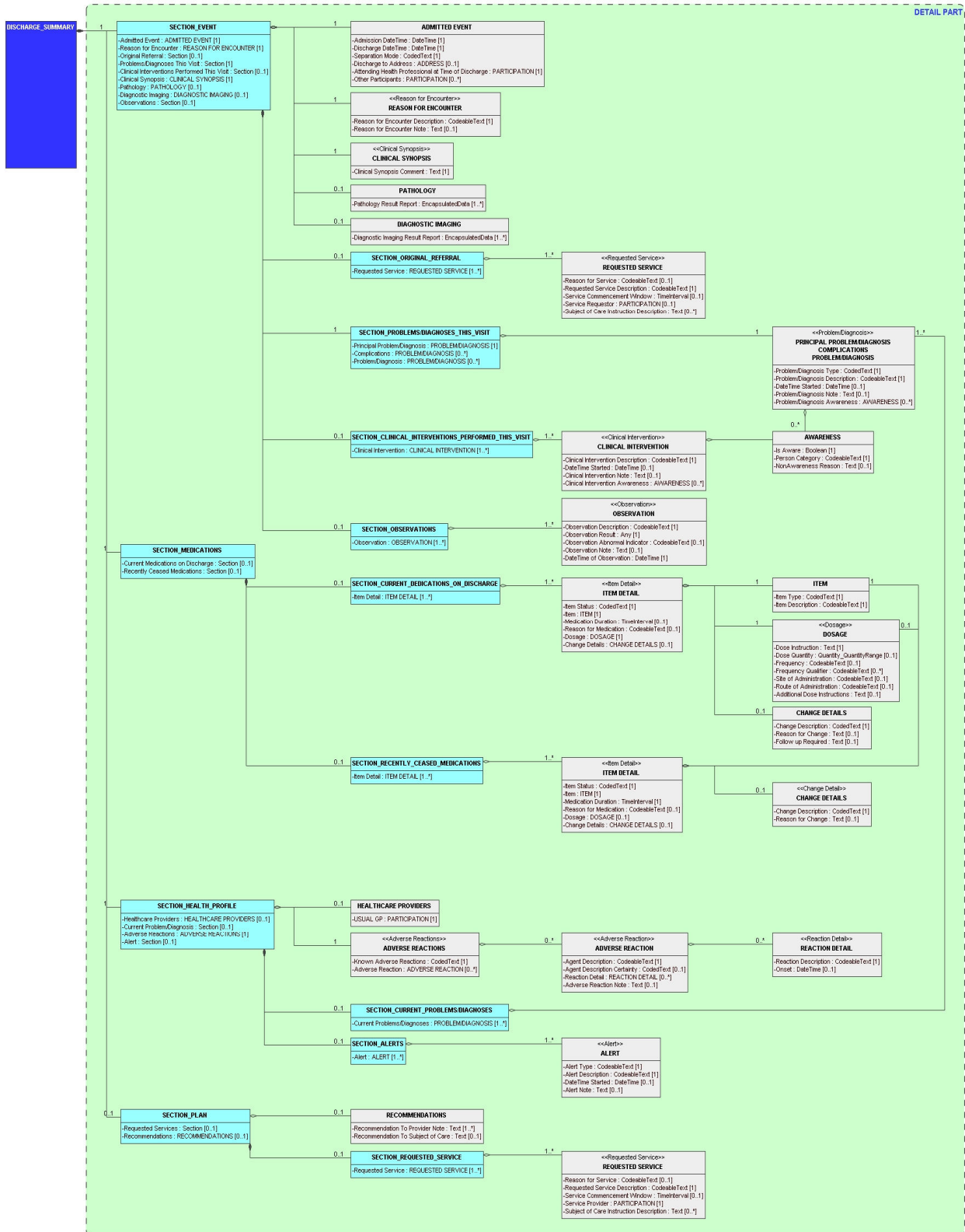
Other data groups have “optional” obligations. They include;

- Clinical Interventions (Procedure);
- Alerts;
- Investigation groups of data such as Pathology, Diagnostic Imaging, and Observations; and
- Requested Services and Recommendations.

A discharge summary may go through several iterations of authoring before or after it is sent to the recipients. For example, an interim discharge summary may be authored and sent before certain diagnostic test (e.g. histology) results are available. When such results become available, or where the specialist may wish to add supplementary information, a new version of the discharge summary may be created. The “Document Control” data group within the Header part contains a number of data elements to support effective version management, e.g. allows different versions of the discharge summary belonging to the same logical set to be uniquely identified and the different versions tracked. Each version should be reproducible retrospectively including attestation details of each version.

For more details on the Discharge Summary lifecycle and business processes refer to the document *Discharge Summary Package Business Requirements Specification* [[DSPBRS2008](#)].










# 2 UML Diagram






### 3 Discharge Summary Header

The Data Hierarchy provides a visual representation of the content and logical layout of the overall Discharge Summary data structure. Individual data elements associated with the Participant data group are not displayed in the data hierarchy providing a more easily read overview. Individual data elements for the PARTICIPANT data group and their hierarchical structure can be found in the related document *Data Specification – Participant* [DS-PART]. Detailed definitions of the datatypes, obligations and all icons can be found in the *NEHTA Data Specification and Structured Document Templates Guide for Use* [DS-GUIDE].

The document header is generic to all Structured Document Templates and is defined in detail in the *Document Header Data Specification* [DS-DH]. Specific constraints related to the headers use for a Discharge Summary are explained later in this section.

	<b>Discharge Summary</b>		
<b>HEADER</b>			
	HEALTH EVENT CONTEXT		!
	SUBJECT OF CARE (PARTICIPANT.PERSON)		!
	FACILITY (PARTICIPANT.ORGANISATION)		!
<b>T/T<sub>0</sub></b>	Care Setting		o
	EPISODE		!
	<b>ID</b>	Episode Identifier	o
		DateTime Episode Started	!
	DOCUMENT CONTEXT		!
	DOCUMENT CONTROL		!
	<b>ID</b>	Document Instance Identifier	!
	<b>ID</b>	Document Set Identifier	!
	<b>12<sup>3</sup></b>	Version Number	!
	<b>ID</b>	Document Originating System Identifier	!
	<b>T<sub>010</sub></b>	Document Type	!
	<b>12<sup>3</sup></b>	Document Type Version Number	!
	<b>T<sub>010</sub></b>	Confidentiality Indicator	!
		DateTime Attested	!
	<b>T<sub>010</sub></b>	Document Status	!
	<b>T<sub>010</sub></b>	Language (default to en-AU)	!

	DOCUMENT AUTHOR (PARTICIPANT.PERSON)	!
	DOCUMENT AUTHORISER/APPROVER (PARTICIPANT.PERSON)	!
	DOCUMENT RECIPIENTS (PARTICIPANT)	! ↻

Each of the data groups in the header is described in the following sections, with specific information on the data that should be included for each data group in the context of a discharge summary sent from an acute care facility to a General Practitioner.

### 3.1 Subject of Care

Identifies the person about whom the healthcare event/encounter/clinical interaction has been captured and/or interchanged, that lead to the creation of the document, i.e. the subject of the information.

Must include the following participant details;

- Entity Identifier
- Address
- Person Name
- Date of Birth (can be an approximate date)
- Sex

### 3.2 Facility

Identifies a healthcare organisation/facility involved in or associated with the delivery of the healthcare services to the subject of care, or caring for their wellbeing. Must include the following participant data groups and data elements;

- Entity Identifier
- Organisation Name
- Address
- Electronic Communication
- Department Name

### 3.3 Episode

Identifies a healthcare event/encounter/clinical interaction or a series of healthcare events/encounters/clinical interactions defined and grouped according to a particular healthcare process.

Such grouping is:

- determined by a healthcare provider
- initiated to address certain health problem(s)/issue(s)
- can cover one or more illnesses
- can involve one or more provider(s)
- can be on-going.

For example the subject of care may attend a pre-admission clinic for a specific health problem, be admitted for treatment of the problem then discharged and followed up in outpatients for review of the outcomes of the treatment. All these

interactions would be grouped within the one episode as they all relate to treatment of the same problem.

As the Episode may cover more than one admitted inpatient event there are no requirements specific to the Discharge Summary Structured Document Template.

### **3.4 Document Control**

Holds versioning information about the document instance that belong to the same logical document set, i.e. that are related to the same healthcare event/encounter/clinical interaction.

The Document Type, which is the name of the Structured Document Template used to create the document instance, shall be "Discharge Summary – Acute Care to GP/Specialist".

### **3.5 Document Author**

The Document Author is the healthcare provider who is the main author of the document. In this case, it refers to the healthcare provider who is chiefly responsible for completing the discharge summary. (The common practice in Australia is that this is the current intern or Resident of the senior clinician responsible for the patient). Must include the following participant data groups;

- Entity Identifier
- Person Name
- Electronic Communication

### **3.6 Document Authoriser/Approver**

The Document Authoriser/Approver is the clinician responsible for authorising the release and distribution of the Discharge Summary document instance. Depending on the business practices of the particular hospital or unit the authoriser/approver and author roles may be filled by the same person. For more details on the Discharge Summary business processes refer to the document *Discharge Summary Package Business Requirements Specification [DSPBRS2008]*. Must include the following participant data groups;

- Entity Identifier
- Person Name
- Electronic Communication

### **3.7 Document Recipients**
















The person(s) and/or organisations(s) who are recipients of the document. A healthcare provider (person or organisation) who/which is involved in the care of the subject may receive the discharge summary either via a clinical information system capable of receiving standard compliant e-health message or by traditional manual methods. The most common recipient is the GP but it could be any healthcare provider on the subject-of-care's care team.

Recipients must include the following participant data groups;
















- Entity Identifier
- Person Name
- Organisation Name (where recipient is an organisation)
- Address
- Electronic Communication

## 4 Discharge Summary Detail















The detail part of the discharge summary contains the information related to the subject of care's admission, problems, interventions, medications and plans proposed for post discharge care as represented in the data hierarchy below.

DETAIL				
	EVENT			!
	ADMITTED EVENT			!
		Admission DateTime		!
		Discharge DateTime		!
	<b>T</b> <sub>010</sub>	Separation Mode		!
	DISCHARGE TO ADDRESS			o
		ATTENDING HEALTH PROFESSIONAL AT TIME OF DISCHARGE (PARTICIPANT.PERSON)		!
		OTHER PARTICIPANTS (PARTICIPANT.PERSON) (Includes Registrar or other Healthcare Provider.)		o ↻
	REASON FOR ENCOUNTER			!
	<b>T/T</b> <sub>010</sub>	Reason for Encounter Description		!
	<b>T</b>	Reason for Encounter Note		o
	ORIGINAL REFERRAL (Required where the admission was the result of a referral)			<i>a→b</i>
	REQUESTED SERVICE			! ↻
	<b>T/T</b> <sub>010</sub>	Reason for Service		o
	<b>T/T</b> <sub>010</sub>	Requested Service Description		!
		Service Commencement Window		o
		SERVICE REQUESTOR (PARTICIPANT.PERSON)		o
	<b>T</b>	Subject of Care Instruction Description		o ↻
	PROBLEMS/DIAGNOSES THIS VISIT			!
	PRINCIPAL PROBLEM/DIAGNOSIS (where Problem/Diagnosis Type = "Principal")			!
	<b>T</b> <sub>010</sub>	Problem/Diagnosis Type		!
	<b>T/T</b> <sub>010</sub>	Problem/Diagnosis Description		!
		DateTime Started		o
	<b>T</b>	Problem/Diagnosis Note		o

			PROBLEM/DIAGNOSIS AWARENESS		o ↻
			✓x	Is Aware	!
			T	Non-Awareness Reason	o
			T/T <sub>010</sub>	Person Category	!
			COMPLICATIONS (where Problem/Diagnosis Type = "Complication")		a→b ↻
			T <sub>010</sub>	Problem/Diagnosis Type	!
			T/T <sub>010</sub>	Problem/Diagnosis Description	!
			DateTime Started		o
			T	Problem/Diagnosis Note	o
			PROBLEM/DIAGNOSIS AWARENESS		o ↻
			✓x	Is Aware	!
			T	Non-Awareness Reason	o
			T/T <sub>010</sub>	Person Category	!
			PROBLEM/DIAGNOSIS		o ↻
			T <sub>010</sub>	Problem/Diagnosis Type	!
			T/T <sub>010</sub>	Problem/Diagnosis Description	!
			DateTime Started		o
			T	Problem/Diagnosis Note	o
			PROBLEM/DIAGNOSIS AWARENESS		o ↻
			✓x	Is Aware	!
			T	Non-Awareness Reason	o
			T/T <sub>010</sub>	Person Category	!
		CLINICAL INTERVENTIONS PERFORMED THIS VISIT			o
			CLINICAL INTERVENTION		! ↻
			T/T <sub>010</sub>	Clinical Intervention Description	!
			DateTime Started		o
			T	Clinical Intervention Note	o
			CLINICAL INTERVENTION AWARENESS		o ↻
			✓x	Is Aware	!
			T	Non-Awareness Reason	o
			T/T <sub>010</sub>	Person Category	!
		CLINICAL SYNOPSIS			!

		<b>T</b>	Clinical Synopsis Comment	!
		PATHOLOGY		o
			PATHOLOGY RESULT REPORT (Refer to <i>Pathology Result Report Structured Document Template v1.0</i> [PRRSDT])	! ↻
		DIAGNOSTIC IMAGING		o
			DIAGNOSTIC IMAGING RESULT REPORT (Refer to <i>Diagnostic Imaging Data Specifications v1.0</i> [DIDS2007])	! ↻
		OBSERVATIONS		o
			OBSERVATION	! ↻
			DateTime of Observation	!
		<b>T/T</b> <sub>010</sub>	Observation Description	!
		<b>any</b>	Observation Result	!
		<b>T/T</b> <sub>010</sub>	Observation Abnormal Indicator (Conditional on OBSERVATION RESULT being present and out of normal range)	a→b
		<b>T</b>	Observation Note	o
		MEDICATIONS		!
		CURRENT MEDICATIONS ON DISCHARGE (Conditional upon whether there are Current Medications)		a→b
			ITEM DETAIL	! ↻
		<b>T</b> <sub>010</sub>	Item Status	!
			ITEM	!
		<b>T</b> <sub>010</sub>	Item Type	!
		<b>T/T</b> <sub>010</sub>	Item Description	!
			Medication Duration	o
		<b>T/T</b> <sub>010</sub>	Reason for Medication	o
			DOSAGE	!
		<b>T</b>	Dose Instruction	!
			Dose Quantity	o
		<b>T/T</b> <sub>010</sub>	Frequency	o
		<b>T/T</b> <sub>010</sub>	Frequency Qualifier	o ↻
		<b>T/T</b> <sub>010</sub>	Site of Administration	o
		<b>T/T</b> <sub>010</sub>	Route of Administration	o
		<b>T</b>	Additional Dose Instructions	o
			CHANGE DETAILS	o

			<b>T</b> <sub>010</sub>	Change Description	!
			<b>T</b>	Reason for Change	o
			<b>T</b>	Follow Up Required	o
	<u>S</u>	RECENTLY CEASED MEDICATIONS (Conditional upon whether there are Ceased Medications)			<i>a→b</i>
			ITEM DETAIL		! ↻
			<b>T</b> <sub>010</sub>	Item Status	!
			ITEM		!
			<b>T</b> <sub>010</sub>	Item Type	!
			<b>T</b> / <b>T</b> <sub>010</sub>	Item Description	!
			Medication Duration		!
			<b>T</b> / <b>T</b> <sub>010</sub>	Reason for Medication	o
			DOSAGE		o
			<b>T</b>	Dose Instruction	!
				Dose Quantity	o
			<b>T</b> / <b>T</b> <sub>010</sub>	Frequency	o
			<b>T</b> / <b>T</b> <sub>010</sub>	Frequency Qualifier	o ↻
			<b>T</b> / <b>T</b> <sub>010</sub>	Site of Administration	o
			<b>T</b> / <b>T</b> <sub>010</sub>	Route of Administration	o
			<b>T</b>	Additional Dose Instructions	o
			CHANGE DETAILS		o
			<b>T</b> <sub>010</sub>	Change Description	!
			<b>T</b>	Reason for Change	o
	<u>S</u>	HEALTH PROFILE			!
			HEALTHCARE PROVIDERS		o
			USUAL GP (PARTICIPANT)		!
	<u>S</u>	CURRENT PROBLEMS/DIAGNOSES			o
			PROBLEM DIAGNOSIS (Where problem/diagnosis type is not constrained)		! ↻
			<b>T</b> <sub>010</sub>	Problem/Diagnosis Type	!
			<b>T</b> / <b>T</b> <sub>010</sub>	Problem/Diagnosis Description	!
			DateTime Started		o
			<b>T</b>	Problem/Diagnosis Note	o
			PROBLEM/DIAGNOSIS AWARENESS		o ↻


				Is Aware	!
			<b>T</b>	Non-Awareness Reason	o
			<b>T/T</b> <sub>010</sub>	Person Category	!
		ADVERSE REACTIONS			!
		<b>T</b> <sub>010</sub>	Known Adverse Reactions		!
		ADVERSE REACTION			o ↻
		<b>T/T</b> <sub>010</sub>	Agent Description		!
		<b>T</b> <sub>010</sub>	Agent Description Certainty		o
		REACTION DETAIL			o ↻
			Onset		o
		<b>T/T</b> <sub>010</sub>	Reaction Description		!
		<b>T</b>	Adverse Reaction Note		o
		ALERTS			o
		ALERT			! ↻
		<b>T/T</b> <sub>010</sub>	Alert Type		!
		<b>T/T</b> <sub>010</sub>	Alert Description		!
			DateTime Started		o
		<b>T</b>	Alert Note		o
		PLAN			o
		REQUESTED SERVICES			o
		REQUESTED SERVICE			! ↻
		<b>T/T</b> <sub>010</sub>	Reason for Service		o
		<b>T/T</b> <sub>010</sub>	Requested Service Description		!
			Service Commencement Window		o
			SERVICE PROVIDER (PARTICIPANT.PERSON)		!
		<b>T</b>	Subject of Care Instruction Description		o ↻
		RECOMMENDATIONS			o
		<b>T</b>	Recommendation to Provider Note		! ↻
		<b>T</b>	Recommendation to Subject of Care		o

# 5 Data Specifications

The following part of the document expands on the details for each Section, Data Group and Data Element shown in the Data Hierarchy. A detailed definition of the table layout and each of the components is contained in the *NEHTA Data Specification and Structured Document Templates Guide for Use* [\[DS-GUIDE\]](#).

## 5.1 DISCHARGE SUMMARY

### Identification





 <b>Name</b>	DISCHARGE SUMMARY
<b>Metadata Type</b>	Structured Document
<b>Identifier</b>	ES-20000
<b>Version</b>	1.0

### Definition



<b>Definition</b>	A collection of information about events during care by a provider or organisation.
<b>Source</b>	Standards Australia IT14-6-6 <a href="#">[AS4700.6-2007]</a>
<b>Synonymous Names</b>	Separation Summary
<b>Notes</b>	<p>A Discharge Summary does not necessarily represent or enable transfer of care, nor is it necessarily intended for any particular provider or organisation. Such a summary may form part of a Discharge Referral. If a Discharge Summary is intended to take on the role of discharge referral then additional constraints are applicable on content, and the full referral information and encapsulating message should be used.</p> <p>A Discharge Summary from a provider facility/organisation includes information summarising the care given to the subject of care during the stay and additional information considered relevant to the ongoing care of the subject of care.</p> <p>This version of the Discharge Summary SDT is primarily intended to support the discharge (also called a separation) of a subject of care from a stay in hospital as an inpatient into the community, with the Discharge Summary document being sent to the GP or Specialist.</p>

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
	HEALTH EVENT CONTEXT	1.0	Essential		1
	DOCUMENT CONTEXT	1.0	Essential		1
	<a href="#">EVENT</a>		Essential		1
	<a href="#">MEDICATIONS</a>		Essential		1

---

	HEALTH PROFILE		Essential		1
	PLAN		Optional		0..1

## 5.2 EVENT

### Identification










 <b>Name</b>	EVENT
<b>Metadata Type</b>	Section
<b>Identifier</b>	S-16006

### Definition


<b>Definition</b>	The details of the healthcare event/encounter/clinical interaction from admission to discharge.
<b>Synonymous Names</b>	
<b>Notes</b>	This section is for the logical grouping of data elements relating to the admission event. An Episode, as described in the Header section of this document, can cover one or more events.

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
	ADMITTED EVENT	1.0	Essential		1
	REASON FOR ENCOUNTER	2.0	Essential		1
	ORIGINAL REFERRAL		Conditional	Required where the admission was the result of a referral.	0..1
	PROBLEMS/DIAGNOSES THIS VISIT		Essential		1
	CLINICAL INTERVENTIONS PERFORMED THIS VISIT		Optional		0..1
	CLINICAL SYNOPSIS	2.0	Essential		1
	PATHOLOGY	1.0	Optional		0..1
	DIAGNOSTIC IMAGING	2.0	Optional		0..1
	OBSERVATIONS		Optional		0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY		Essential		1

## 5.2.1 ADMITTED EVENT

### Identification







 <b>Name</b>	ADMITTED EVENT
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-20136
<b>Version</b>	1.0

### Definition


<b>Definition</b>	Describes the admission and discharge details for a subject of care into a healthcare facility.
<b>Synonymous Names</b>	Admission
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
	Admission DateTime		Essential		1
	Discharge DateTime		Essential		1
	Separation Mode		Essential		1
	DISCHARGE TO ADDRESS	1.0	Optional		0..1
	ATTENDING HEALTH PROFESSIONAL AT TIME OF DISCHARGE	1.0	Essential		1
	OTHER PARTICIPANTS	1.0	Optional		0..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	EVENT		Essential		1

## 5.2.2 Admission DateTime

### Identification



<b>Name</b>	Admission DateTime
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-20122

### Definition

<b>Definition</b>	The datetime when the subject of care is admitted to the healthcare facility.
<b>Synonymous Names</b>	Admission Date or Admission Date and Time Encounter Date or Encounter Date and Time
<b>Notes</b>	This item must include a date component and should include a time component if available.
<b>Datatype</b>	DateTime

### Usage

<b>Example/s</b>	2008-10-3011:20
------------------	-----------------


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ADMITTED EVENT	1.0	Essential		1

## 5.2.3 Discharge DateTime

### Identification

	<b>Name</b>	Discharge DateTime
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-20120

### Definition


<b>Definition</b>	The datetime when the subject of care is discharged from the healthcare facility.
<b>Synonymous Names</b>	Discharge Date Separation Date
<b>Notes</b>	This item denotes the date or date and time at which the subject of care is released/discharged from the healthcare facility at completion of a healthcare event/encounter. Must include a date component and should include a time component if available.
<b>Datatype</b>	DateTime

### Usage

<b>Example/s</b>	2008-11-1709:30
------------------	-----------------

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ADMITTED EVENT	1.0	Essential		1

## 5.2.4 Separation Mode

### Identification

T<sub>010</sub>

<b>Name</b>	Separation Mode
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-20121

### Definition


<b>Definition</b>	Status at separation of the subject of care (discharge/transfer/death) and place to which person is released.
<b>Synonymous Names</b>	Separation Reason Discharge Reason Discharge To
<b>Notes</b>	
<b>Datatype</b>	CodedText
<b>Value Domain</b>	AIHW Mode of Separation – METeOR identifier: 270094

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Discharge/transfer to a residential aged care service, unless this is the usual place of residence.</li> <li>2. Left against medical advice/discharge at own risk</li> <li>3. Other (includes discharge to usual residence, own accommodation/welfare institution (includes prisons, hostels and group homes providing primarily welfare services)).</li> </ol>
------------------	---


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">ADMITTED EVENT</a>	1.0	Essential		1

## 5.2.5 DISCHARGE TO ADDRESS

### Identification

 <b>Name</b>	DISCHARGE TO ADDRESS (ADDRESS)
<b>Metadata Type</b>	Data Group (reuse of ADDRESS data group, refer to the PARTICIPANT Data Specification <a href="#">[DS-PART]</a> for more detail).
<b>Identifier</b>	DG-20137
<b>Version</b>	1.0

### Definition


<b>Definition</b>	The location where the subject of care is discharged to.
<b>Synonymous Names</b>	Discharge Destination
<b>Notes</b>	Use in the event that the "discharged to" address is different from the subject of care's address of usual residence. For example, the subject of care might be discharged to a relative or carer's place of residence for ongoing care.

### Usage

<b>Example/s</b>	17 Streetname Road Suburb, QLD 5555
------------------	--


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">ADMITTED EVENT</a>	1.0	Optional		0..1

## 5.2.6 ATTENDING HEALTH PROFESSIONAL AT TIME OF DISCHARGE

### Identification









 <b>Name</b>	ATTENDING HEALTH PROFESSIONAL AT TIME OF DISCHARGE (PARTICIPANT.PERSON)
<b>Metadata Type</b>	Data Group (reuse of PARTICIPANT.PERSON, refer to the PARTICIPANT Data Specification <a href="#">[DS-PART]</a> for more detail).
<b>Identifier</b>	DG-10296
<b>Version</b>	1.0

### Definition


<b>Definition</b>	The healthcare provider who was responsible for the care given to the subject of care at the time of discharge from the healthcare event/encounter/clinical interaction.
<b>Synonymous Names</b>	Consultant Specialist Nurse Practitioner
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Condition	Occ.
	Role Name	Role name.description="Attending Health Professional at time of Discharge"	1
	ENTITY IDENTIFIER	<b>Must</b> contain the Healthcare Provider Identifier - Individual (HPI-I).	1
	ADDRESS	<b>Should Not</b> be included	0..*
	ELECTRONIC COMMUNICATION DETAILS	<b>Should</b> include at least one method of electronic communication.	0..*
	PERSON NAME	<b>Must</b> contain name details and name usage type.	1
	PERSON ADDITIONAL DEMOGRAPHIC DATA	<b>Should Not</b> be included	0..1
	HEALTHCARE PROVIDER PRACTICE DETAILS	<b>Should Not</b> be included	0..*
	EMPLOYER ORGANISATION DETAILS	<b>Should Not</b> be included	0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">ADMITTED EVENT</a>	1.0	Essential		1

## 5.2.7 OTHER PARTICIPANTS

### Identification



<b>Name</b>	OTHER PARTICIPANTS (PARTICIPANT.PERSON)
<b>Metadata Type</b>	Data Group (reuse of PARTICIPANT.PERSON, refer to the PARTICIPANT Data Specification [DS-PART] for more detail).
<b>Identifier</b>	DG-10296
<b>Version</b>	1.0

### Definition

<b>Definition</b>	The healthcare provider who was involved in the healthcare event/encounter/clinical interaction.
<b>Synonymous Names</b>	
<b>Notes</b>	Identifies other healthcare providers who are also involved in the healthcare event/encounter/clinical interaction such as a Registrar. This item is repeated for every instance of a Participant to be included.

### Relationships

#### Children

Type	Name	Condition	Occ.
	Role Name	Role name.description="Other Participants"	1
	ENTITY IDENTIFIER	<b>Must</b> contain the Healthcare Provider Identifier - Individual (HPI-I).	1
	ADDRESS	<b>Should Not</b> be included	0..*
	ELECTRONIC COMMUNICATION DETAILS	<b>Should</b> include at least one method of electronic communication.	0..*
	PERSON NAME	<b>Must</b> contain name details and name usage type.	1
	PERSON ADDITIONAL DEMOGRAPHIC DATA	<b>Should Not</b> be included	0..1
	HEALTHCARE PROVIDER PRACTICE DETAILS	<b>Should Not</b> be included	0..*
	EMPLOYER ORGANISATION DETAILS	<b>Should Not</b> be included	0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ADMITTED EVENT	1.0	Optional		0..*

## 5.2.8 REASON FOR ENCOUNTER

### Identification

<b>Name</b>	REASON FOR ENCOUNTER
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-15502
<b>Version</b>	2.0

### Definition

<b>Definition</b>	The reason why a person engages with the healthcare system, representing the demand for care/service by that subject of care.
<b>Synonymous Names</b>	Reason for Admission Problem on Admission
<b>Notes</b>	This item is also used for encounters other than hospital admissions, such as outpatients or emergency attendances, however for the Discharge Summary it relates specifically to the reason the subject of care was admitted to hospital.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T/T</b> <sub>010</sub>	<a href="#">Reason for Encounter Description</a>		Essential		1
<b>T</b>	<a href="#">Reason for Encounter Note</a>		Optional		0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
<b>S</b> <sub>3</sub>	<a href="#">EVENT</a>		Essential		1

## 5.2.9 Reason for Encounter Description

### Identification

T/T<sub>010</sub>

<b>Name</b>	Reason for Encounter Description
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15501

### Definition


<b>Definition</b>	The reason why the subject of care is seeking or receiving health advice and/or attention.
<b>Synonymous Names</b>	
<b>Notes</b>	This item identifies the reason why a subject of care has presented for examination by a healthcare provider and is usually the first step of the encounter. In a referral situation (healthcare provider to healthcare provider) the referring healthcare provider might specify a provisional diagnosis as a reason for encounter.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	Elective admission for Right Total Knee Replacement.
------------------	--

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">REASON FOR ENCOUNTER</a>	2.0	Essential		1

## 5.2.10 Reason for Encounter Note

### Identification

<b>T</b>	<b>Name</b>	Reason for Encounter Note
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-15596

### Definition


<b>Definition</b>	Comments relevant to the reason for encounter.
<b>Synonymous Names</b>	
<b>Notes</b>	This item provides additional narrative information in relation to the reason for encounter.
<b>Datatype</b>	Text

### Usage

<b>Example/s</b>	Readmission following cancellation of scheduled procedure 3 weeks ago.
------------------	--

### Relationships

#### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">REASON FOR ENCOUNTER</a>	2.0	Optional		0..1

## 5.2.11 ORIGINAL REFERRAL

### Identification


<b>Name</b>	ORIGINAL REFERRAL
<b>Metadata Type</b>	Section
<b>Identifier</b>	S-20125

### Definition


<b>Definition</b>	Describes the initiating referral when the admission is initiated by a referral.
<b>Synonymous Names</b>	Referral & Services Requested
<b>Notes</b>	<p>Identifies the original referrer, services requested and reason(s) for request. For use where the healthcare event (i.e. in-hospital/admission encounter) may be the result of a referral from the subject's GP, private specialist, aged care facility. In a discharge summary, this data group is used to group together information about the referral which initiated the hospital encounter.</p> <p>It is possible that the subject of care is admitted to the hospital without a referral, e.g. through the Emergency Department. In such a case, there may not be a referrer and reasons for referral, etc. information may not be available. The use of this section in the Discharge Summary template is hence considered conditional upon the presence of a referrer in the healthcare event/encounter.</p> <p>This item should not be used to carry referral information from the hospital to the subject's GP or other providers within or outside the hospital.</p> <p><u>Condition</u></p> <p>If the subject of care has been referred to the hospital by a referrer, e.g. healthcare provider such as GP, referrer information is essential.</p> <p>If the subject of care has not been referred to the hospital by a referrer, e.g. healthcare provider such as GP, referrer information is not permitted.</p>

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
	REQUESTED SERVICE	1.0	Essential		1..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	EVENT		Conditional	Required where the admission was the result of a referral.	0..1

## 5.2.12 REQUESTED SERVICE

### Identification

<b>Name</b>	REQUESTED SERVICE
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-20158
<b>Version</b>	1.0

### Definition



**Definition** Describes the type(s) of service requested for, or provided to, the subject of care.

#### Synonymous Names

**Notes** This item does not include details of medication prescriptions and/or diagnostic investigation requests. This item is repeated for every instance of a service requested.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T/T</b> <sub>010</sub>	<a href="#">Reason for Service</a>		Optional		0..1
<b>T/T</b> <sub>010</sub>	<a href="#">Requested Service Description</a>		Essential		1
	<a href="#">Service Commencement Window</a>		Optional		0..1
	<a href="#">SERVICE REQUESTOR</a>	1.0	Optional		0..1
<b>T</b>	<a href="#">Subject of Care Instruction Description</a>		Optional		0..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
<b>S</b> <sub>≡</sub>	<a href="#">ORIGINAL REFERRAL</a>		Essential		1..*

## 5.2.13 PROBLEMS/DIAGNOSES THIS VISIT

### Identification




<b>Name</b>	PROBLEMS/DIAGNOSES THIS VISIT
<b>Metadata Type</b>	Section
<b>Identifier</b>	S-20104

### Definition


<b>Definition</b>	Describes the diagnostic labels or problem statements assigned by the healthcare provider to describe the diagnoses, health/medical problems pertaining to the subject of care during a healthcare event/encounter/clinical interaction, and complications that the subject of care might have suffered during the same healthcare event/encounter/clinical interaction.
<b>Synonymous Names</b>	Problems/Diagnoses This Admission Problems/Diagnoses During This Visit Problems/Diagnosis During This Admission.
<b>Notes</b>	This section specifically relates to the problems associated with this healthcare event/encounter/clinical interaction and should not include details of unrelated historical problems.

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
	PRINCIPAL PROBLEM/DIAGNOSIS	2.0	Essential		1
	COMPLICATIONS	2.0	Conditional	Required where complications are present for the admitted event	0..*
	PROBLEM/DIAGNOSIS	2.0	Optional		0..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	EVENT		Essential		1

## 5.2.14 PRINCIPAL PROBLEM/DIAGNOSIS

### Identification





 <b>Name</b>	PRINCIPAL PROBLEM/DIAGNOSIS (PROBLEM DIAGNOSIS)
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-15530
<b>Version</b>	2.0

### Definition


<b>Definition</b>	Contains a diagnostic label or problem statement assigned by the healthcare provider to describe the principal problem/diagnosis pertaining to the subject of care during a healthcare event/encounter/clinical interaction.
<b>Synonymous Names</b>	Chief Complaint
<b>Notes</b>	Contains instances of Problem/Diagnosis where Problem/Diagnosis Type = "Principal". Should not include problems/diagnoses not related to the healthcare event/encounter/clinical interaction that the discharge summary is created for.

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
 <b>T</b> <sub>010</sub>	Problem/Diagnosis Type		Essential		1
 <b>T</b> / <b>T</b> <sub>010</sub>	Problem/Diagnosis Description		Essential		1
	DateTime Started		Optional		0..1
<b>T</b>	Problem/Diagnosis Note		Optional		0..1
	PROBLEM/DIAGNOSIS AWARENESS	1.0	Optional		0..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
 <b>S</b> <sub>==</sub>	PROBLEMS/DIAGNOSES THIS VISIT		Essential		1

## 5.2.15 COMPLICATIONS

### Identification






 <b>Name</b>	COMPLICATIONS (PROBLEM DIAGNOSIS)
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-15530
<b>Version</b>	2.0

### Definition


<b>Definition</b>	Contains a diagnostic label or problem statement assigned by the healthcare provider to describe the complications pertaining to the subject of care during a healthcare event/encounter/clinical interaction.
<b>Synonymous Names</b>	
<b>Notes</b>	<p>Contains instances where Problem/Diagnosis Type = "Complication".</p> <p><u>Condition</u></p> <p>If Problem/Diagnosis Type equals "Complication" Complications information relevant to the healthcare event/encounter/clinical interaction is essential.</p> <p>If Problem/Diagnosis Type does not equal "Complication" Complications information relevant to the healthcare event/encounter/clinical interaction is not permitted.</p> <p>Should not include complications not related to the healthcare event/encounter/clinical interaction that the discharge summary is created for.</p>

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
 <b>T</b> <sub>010</sub>	Problem/Diagnosis Type		Essential		1
 <b>T/T</b> <sub>010</sub>	Problem/Diagnosis Description		Essential		1
	DateTime Started		Optional		0..1
 <b>T</b>	Problem/Diagnosis Note		Optional		0..1
	PROBLEM/DIAGNOSIS AWARENESS	1.0	Optional		0..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
 <b>S</b> <sub>==</sub>	PROBLEMS/DIAGNOSES THIS VISIT		Conditional	Required where complications are present for the admitted event	0..*

## 5.2.16 PROBLEM/DIAGNOSIS

### Identification






 <b>Name</b>	PROBLEM/DIAGNOSIS (PROBLEM/DIAGNOSIS)
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-15530
<b>Version</b>	2.0

### Definition


<b>Definition</b>	Contains a diagnostic label or problem statement assigned by the healthcare provider to describe other problems/diagnoses (i.e. not principal and not complications) pertaining to the subject of care during a healthcare event/encounter/clinical interaction.
<b>Synonymous Names</b>	
<b>Notes</b>	<p>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.</p> <p>This item is repeated for every instance of a problem/diagnosis, generally constrained by the Problem/Diagnosis Type.</p> <p>Contains instances where Problem/Diagnosis Type is not "Principal" and not "Complications".</p> <p>Should only include problems/diagnoses related to the healthcare event/encounter/clinical interaction that the discharge summary is created for.</p>

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
 <b>T</b> <sub>010</sub>	Problem/Diagnosis Type		Essential		1
 <b>T/T</b> <sub>010</sub>	Problem/Diagnosis Description		Essential		1
 <b>112</b>	DateTime Started		Optional		0..1
 <b>T</b>	Problem/Diagnosis Note		Optional		0..1
 <b>PROBLEM/DIAGNOSIS AWARENESS</b>		1.0	Optional		0..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
 <b>S</b> <sub>≡</sub>	PROBLEMS/DIAGNOSES THIS VISIT		Optional		0..*

## 5.2.17 CLINICAL INTERVENTIONS PERFORMED THIS VISIT

### Identification


<b>Name</b>	CLINICAL INTERVENTIONS PERFORMED THIS VISIT
<b>Metadata Type</b>	Section
<b>Identifier</b>	S-20109

### Definition


<b>Definition</b>	Describes clinical interventions (diagnostic or interventional/therapeutic procedures) performed on the subject of care during a healthcare event/encounter/clinical interaction.
<b>Synonymous Names</b>	Procedures Performed This Admission
<b>Notes</b>	Formerly called Procedures Performed This Visit.

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
	CLINICAL INTERVENTION	2.0	Essential		1..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	EVENT		Optional		0..1

## 5.2.18 CLINICAL INTERVENTION

### Identification




 <b>Name</b>	CLINICAL INTERVENTION
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-15514
<b>Version</b>	2.0

### Definition


<b>Definition</b>	Describes an intervention carried out by a healthcare provider to improve, maintain or assess the health of a subject of care, in a clinical situation that may require clinical judgement to produce a subjective finding (i.e. an 'action' that may include an 'evaluation'). Clinical interventions include invasive and non-invasive procedures, and cognitive interventions.
<b>Synonymous Names</b>	Diagnostic intervention Therapeutic intervention Diagnostic procedure Therapeutic procedure Treatment Procedure Counseling/Advising
<b>Notes</b>	Captures detailed information on relevant clinical interventions, as performed by a healthcare provider. Includes information on therapeutic/treatment procedures during the healthcare visit/encounter and can include diagnostic procedures.  This item is repeated for every instance of a clinical intervention. Should not be used for recording Medications prescribed; or Reporting Pathology or Diagnostic Imaging results.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
 <b>T/T</b> <sub>010</sub>	<a href="#">Clinical Intervention Description</a>		Essential		1
	<a href="#">DateTime Started</a>		Optional		0..1
<b>T</b>	<a href="#">Clinical Intervention Note</a>		Optional		0..1
	<a href="#">CLINICAL INTERVENTION AWARENESS</a>	1.0	Optional		0..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">CLINICAL INTERVENTIONS PERFORMED THIS VISIT</a>		Essential		1..*

## 5.2.19 Clinical Intervention Description

### Identification

T/T<sub>010</sub>

<b>Name</b>	Clinical Intervention Description
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15579

### Definition


<b>Definition</b>	Describes the clinical intervention undertaken on or provided to the subject of care.
<b>Synonymous Names</b>	
<b>Notes</b>	Captures information on relevant clinical interventions, as performed by a healthcare provider. Specifies therapeutic/treatment procedures performed during the healthcare visit/encounter/interaction.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Creation of Arterio-venous shunt for haemodialysis</li> <li>2. Peritoneal Dialysis</li> </ol>
------------------	---

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">CLINICAL INTERVENTION</a>	2.0	Essential		1

## 5.2.20 DateTime Started

### Identification



<b>Name</b>	DateTime Started
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15507

### Definition


<b>Definition</b>	The datetime when a clinical intervention is performed on the subject of care.
<b>Synonymous Names</b>	Date and Time Performed Date and Time Procedure Performed Date and Time Test Performed
<b>Notes</b>	Captures the date and time values of a procedure being performed. This item must include a date component and time component.
<b>Datatype</b>	DateTime

### Usage

<b>Example/s</b>	2008-10-2514:30
------------------	-----------------

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">CLINICAL INTERVENTION</a>	2.0	Optional		0..1

## 5.2.21 Clinical Intervention Note

### Identification

<b>T</b>	<b>Name</b>	Clinical Intervention Note
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-15595

### Definition


<b>Definition</b>	Additional information relevant to the clinical intervention.
<b>Synonymous Names</b>	Procedure Note
<b>Notes</b>	
<b>Datatype</b>	Text

### Usage

<b>Example/s</b>	For the intervention "Lumbar Epidural Block" the note may be "Performed due to COPD prior to general anaesthetic".
------------------	--


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	CLINICAL INTERVENTION	2.0	Optional		0..1

## 5.2.22 CLINICAL INTERVENTION AWARENESS

### Identification


 <b>Name</b>	CLINICAL INTERVENTION AWARENESS (AWARENESS)
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-20147
<b>Version</b>	1.0

### Definition


<b>Definition</b>	Indicates whether a person (which may be a subject of care or his/her relative or family member) is aware of the specified information in question.
<b>Synonymous Names</b>	Awareness of Procedure Performed Procedure Performed Awareness
<b>Notes</b>	Captures detailed information about a person's (subject of care or persons related to the subject of care) awareness of clinical intervention(s) performed during current healthcare event/encounter.  This item is repeated for every instance of clinical intervention awareness as required.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
	Is Aware		Essential		1
<b>T</b>	Non-Awareness Reason		Optional		0..1
<b>T/T</b> <sub>010</sub>	Person Category		Essential		1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	CLINICAL INTERVENTION	2.0	Optional		0..*

## 5.2.23 CLINICAL SYNOPSIS

### Identification

<b>Name</b>	CLINICAL SYNOPSIS
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-15513
<b>Version</b>	2.0

### Definition

<b>Definition</b>	Contains summary information/comments on the clinical management of the subject of care, and the prognosis of diagnosis/problems identified during a healthcare event/encounter/clinical interaction. It may also include health related information pertinent to the subject of care.
<b>Synonymous Names</b>	Clinical Comment Clinical Note Clinical Summary Clinical Management
<b>Notes</b>	Should not be used to list discharge medications.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T</b>	<a href="#">Clinical Synopsis Comment</a>		Essential		1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
<a href="#">S</a>	<a href="#">EVENT</a>		Essential		1

## 5.2.24 Clinical Synopsis Comment

### Identification

<b>T</b>	<b>Name</b>	Clinical Synopsis Comment
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-15582

### Definition


<b>Definition</b>	Comments on the subject of care's health issues/problems. The description includes summary of the issues/problems, management strategies, outcomes/progress and possible prognosis.
<b>Synonymous Names</b>	Clinical Synopsis Description Clinical Summary Description
<b>Notes</b>	
<b>Datatype</b>	Text

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>Admitted for elective bronchoscopy for assessment of left lingular and bibasal pneumonia. No focal endobronchial pathology identified. No evidence of malignancy and no pathogens isolated on bronchial brushings and washings.</li> <li>3/52 ago involved in a rear end motor vehicle accident, mid-velocity impact- complaining of neck pain, dizziness, nausea and difficulties concentrating. Disturbed sleep. No spinal cord signs.</li> </ol>
------------------	--

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">CLINICAL SYNOPSIS</a>	2.0	Essential		1

## 5.2.25 PATHOLOGY


<b>Name</b>	PATHOLOGY
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-16012
<b>Version</b>	1.0

### Definition


<b>Definition</b>	Describes relevant diagnostic tests (e.g. microbiology, immunology, histology/cytology, biochemistry, haematology) undertaken on the subject of care during the healthcare event/encounter/clinical interaction.
<b>Synonymous Names</b>	
<b>Notes</b>	<p>There are several different areas of activity within the Pathology field including Microbiology, Anatomical, Chemical, Genetics, Haematology and Immunology. Should not be used for non-pathology diagnostic tests performed on the subject of care during a healthcare event/encounter/clinical interaction.</p> <p>Further consultation on the full requirements for inclusion of Pathology results in the discharge summary is required to determine the optimal method of implementation. In the interim the pathology result report has been included as a single data item of encapsulated data.</p> <p>For details on pathology please refer to the <i>Pathology Result Report Structured Document Template v1.0</i> <a href="#">[PRRSDT]</a>.</p>

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
	PATHOLOGY RESULT REPORT		Essential		1..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	EVENT		Optional		0..1

## 5.2.26 DIAGNOSTIC IMAGING

### Identification


<b>Name</b>	DIAGNOSTIC IMAGING
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-12000
<b>Version</b>	2.0

### Definition


<b>Definition</b>	Describes relevant diagnostic imaging procedures (e.g. radiology studies such as x-rays, CT scan, MRI; ultrasonic studies, nuclear medicine studies, bone densitometry) undertaken on the subject of care during the healthcare event/encounter/clinical interaction.
<b>Synonymous Names</b>	Radiology
<b>Notes</b>	<p>Diagnostic Imaging (Radiology) tests only, should not be used for other diagnostic tests performed on the subject of care during a healthcare event/visit.</p> <p>Further consultation on the full requirements for inclusion of Diagnostic Imaging results in the discharge summary is required to determine the optimal method of implementation. In the interim the diagnostic imaging result report has been included as a single data item of encapsulated data.</p> <p>For details on diagnostic imaging reports refer to the <i>Diagnostic Imaging Data Specification v1.0</i> <a href="#">[DIDS2007]</a>.</p>

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
	DIAGNOSTIC IMAGING REPORTING		Essential		1..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">EVENT</a>		Optional		0..1

## 5.2.27 OBSERVATIONS

### Identification


<b>Name</b>	OBSERVATIONS
<b>Metadata Type</b>	Section
<b>Identifier</b>	S-20120

### Definition


<b>Definition</b>	Describes relevant health assessments (other than pathology and diagnostic imaging procedures) including observation or diagnostic procedures undertaken on the subject of care during the healthcare event/encounter/clinical interaction.
<b>Synonymous Names</b>	
<b>Notes</b>	Most encounters will include numerous routine observations which are irrelevant by the time of discharge, and it is not intended that such routine observations be included. It is intended that the document author enter or select only those observations that are specifically relevant.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
	OBSERVATION	2.0	Essential		1..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	EVENT		Optional		0..1

## 5.2.28 OBSERVATION

### Identification


<b>Name</b>	OBSERVATION
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-15529
<b>Version</b>	2.0

### Definition


<b>Definition</b>	Describes the health or physical assessment and/or observation undertaken on the subject of care. The assessment or observation may be subjective, e.g. description of symptoms, appearance; or it may be objective, e.g. body weight, height, heart rate.
<b>Synonymous Names</b>	
<b>Notes</b>	Captures detailed information on Investigations excluding pending investigations, Pathology/Laboratory and Diagnostic Imaging tests.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">DateTime of Observation</a>		Essential		1
<b>T</b> / <b>T</b> <sub>010</sub>	<a href="#">Observation Description</a>		Essential		1
<b>any</b>	<a href="#">Observation Result</a>		Essential		1
<b>T</b> / <b>T</b> <sub>010</sub>	<a href="#">Observation Abnormal Indicator</a>		Conditional	OBSERVATION RESULT must be present and out of normal range.	0..1
<b>T</b>	<a href="#">Observation Note</a>		Optional		0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">OBSERVATIONS</a>		Essential		1..*

## 5.2.29 DateTime of Observation

### Identification



<b>Name</b>	DateTime of Observation
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15561

### Definition


<b>Definition</b>	The datetime when the health assessment/observation is performed.
<b>Synonymous Names</b>	
<b>Notes</b>	Requires both the Date and Time component.
<b>Datatype</b>	DateTime

### Usage

<b>Example/s</b>	2008-10-1811:52
------------------	-----------------

### Relationships

#### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">OBSERVATION</a>	2.0	Essential		1

## 5.2.30 Observation Description

### Identification



<b>Name</b>	Observation Description
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15515

### Definition

<b>Definition</b>	Describes the Observation taken (on the subject of care).
<b>Synonymous Names</b>	
<b>Notes</b>	Captures the name of the investigation, or the entity or level of function being observed. For each observation description, there is a corresponding finding or value - see Observation Result.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Blood Pressure</li> <li>2. Temperature</li> </ol>
------------------	---

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">OBSERVATION</a>	2.0	Essential		1

## 5.2.31 Observation Result

### Identification

any	<b>Name</b>	Observation Result
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-15516

### Definition


<b>Definition</b>	The outcome of the observation undertaken.
<b>Synonymous Names</b>	
<b>Notes</b>	This item can be any data type such as text, quantity number etc. In the examples provided the result groups together the value and unit of measure for the observation.
<b>Datatype</b>	Any

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. 120/70 mm Hg (Blood Pressure)</li> <li>2. 38.6°C (Temperature)</li> </ol>
------------------	---

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">OBSERVATION</a>	2.0	Essential		1

## 5.2.32 Observation Abnormal Indicator

### Identification

T/T<sub>010</sub>

<b>Name</b>	Observation Abnormal Indicator
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15505

### Definition


<b>Definition</b>	Indicates the degree of abnormality from the normal limits of the result.
<b>Synonymous Names</b>	Abnormal Flag
<b>Notes</b>	<p><u>Condition</u></p> <p>If OBSERVATION RESULT is out of normal range then Abnormal Observation Indicator information is essential.</p> <p>If OBSERVATION RESULT is not out of normal range then Abnormal Observation Indicator information is optional.</p>
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Abnormal (applies to non numeric result).</li> <li>2. Critical high (markedly above upper limit of reference range).</li> <li>3. Below low normal.</li> <li>4. Above upper panic limit.</li> </ol>
------------------	--

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	OBSERVATION	2.0	Conditional	OBSERVATION RESULT must be present and out of normal range.	0..1

### 5.2.33 Observation Note

#### Identification

<b>T</b>	<b>Name</b>	Observation Note
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-15600

#### Definition


<b>Definition</b>	Additional comments relevant to the observation in question.
<b>Synonymous Names</b>	
<b>Notes</b>	Used to provide additional information not included in or catered for by the Observation Result data elements.
<b>Datatype</b>	Text

#### Usage

<b>Example/s</b>	
------------------	--


#### Relationships

##### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">OBSERVATION</a>	2.0	Optional		0..1

## 5.3 MEDICATIONS

### Identification



<b>Name</b>	MEDICATIONS
 <b>Metadata Type</b>	Section
<b>Identifier</b>	S-16022

### Definition


<b>Definition</b>	Describes relevant medication information for the subject of care to be communicated to the general practitioner. Includes sections on current medications on discharge and recently ceased medications.
<b>Synonymous Names</b>	
<b>Notes</b>	This section outlines the data groups and data elements with obligations for Current and Recently Ceased Medications for the Discharge Summary and both sections utilise the ITEM DETAIL data group. As the obligations of different parts of the ITEM DETAIL data group vary between current and ceased medications the data group is repeated in detail for each section.

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
	CURRENT MEDICATIONS ON DISCHARGE		Conditional	Required if there are current medications at the time of discharge.	0..1
	RECENTLY CEASED MEDICATIONS		Conditional	Required if there are medications ceased during the Admitted Event.	0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY		Essential		1

### 5.3.1 CURRENT MEDICATIONS ON DISCHARGE

#### Identification


 <b>Name</b>	CURRENT MEDICATIONS ON DISCHARGE
<b>Metadata Type</b>	Section
<b>Identifier</b>	S-20110

#### Definition


<b>Definition</b>	Contains information about a subject of care's medication(s) that are continued on discharge.
<b>Synonymous Names</b>	Discharge Medications Medications on Discharge
<b>Notes</b>	<p>The CURRENT MEDICATIONS ON DISCHARGE section in a discharge summary includes:</p> <ul style="list-style-type: none"> <li>• Admission Medications - i.e. medications known on admission which are continued on discharge; and</li> <li>• Medications prescribed during encounter/admission which are continued on discharge.</li> </ul> <p>The "Admission Medications" included in this section include both those that are continued unchanged on discharge or continued with some changes on discharge.</p> <p><u>Condition</u></p> <p>If the Status of the Item Detail does not equal "Ceased" then Current Medications on Discharge information is essential.</p> <p>If the Status of the Item Detail equals "Ceased" then Current Medications on Discharge information is not permitted.</p>

#### Relationships

##### Children


Type	Name	Version	Obligation	Condition	Occurrence
	ITEM DETAIL	2.0	Essential		1..*

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	MEDICATIONS		Conditional	Required if there are current medications at the time of discharge.	0..1

## 5.3.2 ITEM DETAIL

### Identification







 <b>Name</b>	ITEM DETAIL
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-10120
<b>Version</b>	2.0

### Definition


<b>Definition</b>	Describes a single unique medication product.
<b>Synonymous Names</b>	
<b>Notes</b>	This data group is repeated for every instance of a medication item being included.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
 <b>T</b> <sub>010</sub>	<a href="#">Item Status</a>		Essential		1
	<a href="#">ITEM</a>	1.0	Essential		1
	<a href="#">Medication Duration</a>		Optional		0..1
 <b>T/T</b> <sub>010</sub>	<a href="#">Reason for Medication</a>		Optional		0..1
	<a href="#">DOSAGE</a>	1.0	Essential		1
	<a href="#">CHANGE DETAILS</a>	1.0	Optional		0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
 <b>S</b> <sub>≡</sub>	<a href="#">CURRENT MEDICATIONS ON DISCHARGE</a>		Essential		1..*

### 5.3.3 Item Status

#### Identification

T<sub>010</sub>

<b>Name</b>	Item Status
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16001

#### Definition


<b>Definition</b>	The status of the medication item at the time of discharge from hospital.
<b>Synonymous Names</b>	
<b>Notes</b>	Must have a status equivalent to active to be included within this section in the discharge summary.
<b>Datatype</b>	CodedText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

#### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Newly Prescribed</li> <li>2. Existing</li> <li>3. Ceased</li> </ol>
------------------	---

#### Relationships

##### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	ITEM DETAIL	2.0	Essential		1

## 5.3.4 ITEM

### Identification

 <b>Name</b>	ITEM
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-16003
<b>Version</b>	1.0

### Definition


<b>Definition</b>	Describes the medication product.
<b>Synonymous Names</b>	
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T</b> <sub>010</sub>	Item Type		Essential		1
<b>T/T</b> <sub>010</sub>	Item Description		Essential		1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ITEM DETAIL	2.0	Essential		1

### 5.3.5 Item Type

#### Identification

T<sub>010</sub>

<b>Name</b>	Item Type
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16004

#### Definition


<b>Definition</b>	The type of item.
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	CodedText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

#### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Medicinal</li> <li>2. Non-Medicinal</li> </ol>
------------------	--

#### Relationships

##### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	ITEM	1.0	Essential		1

## 5.3.6 Item Description

### Identification

T/T<sub>010</sub>

<b>Name</b>	Item Description
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10194

### Definition


<b>Definition</b>	The description of the Prescribed item.
<b>Synonymous Names</b>	Drug name; Medication; Qualified name
<b>Notes</b>	<p>When prescribers are describing a medication, they may do so at differing levels of specificity, depending upon the clinical context, the healthcare setting, the type of medication being prescribed, their knowledge of specific drugs, the functionality of their prescribing system and other factors.</p> <p>This data element is designed to carry a term from a terminology which may include form, active ingredients and strength and may also include pack size as part of the term (if applicable).</p>
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	MPUU, MPP, TPUU, TPP or CTPP from the Australian Medicines Terminology

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Paracetamol 500mg + codeine phosphate 30 mg tablet (MPUU – Medicinal Product Unit of Use)</li> <li>2. Paracetamol 500mg + codeine phosphate 30 mg tablet, 20 (MPP – Medicinal Product)</li> <li>3. Panadeine Forte tablet: uncoated, 20 tablets (TPP – Trade Product Pack)</li> <li>4. Panadeine Forte (paracetamol 500 mg + codeine phosphate 30mg) tablet: uncoated, 1 tablet (TPUU – Trade Product Unit of Use)</li> <li>5. Panadeine Forte tablet: uncoated, 20 tablets, blister pack (CTPP – Containered trade product pack)</li> </ol>
------------------	--

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ITEM	1.0	Essential		1

## 5.3.7 Medication Duration

### Identification



<b>Name</b>	Medication Duration
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10143

### Definition

<b>Definition</b>	The period for which the subject of care will take the prescribed medication.
<b>Synonymous Names</b>	
<b>Notes</b>	May be expressed as a duration (e.g. 3 days) or a time interval with a start and/or end date.
<b>Datatype</b>	TimeInterval

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>2005 to 2008-05-18</li> <li>3 months</li> </ol>
------------------	--

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">ITEM DETAIL</a>	2.0	Optional		0..1

### 5.3.8 Reason for Medication

#### Identification

T/T<sub>010</sub>

<b>Name</b>	Reason for Medication
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10141

#### Definition


<b>Definition</b>	The clinical justification (esp. specific therapeutic effect intended) for use of the medication.
<b>Synonymous Names</b>	Reason for prescribing
<b>Notes</b>	
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

#### Usage

<b>Example/s</b>	Long-term maintenance treatment of bronchospasm and dyspnoea.
------------------	---


#### Relationships

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">ITEM DETAIL</a>	2.0	Optional		0..1

## 5.3.9 DOSAGE

### Identification


 <b>Name</b>	DOSAGE
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-16007
<b>Version</b>	1.0

### Definition


<b>Definition</b>	A data group to describe how a particular product is being taken by the subject of care as at the date of discharge or is intended to be taken immediately following discharge.
<b>Synonymous Names</b>	
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T</b>	<a href="#">Dose Instruction</a>		Essential		1
	<a href="#">Dose Quantity</a>		Optional		0..1
<b>T/T</b> <sub>010</sub>	<a href="#">Frequency</a>		Optional		0..1
<b>T/T</b> <sub>010</sub>	<a href="#">Frequency Qualifier</a>		Optional		0..*
<b>T/T</b> <sub>010</sub>	<a href="#">Site of Administration</a>		Optional		0..1
<b>T/T</b> <sub>010</sub>	<a href="#">Route of Administration</a>		Optional		0..1
<b>T</b>	<a href="#">Additional Dose Instructions</a>		Optional		0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">ITEM DETAIL</a>	2.0	Essential		1

### 5.3.10 Dose Instruction

#### Identification

<b>T</b>	<b>Name</b>	Dose Instruction
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-16008

#### Definition


<b>Definition</b>	A free text representation of the complete dosage instruction to support legacy computer systems.
<b>Synonymous Names</b>	
<b>Notes</b>	This text must represent a concatenation of all the following dosage data elements. It is recommended, for safety reasons, that this data element is machine generated.
<b>Datatype</b>	Text

#### Usage

<b>Example/s</b>	
------------------	--

#### Relationships

##### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	DOSAGE	1.0	Essential		1

### 5.3.11 Dose Quantity

#### Identification



<b>Name</b>	Dose Quantity
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10152

#### Definition

<b>Definition</b>	The amount of medication to be taken/administered at one time.
<b>Synonymous Names</b>	
<b>Notes</b>	Quantity range datatype – range includes low and high quantity value and units (e.g. 65 micrograms; 2.5 mg; or 2 tablets).
<b>Datatype</b>	Quantity Range

#### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. 65 micrograms</li> <li>2. 2 tablets</li> </ol>
------------------	--

#### Relationships

##### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	DOSAGE	1.0	Optional		0..1

## 5.3.12 Frequency

### Identification

T/T<sub>010</sub>

<b>Name</b>	Frequency
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10153

### Definition


<b>Definition</b>	How often each dose of the medication has to be taken / administered.
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	NEHTA SCT-AU Dose Frequency Reference Set

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>Once only</li> <li>Three times daily</li> <li>6 hourly</li> </ol>
------------------	--

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DOSAGE	1.0	Optional		0..1

### 5.3.13 Frequency Qualifier

#### Identification

T/T<sub>010</sub>

<b>Name</b>	Frequency Qualifier
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10154

#### Definition


<b>Definition</b>	Information provided in addition to the frequency that provides more detail or guidance about the timing of medication administration.
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	NEHTA SCT-AU Dose Frequency Qualifier Reference Set

#### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. After Meals</li> <li>2. In the morning</li> <li>3. Before bed</li> </ol>
------------------	--

#### Relationships

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DOSAGE	1.0	Optional		0..*

### 5.3.14 Site of Administration

#### Identification

T/T<sub>010</sub>

<b>Name</b>	Site of Administration
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10156

#### Definition


<b>Definition</b>	Location on or in the body of the subject of care that the medication is to be administered.
<b>Synonymous Names</b>	
<b>Notes</b>	Used for medicines for which site of administration is important.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

#### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Outer thigh</li> <li>2. Right eye</li> </ol>
------------------	--

#### Relationships

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DOSAGE	1.0	Optional		0..1

### 5.3.15 Route of Administration

#### Identification

T/T<sub>010</sub>

<b>Name</b>	Route of Administration
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10147

#### Definition


<b>Definition</b>	The way through which a medication is administered (e.g. Oral, Subcutaneous injection, Epidural, nebuliser).
<b>Synonymous Names</b>	Route
<b>Notes</b>	Describes which route the administered medication takes into the body. In some cases this can be implied from the Item Description and therefore need not be specifically articulated (e.g. Paracetamol 500 mg tablets). In other cases, route must be explicitly stated at time of prescribing where confusion may otherwise arise.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	NEHTA SCT-AU Dose Route of Administration Reference Set

#### Usage

<b>Example/s</b>	1. Oral 2. Subcutaneous injection 3. Epidural
------------------	---

#### Relationships

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DOSAGE	1.0	Optional		0..1

### 5.3.16 Additional Dose Instructions

#### Identification

<b>T</b>	<b>Name</b>	Additional Dose Instructions
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-10166

#### Definition


<b>Definition</b>	Additional text that may be required to fully describe a complex dosage instruction.
<b>Synonymous Names</b>	
<b>Notes</b>	<p>The Dose Instruction data element is required to be equivalent to the related coded data elements. This does not allow for complex dosage instructions to be captured and communicated.</p> <p>This additional data element has therefore been included to enable capture and communication of additional important information not able to be captured in the earlier data elements.</p> <p>It may also include cautionary advice for the subject of care or person administering the medication when taking / administering the medication. This may be required for certain medications to reduce risks or complications after administration.</p>
<b>Datatype</b>	Text

#### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Take as per advised by pathology.</li> <li>2. Do not expose skin to sun after application of medicine.</li> </ol>
------------------	---


#### Relationships

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DOSAGE	1.0	Optional		0..1

### 5.3.17 CHANGE DETAILS

#### Identification

 <b>Name</b>	CHANGE DETAILS
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-10128
<b>Version</b>	1.0

#### Definition


<b>Definition</b>	Describes information about any changes made to the medication item during the subject of care's healthcare encounter/event/interaction which may be relevant to be known by the subject of care's healthcare provider, and the reason for that change.
<b>Synonymous Names</b>	
<b>Notes</b>	

#### Relationships

##### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T</b> <sub>010</sub>	<a href="#">Change Description</a>		Essential		1
<b>T</b>	<a href="#">Reason for Change</a>		Optional		0..1
<b>T</b>	<a href="#">Follow Up Required</a>		Optional		0..1

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">ITEM DETAIL</a>	2.0	Optional		0..1

## 5.3.18 Change Description

### Identification

T<sub>010</sub>

<b>Name</b>	Change Description
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10176

### Definition


<b>Definition</b>	Description of any change made during the healthcare encounter where the change is intended to continue after discharge.
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	CodedText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Change of Dose.</li> <li>2. Correction of prescription error.</li> </ol>
------------------	--

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">CHANGE DETAILS</a>	1.0	Essential		0..1

### 5.3.19 Reason for Change

#### Identification

<b>T</b>	<b>Name</b>	Reason for Change
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-10177

#### Definition


<b>Definition</b>	The justification for the stated change.
<b>Synonymous Names</b>	
<b>Notes</b>	Should be completed if a change has been made.
<b>Datatype</b>	Text

#### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Optimise drug therapy.</li> <li>2. Intolerable side effect of dizziness.</li> </ol>
------------------	---

#### Relationships

##### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">CHANGE DETAILS</a>	1.0	Optional		0..1

## 5.3.20 Follow Up Required

### Identification

<b>T</b>	<b>Name</b>	Follow Up Required
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-16009

### Definition


<b>Definition</b>	Describes any information that may be needed to ensure continuity of supply or continued proper use of the medication.
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	Text

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Patient will require new script within 3 days of discharge.</li> <li>2. Dosage to be reviewed in 10 days.</li> </ol>
------------------	--


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">CHANGE DETAILS</a>	1.0	Optional		0..1

### 5.3.21 RECENTLY CEASED MEDICATIONS

#### Identification


	<b>Name</b>	RECENTLY CEASED MEDICATIONS
	<b>Metadata Type</b>	Section
	<b>Identifier</b>	S-20111

#### Definition


<b>Definition</b>	Contains information about a subject of care's relevant medication(s) that had been stopped during the healthcare encounter or on discharge.
<b>Synonymous Names</b>	Medications Ceased This Visit Medications Ceased This Admission
<b>Notes</b>	<p><u>Condition</u></p> <p>If the Status of the Item Detail equals "Ceased" and the finish of the Medication Duration is later than the Admission DateTime then Recently Ceased Medications information is essential.</p> <p>If the Status of the Item Detail does not equal "Ceased" then Recently Ceased Medications information is not permitted.</p> <p>If the Status of the Item Detail does not equal "Ceased" and the finish of the Medication Duration is earlier than the Admission DateTime then Recently Ceased Medications information is optional.</p>

#### Relationships

##### Children

Type	Name	Version	Obligation	Condition	Occurrence
	ITEM DETAIL	2.0	Essential		1..*

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	MEDICATIONS		Conditional	Required if there are medications ceased during the Admitted Event.	0..1

## 5.3.22 ITEM DETAIL

### Identification







<b>Name</b>	ITEM DETAIL
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-10120
<b>Version</b>	2.0

### Definition


<b>Definition</b>	Describes a single unique medication product.
<b>Synonymous Names</b>	
<b>Notes</b>	This data group is repeated for every instance of a medication item being included.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
	Item Status		Essential		1
	ITEM	1.0	Essential		1
	Medication Duration		Essential		1
	Reason for Medication		Optional		0..1
	DOSAGE	1.0	Optional		0..1
	CHANGE DETAILS	1.0	Optional		0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	RECENTLY CEASED MEDICATIONS		Essential		1..*

### 5.3.23 Item Status

#### Identification

T<sub>010</sub>

<b>Name</b>	Item Status
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16001

#### Definition


<b>Definition</b>	The status of the medication item at the time of discharge from hospital.
<b>Synonymous Names</b>	
<b>Notes</b>	Must have a status equivalent to ceased to be included within this section in the discharge summary.
<b>Datatype</b>	CodedText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

#### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Newly Prescribed</li> <li>2. Existing</li> <li>3. Ceased</li> </ol>
------------------	---


#### Relationships

##### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	ITEM DETAIL	2.0	Essential		1

## 5.3.24 ITEM

### Identification

 <b>Name</b>	ITEM
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-16003
<b>Version</b>	1.0

### Definition


<b>Definition</b>	Describes the medication product.
<b>Synonymous Names</b>	
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T</b> <sub>010</sub>	Item Type		Essential		1
<b>T/T</b> <sub>010</sub>	Item Description		Essential		1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ITEM DETAIL	2.0	Essential		1

## 5.3.25 Item Type

### Identification

T<sub>010</sub>

<b>Name</b>	Item Type
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16004

### Definition


<b>Definition</b>	The type of item.
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	CodedText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Medicinal</li> <li>2. Non-Medicinal</li> </ol>
------------------	--

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ITEM	1.0	Essential		1

## 5.3.26 Item Description

### Identification

T/T<sub>010</sub>

<b>Name</b>	Item Description
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10194

### Definition


<b>Definition</b>	The description of the prescribed item.
<b>Synonymous Names</b>	Drug name; Medication; Qualified name
<b>Notes</b>	<p>When prescribers are describing a medication, they may do so at differing levels of specificity, depending upon the clinical context, the healthcare setting, the type of medication being prescribed, their knowledge of specific drugs, the functionality of their prescribing system and other factors.</p> <p>This data element is designed to carry a term from a terminology which may include form, active ingredients and strength and may also include pack size as part of the term (if applicable).</p>
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	MP, MPUU, MPP, TP, TPUU, TPP or CTPP from the Australian Medicines Terminology

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Paracetamol 500mg + codeine phosphate 30 mg tablet (MPUU – Medicinal Product Unit of Use)</li> <li>2. Paracetamol 500mg + codeine phosphate 30 mg tablet, 20 (MPP – Medicinal Product)</li> <li>3. Panadeine Forte tablet: uncoated, 20 tablets (TPP – Trade Product Pack)</li> <li>4. Panadeine Forte (paracetamol 500 mg + codeine phosphate 30mg) tablet: uncoated, 1 tablet (TPUU – Trade Product Unit of Use)</li> <li>5. Panadeine Forte tablet: uncoated, 20 tablets, blister pack (CTPP – Containered trade product pack)</li> </ol>
------------------	--

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ITEM	1.0	Essential		1

## 5.3.27 Medication Duration

### Identification



<b>Name</b>	Medication Duration
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10143

### Definition

<b>Definition</b>	The period for which the subject of care will take the prescribed medication.
<b>Synonymous Names</b>	
<b>Notes</b>	May be expressed as a duration (e.g. 3 days) or a time interval with a start and/or end date.
<b>Datatype</b>	TimeInterval

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>2005 – 2008-05-18</li> <li>3 months</li> </ol>
------------------	---

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">ITEM DETAIL</a>	2.0	Essential		1

## 5.3.28 Reason for Medication

### Identification



<b>Name</b>	Reason for Medication
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10141

### Definition

<b>Definition</b>	The clinical justification (esp. specific therapeutic effect intended) for use of the medication.
<b>Synonymous Names</b>	Reason for prescribing
<b>Notes</b>	
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	Long-term maintenance treatment of bronchospasm and dyspnoea.
------------------	---


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">ITEM DETAIL</a>	2.0	Optional		0..1

## 5.3.29 DOSAGE

### Identification


 <b>Name</b>	DOSAGE
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-16007
<b>Version</b>	1.0

### Definition


<b>Definition</b>	A data group to describe how a particular product is being taken by the subject of care as at the date of discharge or is intended to be taken immediately following discharge.
<b>Synonymous Names</b>	
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T</b>	<a href="#">Dose Instruction</a>		Essential		1
	<a href="#">Dose Quantity</a>		Optional		0..1
<b>T/T</b> <sub>010</sub>	<a href="#">Frequency</a>		Optional		0..1
<b>T/T</b> <sub>010</sub>	<a href="#">Frequency Qualifier</a>		Optional		0..*
<b>T/T</b> <sub>010</sub>	<a href="#">Site of Administration</a>		Optional		0..1
<b>T/T</b> <sub>010</sub>	<a href="#">Route of Administration</a>		Optional		0..1
<b>T</b>	<a href="#">Additional Dose Instructions</a>		Optional		0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">ITEM DETAIL</a>	2.0	Optional		0..1

### 5.3.30 Dose Instruction

#### Identification

<b>T</b>	<b>Name</b>	Dose Instruction
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-16008

#### Definition


<b>Definition</b>	A free text representation of the complete dosage instruction to support legacy computer systems.
<b>Synonymous Names</b>	
<b>Notes</b>	This text must represent a concatenation of all the following dosage data elements. It is recommended, for safety reasons, that this data element is machine generated.
<b>Datatype</b>	Text

#### Usage

<b>Example/s</b>	
------------------	--

#### Relationships

##### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	DOSAGE	1.0	Essential		1

### 5.3.31 Dose Quantity

#### Identification



<b>Name</b>	Dose Quantity
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10152

#### Definition

<b>Definition</b>	The amount of medication to be taken/administered at one time.
<b>Synonymous Names</b>	
<b>Notes</b>	Quantity range datatype – range includes low and high quantity value and units (e.g. 65 micrograms; 2.5 mg; or 2 tablets).
<b>Datatype</b>	Quantity Range

#### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>65 micrograms</li> <li>2 tablets</li> </ol>
------------------	--

#### Relationships

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DOSAGE	1.0	Optional		0..1

### 5.3.32 Frequency

#### Identification



<b>Name</b>	Frequency
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10153

#### Definition

<b>Definition</b>	How often each dose of the medication has to be taken / administered
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	NEHTA SCT-AU Dose Frequency Reference Set

#### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Once only</li> <li>2. Three times daily</li> <li>3. 6 hourly</li> </ol>
------------------	---

#### Relationships

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DOSAGE	1.0	Optional		0..1

### 5.3.33 Frequency Qualifier

#### Identification

T/T<sub>010</sub>

<b>Name</b>	Frequency Qualifier
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10154

#### Definition


<b>Definition</b>	Information provided in addition to the frequency that provides more detail or guidance about the timing of medication administration.
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	NEHTA SCT-AU Dose Frequency Qualifier Reference Set

#### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. After Meals</li> <li>2. In the morning</li> <li>3. Before bed</li> </ol>
------------------	--

#### Relationships

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DOSAGE	1.0	Optional		0..*

### 5.3.34 Site of Administration

#### Identification



<b>Name</b>	Site of Administration
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10156

#### Definition

<b>Definition</b>	Location on or in the body of the subject of care that the medication is to be administered.
<b>Synonymous Names</b>	
<b>Notes</b>	Used for medicines for which site of administration is important.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

#### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Outer thigh</li> <li>2. Right eye</li> </ol>
------------------	--

#### Relationships

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DOSAGE	1.0	Optional		0..1

### 5.3.35 Route of Administration

#### Identification

T/T<sub>010</sub>

<b>Name</b>	Route of Administration
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10147

#### Definition


<b>Definition</b>	The way through which a medication is administered (e.g. Oral, Subcutaneous injection, Epidural, nebuliser).
<b>Synonymous Names</b>	Route
<b>Notes</b>	Describes which route the administered medication takes into the body. In some cases this can be implied from the Item Description and therefore need not be specifically articulated (e.g. Paracetamol 500 mg tablets). In other cases, route must be explicitly stated at time of prescribing where confusion may otherwise arise.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	NEHTA SCT-AU Dose Route of Administration Reference Set

#### Usage

<b>Example/s</b>	1. Oral 2. Subcutaneous injection 3. Epidural
------------------	---

#### Relationships

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DOSAGE	1.0	Optional		0..1

### 5.3.36 Additional Dose Instructions

#### Identification

<b>T</b>	<b>Name</b>	Additional Dose Instructions
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-10166

#### Definition


<b>Definition</b>	Additional text that may be required to fully describe a complex dosage instruction.
<b>Synonymous Names</b>	
<b>Notes</b>	<p>The Dose Instruction data element is required to be equivalent to the related coded data elements. This does not allow for complex dosage instructions to be captured and communicated.</p> <p>This additional data element has therefore been included to enable capture and communication of additional important information not able to be captured in the earlier data elements.</p> <p>It may also include cautionary advice for the subject of care or person administering the medication when taking / administering the medication. This may be required for certain medications to reduce risks or complications after administration.</p>
<b>Datatype</b>	Text

#### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Take as per advised by pathology.</li> <li>2. Do not expose skin to sun after application of medicine.</li> </ol>
------------------	---


#### Relationships

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DOSAGE	1.0	Optional		0..1

### 5.3.37 CHANGE DETAILS

#### Identification

 <b>Name</b>	CHANGE DETAILS
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-10128
<b>Version</b>	1.0

#### Definition


<b>Definition</b>	Describes information about any changes made to the medication item during the subject of care's healthcare encounter/event/interaction which may be relevant to be known by the subject of care's healthcare provider, and the reason for that change.
<b>Synonymous Names</b>	
<b>Notes</b>	

#### Relationships

##### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T</b> <sub>010</sub>	<a href="#">Change Description</a>		Essential		1
<b>T</b>	<a href="#">Reason for Change</a>		Optional		0..1

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">ITEM DETAIL</a>	2.0	Optional		0..1

## 5.3.38 Change Description

### Identification

T<sub>010</sub>

<b>Name</b>	Change Description
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10176

### Definition


<b>Definition</b>	Description of any change made during the healthcare encounter.
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	CodedText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Change of Dose.</li> <li>2. Correction of prescription error.</li> </ol>
------------------	--

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">CHANGE DETAILS</a>	1.0	Optional		0..1

### 5.3.39 Reason for Change

#### Identification

<b>T</b>	<b>Name</b>	Reason for Change
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-10177

#### Definition


<b>Definition</b>	The justification for the stated change.
<b>Synonymous Names</b>	
<b>Notes</b>	Should be completed if a change has been made.
<b>Datatype</b>	Text

#### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Optimise drug therapy.</li> <li>2. Intolerable side effect of dizziness.</li> </ol>
------------------	---


#### Relationships

##### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">CHANGE DETAILS</a>	1.0	Optional		0..1

## 5.4 HEALTH PROFILE

### Identification





 <b>Name</b>	HEALTH PROFILE
<b>Metadata Type</b>	Section
<b>Identifier</b>	S-16011

### Definition


<b>Definition</b>	Contains information related to the subject of care that is not specific to the healthcare event/encounter/clinical interaction that generated the discharge summary.
<b>Synonymous Names</b>	
<b>Notes</b>	<p>The data in this section is not restricted to the context of this document.</p> <p>The purpose of this section is to differentiate the data groups that are specific to the event for which the Discharge Summary is created from those that are generic to the subject of care overall. For example the subject of care's usual GP is not specifically related to the admitted event and similarly there are problems/diagnoses that are likely to be known prior to the event and will be applicable after the event.</p>

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
	HEALTHCARE PROVIDERS	1.0	Optional		0..1
	CURRENT PROBLEMS/DIAGNOSES		Optional		0..1
	ADVERSE REACTIONS	2.0	Essential		1
	ALERTS		Optional		0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY		Essential		1

## 5.4.1 HEALTHCARE PROVIDERS

### Identification


 <b>Name</b>	HEALTHCARE PROVIDERS
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-20002
<b>Version</b>	1.0

### Definition


<b>Definition</b>	Contains details of the subject of care's healthcare providers.
<b>Synonymous Names</b>	
<b>Notes</b>	<p>This item currently only includes the Usual GP but may include other providers in the future.</p> <p>It is recognised that not all subjects will have a Usual GP and as such this data group is optional, however it is recommended that implementers populate this data group where possible.</p>

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
	USUAL GP	1.0	Essential		1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	HEALTH PROFILE		Optional		0..1

## 5.4.2 USUAL GP

### Identification



<b>Name</b>	USUAL GP (PARTICIPANT)
<b>Metadata Type</b>	Data Group (reuse of PARTICIPANT, refer to the PARTICIPANT Data Specification [DS-PART] for more detail)
<b>Identifier</b>	DG-10296
<b>Version</b>	1.0

### Definition

<b>Definition</b>	The healthcare provider person or organisation who/that is associated with the delivery of healthcare to the subject of care. In this case, it refers to the General Practitioner provider and/or the General Practitioner clinic/facility, or a similar primary care facility such as a remote area clinic.
<b>Synonymous Names</b>	Usual General Practitioner Usual Healthcare Provider
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Condition	Occ.
	Role Name	Role name.description="Usual GP"	1
	ENTITY IDENTIFIER	<b>Must</b> contain the Healthcare Provider Identifier for the Individual (HPI-I) or Organisation (HPI-O) if available.	1
	ADDRESS	<b>Should</b> contain address details	0..*
	ELECTRONIC COMMUNICATION DETAILS	<b>Should</b> include at least one method of electronic communication.	0..*
	PERSON NAME	<b>Must</b> contain name details if service is requested of a PARTICIPANT.PERSON	0..*
	ORGANISATION NAME	<b>Must</b> contain name details if service is requested of a PARTICIPANT.ORGANISATION	0..*
	PERSON ADDITIONAL DEMOGRAPHIC DATA	<b>Should Not</b> be included.	0..1
	HEALTHCARE PROVIDER PRACTICE DETAILS	<b>Should</b> provide practice details if available.	0..1
	EMPLOYER ORGANISATION DETAILS	<b>Should Not</b> be included.	0..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">HEALTHCARE PROVIDERS</a>	1.0	Essential		1

### 5.4.3 CURRENT PROBLEMS/DIAGNOSES

#### Identification



<b>Name</b>	CURRENT PROBLEMS/DIAGNOSES
<b>Metadata Type</b>	Section
<b>Identifier</b>	S-16014

#### Definition

<b>Definition</b>	Describes the diagnostic labels or problem statements assigned by the healthcare provider to describe the current diagnoses, health/medical problems pertaining to the subject of care.
<b>Synonymous Names</b>	
<b>Notes</b>	<p>Deals with problems the subject of care has that are not specific to the event for which this document is generated, and are not otherwise included elsewhere in this document. For instance long term co-morbidities.</p> <p>For Example the subject of care is admitted for a Right total knee replacement for Osteoarthritis of the right knee and has had Chronic Radiation Cystitis for the past 3 years. The Osteoarthritis is the principal diagnosis for the visit and the Cystitis is a current problem but is not the reason for which the subject of care was admitted.</p>

#### Relationships

##### Children


Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM DIAGNOSIS	2.0	Essential		1..*

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	HEALTH PROFILE		Optional		0..1

## 5.4.4 PROBLEM DIAGNOSIS

### Identification





 <b>Name</b>	PROBLEM/DIAGNOSIS
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-15530
<b>Version</b>	2.0

### Definition


<b>Definition</b>	Contains a diagnostic label or problem statement assigned by the healthcare provider to describe the problem/diagnosis pertaining to the subject of care.
<b>Synonymous Names</b>	
<b>Notes</b>	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. This item is repeated for every instance of a current problem/diagnosis.

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
 <b>T</b> <sub>010</sub>	Problem/Diagnosis Type		Essential		1
 <b>T</b> / <b>T</b> <sub>010</sub>	Problem/Diagnosis Description		Essential		1
	DateTime Started		Optional		0..1
<b>T</b>	Problem/Diagnosis Note		Optional		0..1
	PROBLEM/DIAGNOSIS AWARENESS	1.0	Optional		0..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
 <b>S</b> <sub>==</sub>	CURRENT PROBLEMS/DIAGNOSES		Essential		1..*

## 5.4.5 ADVERSE REACTIONS

### Identification



 <b>Name</b>	ADVERSE REACTIONS
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-15536
<b>Version</b>	2.0

### Definition


<b>Definition</b>	Describes the known adverse reactions for the subject of care and any relevant reaction details.
<b>Synonymous Names</b>	
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
 <b>T</b> <sub>010</sub>	<a href="#">Known Adverse Reactions</a>		Essential		1
	<a href="#">ADVERSE REACTION</a>	2.0	Optional		0..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
 <b>S</b> <sub>≡</sub>	<a href="#">HEALTH PROFILE</a>		Essential		1

## 5.4.6 Known Adverse Reactions

### Identification

T<sub>010</sub>

<b>Name</b>	Known Adverse Reactions
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15537

### Definition


<b>Definition</b>	Indicates if there are any known adverse reactions for the subject of care.
<b>Synonymous Names</b>	
<b>Notes</b>	This item is applicable to the subject of care overall and is used to indicate if there are any known adverse reactions.
<b>Datatype</b>	CodedText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>Known</li> <li>Nil Known</li> <li>Unknown</li> </ol>
------------------	---

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">ADVERSE REACTIONS</a>	2.0	Essential		1

## 5.4.7 ADVERSE REACTION

### Identification


<b>Name</b>	ADVERSE REACTION
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-15517
<b>Version</b>	2.0

### Definition


<b>Definition</b>	Describes a harmful or undesirable response to an agent/substance. An adverse reaction may occur within a variable timeframe after exposure to an agent/substance and may range from minor reactions like a skin rash to serious and life-threatening events such as anaphylaxis. Exposure may be by ingestion, inhalation, injection or direct contact. An adverse reaction includes allergies, intolerances and sensitivities but excludes poisoning, medical errors or mishaps that may occur during surgical or medical care, as these are generally classified as an adverse event.
<b>Synonymous Names</b>	Allergic Reaction/Allergy Intolerance Sensitivity
<b>Notes</b>	The Adverse Reaction item is used to capture the body's response to the effect of an agent or substance whereas the Alert item notifies a healthcare provider of any special considerations that may need to be known, such as infectious disease carrier, pregnant or elite athlete. The process of identifying adverse reactions is a critical element of good clinical practice and is essential for safety and quality. This item is repeated for every instance of an adverse reaction. Adverse reactions to immunisations should be included here. Should not be used for recording alerts.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T/T</b> <sub>010</sub>	<a href="#">Agent Description</a>		Essential		1
<b>T</b> <sub>010</sub>	<a href="#">Agent Description Certainty</a>		Optional		0..1
	<a href="#">REACTION DETAIL</a>	2.0	Optional		0..*
<b>T</b>	<a href="#">Adverse Reaction Note</a>		Optional		0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">ADVERSE REACTIONS</a>	2.0	Optional		0..*

## 5.4.8 Agent Description

### Identification

T/T<sub>010</sub>

<b>Name</b>	Agent Description
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15521

### Definition


<b>Definition</b>	The agent/substance causing the adverse reaction experienced by the subject of care.
<b>Synonymous Names</b>	Agent
<b>Notes</b>	An agent can be a substance such as food, drug or an environmental allergen.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Peanut</li> <li>2. Penicillin</li> <li>3. Bee venom</li> <li>4. Animal protein</li> <li>5. Latex</li> </ol>
------------------	---

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ADVERSE REACTION	2.0	Essential		1

## 5.4.9 Agent Description Certainty

### Identification

T<sub>010</sub>

<b>Name</b>	Agent Description Certainty
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15568

### Definition

<b>Definition</b>	The degree of confidence that the agent/substance referred to in the agent description has caused the adverse reaction.
<b>Synonymous Names</b>	
<b>Notes</b>	It is important to know the degree of certainty of an adverse reaction to an agent/substance as there may be instances where it is not clear whether it is the active agent or a secondary component causing the problem. For example, it may be the filler in a tablet that may be the allergen rather than the active drug. Another example is where there is suspicion of a reaction which warrants recording but it has not been confirmed objectively, or where a reaction has been recorded but is subsequently discounted following further observation and/or investigation.
<b>Datatype</b>	CodedText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Certain</li> <li>2. Probable</li> <li>3. Unlikely</li> </ol>
------------------	--


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ADVERSE REACTION	2.0	Optional		0..1

## 5.4.10 REACTION DETAIL

### Identification



 <b>Name</b>	REACTION DETAIL
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-15511
<b>Version</b>	2.0

### Definition


<b>Definition</b>	Describes one or more reactions (harmful or undesirable responses) to an agent.
<b>Synonymous Names</b>	
<b>Notes</b>	This item associates information that captures details of the adverse reaction (excluding the Agent that caused the reaction).

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
	Onset		Optional		0..1
	Reaction Description		Essential		1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ADVERSE REACTION	2.0	Optional		0..*

## 5.4.11 Onset

### Identification



<b>Name</b>	Onset
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15507

### Definition

<b>Definition</b>	The datetime when a subject of care's adverse reaction commenced.
<b>Synonymous Names</b>	DateTime Started
<b>Notes</b>	Sometimes, the date or age at which a person reacts to an agent is a relevant to understanding a condition, or to determining appropriate treatment. Often, this will be an approximate, self-reported age, date or datetime. Where possible, exact dates should be used. Incomplete dates should generally only be used for retrospective data collection.
<b>Datatype</b>	DateTime

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. 2004-03-31</li> <li>2. 2004-03</li> <li>3. 2004</li> <li>4. 2004-03-3113:10</li> </ol>
------------------	--

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">REACTION DETAIL</a>	2.0	Optional		0..1

## 5.4.12 Reaction Description

### Identification



<b>Name</b>	Reaction Description
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15563

### Definition

<b>Definition</b>	The signs and/or symptoms experienced or exhibited by the subject of care as a consequence of the adverse reaction to a specific agent/substance.
<b>Synonymous Names</b>	Reaction
<b>Notes</b>	<p>The signs and/or symptoms of the adverse reaction are relevant as it contributes 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>
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Itchy eyes</li> <li>2. Dysphagia</li> <li>3. Tinnitus</li> </ol>
------------------	--

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">REACTION DETAIL</a>	2.0	Essential		1

### 5.4.13 Adverse Reaction Note

#### Identification

<b>T</b>	<b>Name</b>	Adverse Reaction Note
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-15590

#### Definition


<b>Definition</b>	Additional comments relevant to the adverse reaction.
<b>Synonymous Names</b>	Reaction Note
<b>Notes</b>	Used to provide additional narrative information in relation to the adverse reaction such as finding site or route of administration.
<b>Datatype</b>	Text

#### Usage

##### Example/s

#### Relationships

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ADVERSE REACTION	2.0	Optional		0..1

## 5.4.14 ALERTS

### Identification


<b>Name</b>	ALERTS
<b>Metadata Type</b>	Section
<b>Identifier</b>	S-20121

### Definition


<b>Definition</b>	Describes alerts pertaining to the subject of care.
<b>Synonymous Names</b>	
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
	ALERT	2.0	Essential		1..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	HEALTH PROFILE		Optional		0..1

## 5.4.15 ALERT

### Identification


<b>Name</b>	ALERT
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-15518
<b>Version</b>	2.0

### Definition

<b>Definition</b>	<p>Describes information pertaining to a subject of care that may:</p> <ul style="list-style-type: none"> <li>• Need special consideration by a healthcare provider before making a decision about his/her actions to avert an unfavourable healthcare event;</li> <li>• Need consideration and/or action by a healthcare provider or facility in relation to the care and safety of the subject of care, staff and/or other individuals; or</li> <li>• Notify the healthcare provider of special circumstances that may be relevant in delivering care and/or interacting with the subject of care.</li> </ul>
<b>Synonymous Names</b>	Warning
<b>Notes</b>	This item is repeated for every instance of an alert. Should not be used for recording Adverse Reactions.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T/T</b> <sub>010</sub>	Alert Type		Essential		1
<b>T/T</b> <sub>010</sub>	Alert Description		Essential		1
	DateTime Started		Optional		0..1
<b>T</b>	Alert Note		Optional		0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
<b>S</b> <sub>≡</sub>	ALERTS		Essential		1..*

## 5.4.16 Alert Type

### Identification



<b>Name</b>	Alert Type
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15584

### Definition

<b>Definition</b>	The type of alert (e.g. administrative, clinical or medical, home environment, infection risk, safety and security, special mental health, special needs and/or preferences).
<b>Synonymous Names</b>	Warning Type Alert Class
<b>Notes</b>	
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Administrative.</li> <li>2. Clinical or Medical.</li> <li>3. Home environment.</li> <li>4. Infection risk.</li> <li>5. Safety and security.</li> <li>6. Special mental health.</li> <li>7. Special needs and/or preferences.</li> </ol>
------------------	---

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ALERT	2.0	Essential		1

## 5.4.17 Alert Description

### Identification

T/T<sub>010</sub>

<b>Name</b>	Alert Description
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15585

### Definition


<b>Definition</b>	Describes of the nature of the alert.
<b>Synonymous Names</b>	Warning Description
<b>Notes</b>	
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Animals present at subject of care's home.</li> <li>2. Anaesthetic risk.</li> <li>3. Pacemaker present.</li> <li>4. Subject of care is a risk to others.</li> <li>5. Subject of care speaks no English.</li> </ol>
------------------	--

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ALERT	2.0	Essential		1

## 5.4.18 DateTime Started

### Identification



<b>Name</b>	DateTime Started
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15507

### Definition

<b>Definition</b>	The datetime when the specific Alert was initiated.
<b>Synonymous Names</b>	Onset
<b>Notes</b>	Where possible, exact dates should be used. Incomplete dates should generally only be used for retrospective data collection.
<b>Datatype</b>	DateTime

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. 2004-03-31</li> <li>2. 2004-03</li> <li>3. 2004</li> <li>4. 2004-03-3113:10</li> </ol>
------------------	--

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ALERT	2.0	Optional		0..1

## 5.4.19 Alert Note

### Identification

<b>T</b>	<b>Name</b>	Alert Note
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-15591

### Definition


<b>Definition</b>	Additional comments relevant to the alert.
<b>Synonymous Names</b>	
<b>Notes</b>	Captures detailed information about the alert in question that is not otherwise captured in other Alert data elements.
<b>Datatype</b>	Text

### Usage

#### Example/s


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ALERT	2.0	Optional		0..1

## 5.5 PLAN

### Identification



 <b>Name</b>	PLAN
<b>Metadata Type</b>	Section
<b>Identifier</b>	S-16020

### Definition


<b>Definition</b>	Describes the clinical referral or services requested for the subject of care.
<b>Synonymous Names</b>	Follow up
<b>Notes</b>	Such activities may include arranged services such as home nursing or community health services, or follow-up management by the GP or specialist(s). Also includes information or instructions to subject of care regarding the planned or requested services and recommendations to providers. Excludes specific medication prescriptions and/or diagnostic test orders made by current provider(s) (at the time of discharge).

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
	REQUESTED SERVICES		Optional		0..1
	RECOMMENDATIONS	1.0	Optional		0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY		Optional		0..1

## 5.5.1 REQUESTED SERVICES

### Identification


S=	<b>Name</b>	REQUESTED SERVICES
	<b>Metadata Type</b>	Section
	<b>Identifier</b>	S-16021

### Definition


<b>Definition</b>	Describes clinical referral or services requested and/or planned for the subject of care.
<b>Synonymous Names</b>	
<b>Notes</b>	

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
	REQUESTED SERVICE	1.0	Essential		1..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	PLAN		Optional		0..1

## 5.5.2 REQUESTED SERVICE

### Identification





 <b>Name</b>	REQUESTED SERVICE
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-20158
<b>Version</b>	1.0

### Definition


<b>Definition</b>	Describes the type(s) of service requested for, or provided to, the subject of care.
<b>Synonymous Names</b>	
<b>Notes</b>	This item does not include details of specific medication prescriptions and/or diagnostic test orders made by current provider(s) (at the time of discharge).

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
 <b>T/T</b> <sub>010</sub>	<a href="#">Reason for Service</a>		Optional		0..1
 <b>T/T</b> <sub>010</sub>	<a href="#">Requested Service Description</a>		Essential		1
	<a href="#">Service Commencement Window</a>		Optional		0..1
	<a href="#">SERVICE PROVIDER</a>	1.0	Essential		1
<b>T</b>	<a href="#">Subject of Care Instruction Description</a>		Optional		0..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
 <b>S</b>	<a href="#">REQUESTED SERVICES</a>		Essential		1..*

## 5.5.3 RECOMMENDATIONS

### Identification

<b>Name</b>	RECOMMENDATIONS
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-20016
<b>Version</b>	1.0

### Definition

<b>Definition</b>	Describes recommendations to the subject of care's healthcare provider and the subject of care.
<b>Synonymous Names</b>	
<b>Notes</b>	Recommendations may include reminders to GP on special management strategies.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T</b>	<a href="#">Recommendation to Provider Note</a>		Essential		1..*
<b>T</b>	<a href="#">Recommendation to Subject of Care</a>		Optional		0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
<b>S</b>	PLAN		Optional		0..1

## 5.5.4 Recommendation to Provider Note

### Identification

<b>T</b>	<b>Name</b>	Recommendation to Provider Note
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-20175

### Definition


<b>Definition</b>	Details of the recommendation given by the healthcare provider(s) from the healthcare facility to the subject of care's healthcare provider, including the General Practitioner.
<b>Synonymous Names</b>	Advice to GP
<b>Notes</b>	The relevant information/recommendation is important for the continuity of care and management of the subject of care after discharge. This item does not include referral details or information specific to a requested service.
<b>Datatype</b>	Text

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. GP to remove the staples on day 10-14.</li> <li>2. Aspirin to recommence at GP's discretion.</li> <li>3. Please arrange a follow up appointment with a community physiotherapist in one week to ensure that post-surgical mobility outcomes are being met.</li> </ol>
------------------	---

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">RECOMMENDATIONS</a>	1.0	Essential		1..*

## 5.5.5 Recommendation to Subject of Care

### Identification

<b>T</b>	<b>Name</b>	Recommendations to Subject of Care
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-10146

### Definition


<b>Definition</b>	Describes recommendations to the subject of care.
<b>Synonymous Names</b>	Advice to Patient
<b>Notes</b>	Includes instructions about medications on discharge, arranged and planned services, etc.
<b>Datatype</b>	Text

### Usage

<b>Example/s</b>	Go for a blood test at the community diagnostic medical laboratory on next Wednesday after discharge. Then see GP on Thursday.
------------------	--

### Relationships


#### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	RECOMMENDATIONS	1.0	Optional		0..1

# 6 REUSED CONCEPTS

## 6.1 REQUESTED SERVICE

### Identification

 <b>Name</b>	REQUESTED SERVICE
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-20158
<b>Version</b>	1.0

### Definition







**Definition** Describes services to be performed during the healthcare event/encounter/clinical intervention.

**Synonymous Names**



**Notes**

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">Reason for Service</a>		Optional		0..1
	<a href="#">Requested Service Description</a>		Essential		1
	<a href="#">Service Commencement Window</a>		Optional		0..1
	<a href="#">SERVICE REQUESTOR</a>	1.0	Optional		0..1
	<a href="#">SERVICE PROVIDER</a>	1.0	Optional		0..1
	<a href="#">Subject of Care Instruction Description</a>		Optional		0..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">ORIGINAL REFERRAL</a>	1.0	Essential		1..*
	<a href="#">REQUESTED SERVICES</a>		Essential		1..*

## 6.1.1 Reason for Service

### Identification

T/T<sub>010</sub>

<b>Name</b>	Reason for Service
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-20172

### Definition


<b>Definition</b>	Describes a clinical reason for a service being requested or received.
<b>Synonymous Names</b>	Reason for Requesting Service Service Reason
<b>Notes</b>	Captures information about reasons for requesting admission if the subject of care was referred to the organisation or for requesting services (by the healthcare provider) to be provided to the subject of care after discharge from the healthcare facility.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	Extensive osteoarthritis of right knee.
------------------	---

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	REQUESTED SERVICE	1.0	Optional		0..1

## 6.1.2 Requested Service Description

### Identification

T/T<sub>010</sub>

<b>Name</b>	Requested Service Description
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-20117

### Definition


<b>Definition</b>	Describes the service requested for, or provided to, the subject of care.
<b>Synonymous Names</b>	Service Requested
<b>Notes</b>	Used to identify diagnostic, clinical procedures or clinical management requested by the healthcare provider to be undertaken on/provided to the subject of care.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Elective Orthopaedic surgery for TKR</li> <li>2. Dialysis.</li> <li>3. Adjustment of heart failure/hypertensive medications.</li> <li>4. Adjust INR to therapeutic range, etc.</li> </ol>
------------------	---

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	REQUESTED SERVICE	1.0	Essential		1

### 6.1.3 Service Commencement Window

#### Identification



<b>Name</b>	Service Commencement Window
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-20173

#### Definition


<b>Definition</b>	Defines the datetime of the earliest and/or the latest that the requesting healthcare provider would like the subject of care to receive the requested services.
<b>Synonymous Names</b>	Service Commences
<b>Notes</b>	This item specifies the range of time within which the requesting provider would like the requested service(s) to be provided to the subject of care.
<b>Datatype</b>	TimeInterval

#### Usage

<b>Example/s</b>	2009-03-31 to 2009-04-15
------------------	--------------------------

#### Relationships

##### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">REQUESTED SERVICE</a>	1.0	Optional		0..1

## 6.1.4 SERVICE REQUESTOR

### Identification



<b>Name</b>	SERVICE REQUESTOR (PARTICIPANT.PERSON)
<b>Metadata Type</b>	Data Group (reuse of PARTICIPANT.PERSON, refer to the PARTICIPANT Data Specification <a href="#">[DS-PART]</a> for more detail).
<b>Identifier</b>	DG-10296
<b>Version</b>	1.0

### Definition

<b>Definition</b>	The healthcare provider who has made the service request.
<b>Synonymous Names</b>	
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Condition	Occ.
	Role Name	Role name.description="Service Requestor"	1
	ENTITY IDENTIFIER	<b>Must</b> contain the Healthcare Provider Identifier - Individual (HPI-I).	1
	ADDRESS	<b>Should Not</b> be included.	0..*
	ELECTRONIC COMMUNICATION DETAILS	<b>Should</b> include at least one method of electronic communication.	0..*
	PERSON NAME	<b>Must</b> contain name details.	1
	PERSON ADDITIONAL DEMOGRAPHIC DATA	<b>Should Not</b> be included.	0..1
	HEALTHCARE PROVIDER PRACTICE DETAILS	<b>Should Not</b> be included.	0..*
	EMPLOYER ORGANISATION DETAILS	<b>Should Not</b> be included.	0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">REQUESTED SERVICE</a>	1.0	Optional		0..1

## 6.1.5 SERVICE PROVIDER

### Identification



<b>Name</b>	SERVICE PROVIDER (PARTICIPANT)
<b>Metadata Type</b>	Data Group (reuse of PARTICIPANT, refer to the PARTICIPANT Data Specification [DS-PART] for more detail).
<b>Identifier</b>	DG-10296
<b>Version</b>	1.0

### Definition

<b>Definition</b>	The healthcare provider who is requested to provide the service.
<b>Synonymous Names</b>	Healthcare Provider Identification: Referred To Referred To Provider Referred To (display name)
<b>Notes</b>	This item captures identification information on the Healthcare Provider Person or Organisation who/which is requested to provide a service after discharge of the subject of care from the healthcare facility at which the healthcare event/encounter/interaction has been completed.

### Relationships

#### Children

Type	Name	Condition	Occ.
T/T <sub>010</sub>	Role Name	Role name.description="Service Provider"	1
	ENTITY IDENTIFIER	<b>Must</b> contain the Healthcare Provider Identifier for the Individual (HPI-I) or Organisation (HPI-O) if available.	1
	ADDRESS	<b>Should</b> contain address details	0..1
	ELECTRONIC COMMUNICATION DETAILS	<b>Should</b> include at least one method of electronic communication.	0..*
	PERSON NAME	<b>Must</b> contain name details if service is requested of a PARTICIPANT.PERSON	0..1
	ORGANISATION NAME	<b>Must</b> contain name details if service is requested of a PARTICIPANT.ORGANISATION	0..1
	PERSON ADDITIONAL DEMOGRAPHIC DATA	<b>Should Not</b> be included.	0..1
	HEALTHCARE PROVIDER PRACTICE DETAILS	<b>Should Not</b> be included.	0..*
	EMPLOYER ORGANISATION DETAILS	<b>Should Not</b> be included.	0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">REQUESTED SERVICE</a>	1.0	Optional		0..1

## 6.1.6 Subject of Care Instruction Description

### Identification

<b>T</b>	<b>Name</b>	Subject of Care Instruction Description
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-10146

### Definition


<b>Definition</b>	Describes the instructions/advice and information that have been given to the subject of care from a healthcare provider in relation to the requested service.
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Data Type</b>	Text

### Usage

<b>Example/s</b>	Bring post-op instruction materials and any old private x-rays.
------------------	---


### Relationships

#### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">REQUESTED SERVICE</a>	1.0	Optional		0..*

## 6.2 PROBLEM/DIAGNOSIS

### Identification

 <b>Name</b>	PROBLEM/DIAGNOSIS
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-15530
<b>Version</b>	2.0

### Definition

**Definition** The assessment, interpretation and identification of historical and/or current problem/diagnosis by a healthcare provider pertaining to a subject of care. A problem is a subject of care's health concern for which a specific diagnosis has not yet been defined. A diagnosis is the decision reached, after assessment by the healthcare provider of the nature and identity of the disease or condition of the subject of care.



### Synonymous Names

**Notes** An account of relevant 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.

This item is repeated for every instance of a problem/diagnosis, generally constrained by the Problem/Diagnosis Type.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T</b> <sub>010</sub>	Problem/Diagnosis Type		Essential		1
<b>T/T</b> <sub>010</sub>	Problem/Diagnosis Description		Essential		1
	DateTime Started		Optional		0..1
<b>T</b>	Problem/Diagnosis Note		Optional		0..1
	PROBLEM/DIAGNOSIS AWARENESS	1.0	Optional		0..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
<b>S</b> <sub>≡</sub>	PROBLEMS/DIAGNOSES THIS VISIT		Essential		1..*
<b>S</b> <sub>≡</sub>	CURRENT PROBLEMS/DIAGNOSES		Essential		1..*

## 6.2.1 Problem/Diagnosis Type

### Identification

T<sub>010</sub>

<b>Name</b>	Problem/Diagnosis Type
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15547

### Definition


<b>Definition</b>	The type of problem/diagnosis.
<b>Synonymous Names</b>	
<b>Notes</b>	The categorisation of a subject of care's problem/diagnosis into predetermined types.
<b>Datatype</b>	CodedText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Principal</li> <li>2. Complications</li> <li>3. Other associated</li> </ol>
------------------	---

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS	2.0	Essential		1

## 6.2.2 Problem/Diagnosis Description

### Identification



<b>Name</b>	Problem/Diagnosis Description
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15514

### Definition

<b>Definition</b>	<p>A concise technical description or statement of problem/diagnosis or situation pertaining to the subject of care. The decision to apply the diagnostic label or problem description/statement by the healthcare provider is based on his/her assessment and interpretation of the cause, nature, or manifestation of the subject of care's medical/health condition(s).</p> <p>A diagnosis: represents the nature and identification of a disease.</p> <p>Problem: a description of a subject of care's condition for which a specific diagnosis has not yet been identified.</p>
<b>Synonymous Names</b>	
<b>Notes</b>	This item presents the name of the condition, after an assessment carried out by healthcare provider to define the health problem or diagnosis experienced by a subject of care.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Appendicitis.</li> <li>2. Acute myocardial infarction.</li> <li>3. Measles.</li> <li>4. Recurrent headaches.</li> <li>5. Acute abdominal pain.</li> <li>6. Acopia.</li> </ol>
------------------	---

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS	2.0	Essential		1

## 6.2.3 DateTime Started

### Identification



<b>Name</b>	DateTime Started
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15507

### Definition

<b>Definition</b>	The datetime when a subject of care's problem started.
<b>Synonymous Names</b>	
<b>Notes</b>	Where possible, exact dates should be used. Incomplete dates should generally only be used for retrospective data collection.
<b>Datatype</b>	DateTime

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. 2004-03-31</li> <li>2. 2004-03</li> <li>3. 2004</li> <li>4. 2004-03-3113:10</li> </ol>
------------------	--

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	PROBLEM/DIAGNOSIS	2.0	Optional		0..1

## 6.2.4 Problem/Diagnosis Note

### Identification

<b>T</b>	<b>Name</b>	Problem/Diagnosis Note
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-15597

### Definition


<b>Definition</b>	Additional information relevant to the problem/diagnosis.
<b>Synonymous Names</b>	
<b>Notes</b>	Used to provide additional narrative information in relation to a problem/diagnosis.
<b>Datatype</b>	Text

### Usage

<b>Example/s</b>	
------------------	--


### Relationships

#### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">PROBLEM/DIAGNOSIS</a>	2.0	Optional		0..1

## 6.2.5 PROBLEM/DIAGNOSIS AWARENESS

### Identification


 <b>Name</b>	PROBLEM/DIAGNOSIS AWARENESS (AWARENESS)
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-20147
<b>Version</b>	1.0

### Definition

<b>Definition</b>	A data group that indicates whether a person (which may be a subject of care or his/her relative or family member) is aware of the specified information in question.
<b>Synonymous Names</b>	
<b>Notes</b>	Captures detailed information about a subject's (healthcare provider, subject of care or persons related to the subject of care) awareness of a clinical diagnosis or health problem, or complications arising from the health event/encounter.


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">PROBLEM/DIAGNOSIS</a>	2.0	Optional		0..*

## 6.3 AWARENESS

### Identification


 <b>Name</b>	AWARENESS
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-20147
<b>Version</b>	1.0

### Definition



<b>Definition</b>	Indicates whether a person (which may be a subject of care or his/her relative or family member) is aware of the clinical diagnosis or health problem, complications or clinical intervention in question.
<b>Synonymous Names</b>	
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
	Is Aware		Essential		1
<b>T</b>	Non-Awareness Reason		Optional		0..1
<b>T/T</b> <sub>010</sub>	Person Category		Essential		1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	CLINICAL INTERVENTION AWARENESS	1.0	Optional		0..*
	PROBLEM/DIAGNOSIS AWARENESS	1.0	Optional		0..*

### 6.3.1 Is Aware

#### Identification

✓x	<b>Name</b>	Is Aware
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-20129

#### Definition


<b>Definition</b>	Denotes whether or not the subject of the Person Category is aware of the specified information in question.
<b>Synonymous Names</b>	Awareness
<b>Notes</b>	
<b>Datatype</b>	Boolean

#### Usage

<b>Example/s</b>	Yes No
------------------	-----------

#### Relationships

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">AWARENESS</a>	1.0	Essential		1

## 6.3.2 Non-Awareness Reason

### Identification

<b>T</b>	<b>Name</b>	Non-Awareness Reason
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-20131

### Definition


<b>Definition</b>	The reason the subject of the Person Category is not aware of the specified information in question.
<b>Synonymous Names</b>	Reason for not being aware Reason
<b>Notes</b>	In the context of situation awareness, the description provides the reason(s) the subject is not aware of the health/clinical problems, issues, clinical interventions, etc. in question.
<b>Datatype</b>	Text

### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Subject not informed at request of spouse.</li> <li>2. Family in opinion that subject of care is unable to cope with the impact/poor prognosis of diagnosis.</li> <li>3. Subject informed at request of patient/subject of care.</li> </ol>
------------------	---

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	AWARENESS	1.0	Optional		0..1

### 6.3.3 Person Category

#### Identification



<b>Name</b>	Person Category
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-20130

#### Definition

<b>Definition</b>	The relationship of an agent of the subject of care (which includes the subject of care) in order to record whether the agent has an awareness of the specified information in question.
<b>Synonymous Names</b>	Person
<b>Notes</b>	Describes the relationship of a carer or agent of the subject of care in order to record whether the subject of care or the carer has an awareness of a condition or intervention.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified - Use existing reference sets until NEHTA determines a suitable common reference set.

#### Usage

<b>Example/s</b>	<ol style="list-style-type: none"> <li>1. Subject of Care</li> <li>2. Spouse</li> <li>3. Partner</li> <li>4. Child</li> <li>5. Parent</li> <li>6. Grandchild</li> <li>7. Grand parent</li> </ol>
------------------	--

#### Relationships


##### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	AWARENESS	1.0	Essential		1

## 7 Examples

This Structured Document Template sets out the logical data structure to support the electronic transmission of a discharge summary. The logical data structure does not necessarily reflect the visual presentation that a clinician would expect to see and therefore an example of a potential document layout is included to assist readers to understand how the data can be presented visually. The last page of the example demonstrates how the data elements defined in the header section are included in a wrapper around the data elements that comprise the document.

The following layout is a sample only and is one possible visualisation of all the data elements specified in this Structured Document Template.

 <b>MARSTEN HEALTH HOSPITAL</b>		* Confidentiality Status: <b>Normal</b>	
<h2 style="text-align: center;">DISCHARGE SUMMARY</h2>		<b>* SUBJECT OF CARE DETAILS</b>	
		* Hospital MRN: 9999999 * IHI: 8003610200002224 * Name: <b>Mr Orthopaedic DEMONSTRATION</b> * Date of Birth: 01/01/1946 (62 years) * Sex: M * Address: 1 Clinician Street, NEHTAVILLE QLD 4000 * Phone: (99) 9988 7766	
<b>DOCUMENT DETAILS</b>		<b>ENCOUNTER DETAILS</b>	
* Summary Status: Final * Version Number: 1 * Date attested: 23/10/2008 15:23 * Summary Author: Dr Peter INTERN HPH: 800362000000111 * Authorised Signatory: Dr Janice REGISTRAR HPH: 800362000000789		* Reason for encounter: Elective surgery for Right total knee replacement Note: - Care setting: Inpatient overnight Department: Orthopaedic Unit Contact: Ph (99) 4444 4444 * Admission Date: 10/10/2008 10:21 * Discharge Date: 17/10/2008 14:31 * Separation Mode: To Home Discharge to Address: 17 Streetname Road, Suburb, QLD, 5555 Phone: (99) 9988 7766	
<b>DISCHARGE SUMMARY ADDRESSEE</b>			
Dr Mary MOULD HPH: 800362000000922		General Practitioner Address: 17 Streetname Road, Suburb, QLD, 5555 Ph: (99) 3333 3333 Fax: (99) 6666 1111 Email: records@jaydonosk.com.au	
Addressee information derived from the 'message header'			
<b>ALERTS</b>			
* Type:	* Description:	* Note:	* Date started:
Clinical	At risk of pressure sores	Easily damaged skin	01/07/2007
<b>* CLINICAL SYNOPSIS</b>			
This 62yo male was admitted for elective, right, total knee replacement. Past history of mild COPD, mild anaemia, and radiation cystitis. A cemented prosthesis was inserted without difficulty under combined lumbar epidural and general anaesthetic. On day 2, he developed bilateral basal atelectasis. Ongoing problems with inadequate pain management because of persistent hypotension secondary to the epidural. The epidural was ceased and the patient was switched to a morphine PCA regime. Due to concern about the potential for pneumonia in the presence of COPD he was commenced on oral antibiotics and given regular chest physiotherapy. Due to mild anaemia prior to surgery and subsequent operative blood loss he required a blood transfusion of three units. He was given regular enoxaparin (Clexane) to reduce the risk of DVT. The patient subsequently makes steady progress, regaining good mobility in his knee and is able to mobilise with the aid of a stick. He is on regular paracetamol and codeine for pain relief, as well as his usual medications for COPD. The Celecoxib was ceased. Aspirin is to be recommenced at the discretion of the GP. Discharged with post-op analgesics and oral antibiotics.			
<b>* RECOMMENDATIONS TO PROVIDER</b>			
<ul style="list-style-type: none"> <li>GP to remove the staples on day 10-14.</li> <li>A follow up Orthopaedic outpatient clinic appointment is booked for 6 weeks to review progress.</li> <li>Aspirin to recommence at GP's discretion.</li> <li>Please arrange a follow up appointment with a community physiotherapist in one week to ensure that post-surgical mobility outcomes are being met.</li> </ul>			
<b>RECOMMENDATIONS TO SUBJECT OF CARE</b>			
The patient was advised to keep up a regular mobility routine as guided by the community physiotherapist. Return to GP day 10-14 post-op to have the staples removed.			
<b>* PROBLEMS/DIAGNOSES RELEVANT TO THIS VISIT</b>			
<b>* Principal Diagnosis:</b> OSTEOARTHRITIS OF KNEE Date Time started: 10/2004 Note: Extensive osteoarthritis of right knee		<b>Awareness:</b> <ul style="list-style-type: none"> <li>Subject of Care is aware</li> <li>Spouse is aware</li> </ul>	
<b>Associated Diagnosis:</b> Chronic Obstructive Pulmonary Disease Date Time started: 2001 Note: Ex smoker (30 per day)		<b>Awareness:</b> <ul style="list-style-type: none"> <li>Subject of Care is aware</li> <li>Spouse is aware</li> </ul>	
<b>Comorbidity:</b> Chronic radiation cystitis Date Time started: 11/2005 Note: Consequence of radiotherapy for prostatic cancer		<b>Awareness:</b> <ul style="list-style-type: none"> <li>Subject of Care is aware</li> <li>Spouse is <b>not</b> aware (preference of Subject of care)</li> </ul>	
<b>Complications:</b> Post-operative pneumonia Date Time started: 12/10/2008 Note: Secondary to post-operative hypo-ventilation, exacerbated by narcotic use		<b>Awareness:</b> <ul style="list-style-type: none"> <li></li> </ul>	
<b>Complications:</b> Hypotension Date Time started: 11/10/2008 Note: Secondary to epidural pain relief		<b>Awareness:</b> <ul style="list-style-type: none"> <li></li> </ul>	
<b>Complications:</b> Intra operative haemorrhage Date Time started: 11/10/2008 Note: Required transfusion 3 units of blood		<b>Awareness:</b> <ul style="list-style-type: none"> <li></li> </ul>	

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<b>MRN:</b> 9999999		<b>Subject of Care:</b> Mr Orthopaedic DEMONSTRATION		<b>DOB:</b> 01/01/1946			
<b>CLINICAL INTERVENTIONS PERFORMED THIS VISIT</b>							
<b>* Clinical Intervention:</b>		Primary cemented total knee replacement (R)		<b>Awareness:</b>			
Date Time:		10/10/2008		• Subject of Care is aware			
Note:		A standard total knee joint replacement of the right knee. No complications.		• Spouse is aware			
<b>* Clinical Intervention:</b>		Lumbar epidural block		<b>Awareness:</b>			
Date Time:		10/10/2008		• Subject of Care is aware			
Note:		Performed due to COPD prior to general anaesthetic		• Spouse is aware			
<b>* Clinical Intervention:</b>		Transfusion of packed red blood cells		<b>Awareness:</b>			
Date Time:		12/10/2008		• Subject of Care is aware			
Note:		3 units of blood		• Spouse is aware			
<b>* Clinical Intervention:</b>		Physiotherapy		<b>Awareness:</b>			
Date Time:				• Subject of Care is aware			
Note:		Post-operative therapy on the knee & chest physio					
<b>* ADVERSE REACTIONS – the following reactions are known (*)</b>							
<b>* Agent:</b>	<b>Certainty:</b>	<b>* Reaction description:</b>	<b>Onset:</b>	<b>Note:</b>			
Penicillin	Certain	• Urticaria	1970	Severe			
		• Nausea and vomiting	1970				
Beta-blocker	Certain	• Acute exacerbation of chronic obstructive airways disease	1995	Short term use for hypertension led to acute stressful situation			
<b>CURRENT MEDICATIONS ON DISCHARGE</b>							
<b>* Status:</b>	<b>* Item:</b>	<b>Duration:</b>	<b>Indication:</b>	<b>* Dose:</b>	<b>Admin Site:</b>	<b>Route:</b>	<b>Change details:</b>
New	Doxycycline 100 mg tablet	17/10/2008 to 19/10/2008 (2 days)	Fever	1 tablet, once daily	-	Oral	
New	Paracetamol 500 mg	17/10/2008 to 11/11/2008 (25 days)	Pain management	1-2 tablets, 4-6 hourly, as required	-	Oral	
<b>Follow up required:</b> Please review ongoing requirements							
New	Codeine phosphate 30 mg	17/10/2008 to 11/11/2008 (25 days)	Pain management	1-2 tablets, every 4 hours, as required	-	Oral	
Existing - unaltered	Spiriva (tiotropium (as bromide monohydrate) 18 mg	17/10/2008 to 16/11/2008 (30 days)	Maintenance treatment in COPD	1 capsule, once daily (30 tabs)	-	Inhalation	
Existing - altered	Ventolin (salbutamol (as sulfate) 200 microgram)	17/10/2008 to 3/11/2008 (17 days)	Maintenance treatment in COPD	2 capsule, three times daily, as required (100 caps)	-	Inhalation via Rotacap	Dose increased
<b>MEDICATIONS CEASED THIS VISIT</b>							
<b>* Item:</b>	<b>* Duration:</b>	<b>Indication:</b>	<b>Dose:</b>	<b>Admin site:</b>	<b>Route:</b>	<b>Reason for change:</b>	
Oxycodone hydrochloride	10/10/2008 to 14/10/2008 (4 days)	Pain management	5 mg, 1 capsule, Every 4 hours, as required	-	Oral	No longer required	
Cardiprin (aspirin)	2003 to 10/10/2008 (5 years)	Stroke prevention	100 mg, 1 tablet, alternate days	-	Oral	No longer required	
Celebrex (celecoxib) capsule hard	7/2006 to 19/10/2006 (2 years)	Chronic pain control	200 mg, 1 capsule, one to two times per day	-	Oral	Ceased due to scheduled surgery	
Enoxaparin sodium 40 mg / 0.4 mL injection, syringe	10/10/2008 to 14/10/2008 (4 days)	Deep venous thrombosis prophylaxis	40 mg daily	-	Subcutaneous	No longer required	
<b>ORIGINAL REFERRAL</b>							
<b>Reason for Service :</b>	Extensive osteoarthritis of right knee		To occur:				
<b>* Requested Service Description:</b>	Elective orthopaedic surgery for TKR		Subject of care Instructions:		Fast from 8am on the morning of admission Bring any private XRays		
<b>Requested by:</b>	<b>Dr Mary Mould (HPI#: 800362000000922)</b> General Practitioner Jaydon Oak GP Practice 22 General Street, Brisbane, QLD 4001		Phone: Fax: Email: HPI-O:		(99) 3333 3333 (99) 6666 1111 records@jaydonoak.com.au 800363000000178		

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<b>MRN: 9999999</b>		<b>Subject of Care: Mr Orthopaedic DEMONSTRATION</b>		<b>DOB: 01/01/1946</b>	
<b>REQUESTED FOLLOW UP SERVICES</b>					
<b>* Description:</b>	<b>Reason for Service:</b>	<b>To commence:</b>	<b>* Provider:</b>	<b>Subject of Care Instruction:</b>	
Orthopaedic outpatient clinic appointment	6 weeks post-discharge review of progress	28/11/2008 to 14/10/2008	Sir Horrace Moorcroft Orthopaedic Surgeon Ph (99) 7777 7777 <i>[HPI# 8003620000000765]</i>	Bring any old private X-Rays	
Ongoing community physio-therapist management	Ensure that post-surgical mobility outcomes are being met	24/10/2008 to 31/10/2008	OrthoRehab Pty Ltd 10 Rehab Lane, BRISBANE 4000 Ph (99) 6666 6666 <i>[HPI# 8003630000000339]</i>	Bring post-op instruction materials & any old private X-Rays	
<b>HOSPITAL PARTICIPANTS</b>					
<b>* Attending Health Professional at Discharge:</b>					
Dr Horace MOORCROFT <i>HPI# 8003620000000755</i>	Orthopaedic Surgeon	The Marsten Health Hospital	Stanley Street, Brisbane, QLD 4001	Ph	(99) 7777 7777
<b>Other Participants:</b>					
* Dr Janice REGISTRAR <i>HPI# 8003620000000789</i>	Orthopaedic Registrar	The Marsten Health Hospital	Stanley Street, Brisbane, QLD 4001	Ph	(77) 6666 6666
* Dr Peter INTERN <i>HPI# 8003620000000111</i>	Orthopaedic Intern	The Marsten Health Hospital	Stanley Street, Brisbane, QLD 4001	Ph	(77) 2222 3333
* Jenny PHYSIO <i>HPI# 8003620000000222</i>	Orthopaedic Physio	The Marsten Health Hospital	Stanley Street, Brisbane, QLD 4001	Ph	(77) 1111 8888
<b>* USUAL GENERAL PRACTITIONER</b>					
Dr Mary MOULD <i>HPI# 8003620000000922</i>	General Practitioner	Jaydon Oak GP Practice <i>HPI# 8003630000000178</i>	22 General Street, Brisbane, QLD 4001	Ph:	(99) 3333 3333
				Fax:	(99) 6666 1111
				Email:	records@jaydonoak.com.au
<b>* FACILITY DETAILS</b>					
		The Marsten Health Hospital <i>HPI# 8003630000001456</i>	Stanley Street, Brisbane, QLD 4001	Ph:	(99) 9999 9999
				Fax:	(99) 8888 8888
				Email:	records@Marsten.health.gov.au
<b>* DISCHARGE SUMMARY RECIPIENT DETAILS</b>					
<b>Name:</b>	<b>Position:</b>	<b>Organisation:</b>	<b>Address:</b>	<b>Contact:</b>	
<b>Dr Mary MOULD</b> <i>HPI# 8003620000000922</i>	General Practitioner	Jaydon Oak GP Practice <i>HPI# 8003630000000178</i>	22 General Street, Brisbane, QLD 4001	Ph:	(99) 3333 3333
				Fax:	(99) 6666 1111
				Email:	records@jaydonoak.com.au
<b>Dr Horace MOORCROFT</b> <i>HPI# 8003620000000755</i>	Orthopaedic Surgeon	Orthopaedic Surgery Pty Ltd <i>HPI# 8003630000000333</i>	100 Generic Road, Brisbane, QLD 4001	Ph:	(99) 4444 7777
				Fax:	(99) 8888 1111
				Email:	records@orthosurg.com.au
		PhysioCare Pty Ltd <i>HPI# 8003630000000999</i>	5 Standard Ave, Brisbane, QLD 4001	Ph:	(99) 5555 5555
				Fax:	(99) 2222 2222
				Email:	records@physiocare.com.au
<b>Mr Orthopaedic DEMONSTRATION</b>	Subject of care		1 Clinician Street, Nehtaville, QLD 4000	Ph:	(99) 9988 7766

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<b>MRN:</b> 9999999		<b>Subject of Care:</b> Mr Orthopaedic DEMONSTRATION		<b>DOB:</b> 01/01/1946	
<b>PATHOLOGY</b>					
<b>* Result Test Name :</b>		<b>* Date time issued:</b>		<b>* Reported by:</b>	
Complete Blood Count		10/10/2008 14:31		Dr Fred Pathologist	
<b>* Primary Laboratory:</b>					
NEHTAPath Pty Ltd (ABN 11 11: 10 Pathology St, Brisbane, QLD Ph: (07) 3333 3333 Fa: HPI# 80036 20000004567		<p>For details on pathology please refer to the <i>Pathology Result Report Structured Document Template v1.0</i></p>		Whole Blood sample	
<b>* Result Name:</b>		<b>* Vt:</b>		<b>* Status:</b>	
Haemoglobin		130		Final	
RBC		4.5 x 10 <sup>12</sup> /L		Final	
PCV		0.40 /L		Final	
MCV		78 fl		Moderately significant L Final	
MCH		28.0 pg		Final	
MCHC		320 g/L		Final	
RDW		11.0 %		Moderately significant L Final	
White Cell Count		20.0 x 10 <sup>9</sup> /L		Highly significant HH Final	
Neutrophils		16.0x10 <sup>9</sup> /L		Highly significant HH Automated cell count method Final	
Neutrophils %		80.0%		Final	
Lymphocytes		3.05 x 10 <sup>9</sup> /L		Automated cell count method Final	
Lymphocytes %		15.25 %		Final	
Monocytes		0.8 x 10 <sup>9</sup> /L		Automated cell count method Final	
Monocytes %		4.0 %		Final	
Eosinophils		0.03 x 10 <sup>9</sup> /L		Automated cell count method Final	
Eosinophils %		0.15 %		Final	
Basophils		0.02 x 10 <sup>9</sup> /L		Automated cell count method Final	
Basophils %		0.1 %		Final	
<b>Report:</b> Microcytic anaemia. Suggest Ferritin and Iron Studies. High white cell count with neutrophilia - ? infection.					
<b>Interpretive Note:</b>					

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<b>MRN:</b> 9999999	<b>Subject of Care:</b> Mr Orthopaedic DEMONSTRATION	<b>DOB:</b> 01/01/1946
<b>RADIOLOGY</b>		
<b>* Investigation :</b>	<b>* Date time performed:</b>	<b>Requestor:</b>
Right knee x-ray	20/10/2008 13:54	Dr Michael Dancer
<b>Report:</b>	The right kn The signific	
<b>Note:</b>	For details on diagnostic imaging reports refer to the <i>Diagnostic Imaging Data Specification v1.0</i>	
<b>* Investigation :</b>	<b>* Date time performed:</b>	<b>Requestor:</b>
X-Ray of chest	21/10/2008 09:28	Dr Michael Dancer
<b>Report:</b>	Normal heart size. No evidence of failure. Bilateral atelectasis noted.	
<b>Note:</b>	1 cysts remain.	
<b>* Investigation :</b>	<b>* Date time performed:</b>	<b>Requestor:</b>
X-Ray of chest	21/10/2008 09:28	Dr Michael Dancer
<b>Report:</b>	Normal heart size. No evidence of failure. Bilateral atelectasis noted.	
<b>Note:</b>	1 cysts remain.	
<b>OTHER INVESTIGATIONS / OBSERVATIONS</b>		
<b>* Description :</b>	<b>* Date time performed:</b>	<b>* Result:</b>
SpO <sub>2</sub> measurement	18/10/2008 11:52	92%
<b>Abnormal indicator:</b>	Low	
<b>Note:</b>		
<b>* Description :</b>	<b>* Date time performed:</b>	<b>* Result:</b>
Body temperature	19/10/2008 10:12	38.5 degrees C
<b>Abnormal indicator:</b>	High	
<b>Note:</b>		

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# Reference List

[REF]	Document Name	Publisher	Repository
[AS4700.6-2007]	AS 4700.6:2007 – Implementation of Health Level 7 (HL7) Version 2.5 – Part 6: Referral, discharge and health record messaging	Standards Australia	<a href="http://www.e-healthstandards.org.au">http://www.e-healthstandards.org.au</a> Accessed 16 December 2008
[DS-DH]	Document Header Data Specification	NEHTA	This document has not been published as at 19 March 2009
[DS-PART]	Participant Data Specification	NEHTA	This document has not been published as at 19 March 2009
[PRRSDT]	Pathology Result Report Structured Document Template v1.0	NEHTA	This document has not been published as at 19 March 2009
[DIDS2007]	Diagnostic Imaging Data Specifications Version 1.0 – 13/07/2007	NEHTA	<a href="http://www.nehta.gov.au/DGL/Resources/Downloads/Diagnostic%20Imaging%20v1.0.pdf">http://www.nehta.gov.au/DGL/Resources/Downloads/Diagnostic Imaging v1.0.pdf</a> Accessed 16 December 2008
[DSPBRS2008]	Discharge Summary Package Business Requirements Specification V1.02 – 07/11/2008	NEHTA	This document has not been published as at 19 March 2009
[AAGT-2005]	NEHTA CDS Acronyms, Abbreviations & Glossary of Terms, Version No.: 1.2, Issued: 25 May 2005	NEHTA	<a href="https://www.nehta.net.au/confluence/download/attachments/24510490/CI_Glossary_v1-2.pdf?version=1">https://www.nehta.net.au/confluence/download/attachments/24510490/CI_Glossary_v1-2.pdf?version=1</a> Accessed 16 December 2008
[NDSD2006]	National Discharge Summary Data Content Specifications Version 1.0 – 21/12/2006	NEHTA	Archived
[DS-GUIDE]	NEHTA Data Specification and Structured Document Template Guide for Use – VX.X 2009	NEHTA	This document has not been published as at 19 March 2009

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