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## **Discharge Summary - Core**

### **Structured Document Template**

Version 2.1 – 26/08/2009

Final

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# Document Information

## Acknowledgements

This Profile draws on the significant work that resulted in the NEHTA *National Discharge Summary Data Content Specifications Version 1.0 – 21/12/2006* [[NDSD2006](#)].

## Change History

Version	Date	Author	Comments
1.0	21/12/2006	NEHTA	First Release
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2.1	26/08/2009	NEHTA	Revision of section 3, other minor editing.

## Authorisation History

Version	Date	Status	Comments
2.0	30/06/2009	Final	
2.1	26/08/2009	Final	

## 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* [[AAGT-2005](#)].

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# 1 Introduction

## 1.1 Document Purpose

This document defines the Structured Document Template (SDT) for discharge summaries in Australia. The SDT organises the data elements and data groups into a logical model for the clinical communication of discharge summaries.

The discharge summary SDT names the complete set of data elements that may be used interoperably in a valid discharge summary instance, and structures the content in a manner that delivers context and meaning. As such, it provides an information framework on which to achieve semantic interoperability, independent of any messaging format, sending/receiving application or data store.

This document is one component of the solution proposed by NEHTA for discharge summaries. Other components include exchange format mappings, terminology reference sets and web service specifications.

## 1.2 Document Scope

This specification document describes the logical information model proposed for use in communicating a discharge summary between a healthcare facility and the discharge summary recipients. The SDT defines the allowable set of data items, which may be used to facilitate interoperability, together with their structure, definition, datatype and constraints (including occurrence frequency, value domains and conditions of use).

The contents of this SDT release are restricted to those data items required to support the 'Core Discharge Summary' [DS-CDS]. The Core Discharge Summary defines the minimum set of data items that are recommended for implementation in any system that creates and transfers discharge summary information in Australia. This defines the core data components for exchange that are common to all clinical specialities/domains. It is anticipated that clinical domain specific discharge summaries will need additional data components to satisfy specialty specific requirements.

National extensions to the Core Discharge Summary will be defined to support particular specialty areas (e.g. Aged Care, Oncology, Obstetrics, Cardiology, Community Nursing). These extensions will be added to this SDT to form a 'maximal' set of nationally-agreed data items for discharge summary interoperable exchange. As such, the SDT will define the allowable set of data items, which may be used to facilitate interoperability at the national level.

It is recommended that discharge summary systems must implement the Core data items, and may also implement a subset of non-core data items, to facilitate the interoperable exchange of this data. In addition to this, local extensions may be added to support specific local requirements. It should be noted that local extensions may be safely interpreted at the local level (subsequent to negotiation and agreement), however consistent interpretation of these additional items at a national level should not be assumed.

## 1.3 Discharge Summary Definition

A discharge summary is defined in [AS4700.6-2007] as:

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

A *discharge summary* is a document produced during a patient's stay in hospital as an admitted or non-admitted patient and issued when or after a patient leaves the care of the hospital.

Its primary function is to support the continuity of care as the patient returns to the care of their community healthcare providers. The primary recipients of the discharge summary are healthcare providers who were providing the patient care prior to the hospital stay, including:

- The patients' nominated primary healthcare provider (or primary health service such as an Aboriginal Community Controlled Health Service).
- The referring clinician (e.g. private specialist).
- Residential Aged Care Facility where the patient usually resides.
- Other health professionals who will be involved in the patient's post-discharge care.

Within this primary function the purpose of the NEHTA discharge summary package is to:

- Assist and improve clinician-to-clinician communication.
- Enable system-to-system communication of semantically interoperable data.

The secondary functions of the discharge summary include:

- Providing summary information regarding an earlier healthcare encounter on the re-presentation of the patient to acute care.
- Use by clinical coders when coding relevant information pertinent to the healthcare encounter.
- Providing the patient with a record of their hospital admission and care.
- Inclusion in an Individual Electronic Health Record (IEHR), which could include a national IEHR or a local repository, for example to support coordinated care.

## 1.4 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
    - the facilitation of semantic interoperability
  - b. To support NEHTA-defined terminology in:
    - clinical 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 who wish to evaluate the clinical suitability of NEHTA-endorsed standards.
3. Researchers who wish 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 [\[AS4700.6-2007\]](#).

## 1.5 Related Documents

Companion documents to this SDT are listed below:

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

## 1.6 Discharge Summary Life-Cycle

A discharge summary is expected to be commenced by the clinicians involved in the care of the patient during the encounter and completed at discharge (or soon after the discharge) of the patient. In the process of generating a discharge summary, clinical information recorded during the healthcare event which is considered important for safe and effective continued management of the subject is included in the summary.

The specific content to be included in a discharge summary will depend upon the nature of the health problems/diagnoses, diagnostic tests performed, medications prescribed, and interventions performed etc. Some of this information is considered to be critical to include in every discharge summary for every patient, and as such is given an Obligation of 'Essential'. For example:

- Patient;
- Facility;
- Document Author;
- Document Recipients;
- Encounter;
- Problems/Diagnoses;
- Clinical Synopsis;
- Current Medications on Discharge;
- Ceased Medications;
- Adverse Reactions;
- Recommendations;
- Document Control;

Other types of information are recommended to be implemented in every discharge summary system, as the information is important for facilitating effective continuity of care. However, this information may not always be relevant to certain types of patients, and hence may not always be collected during the encounter or included in every discharge summary. Examples include:

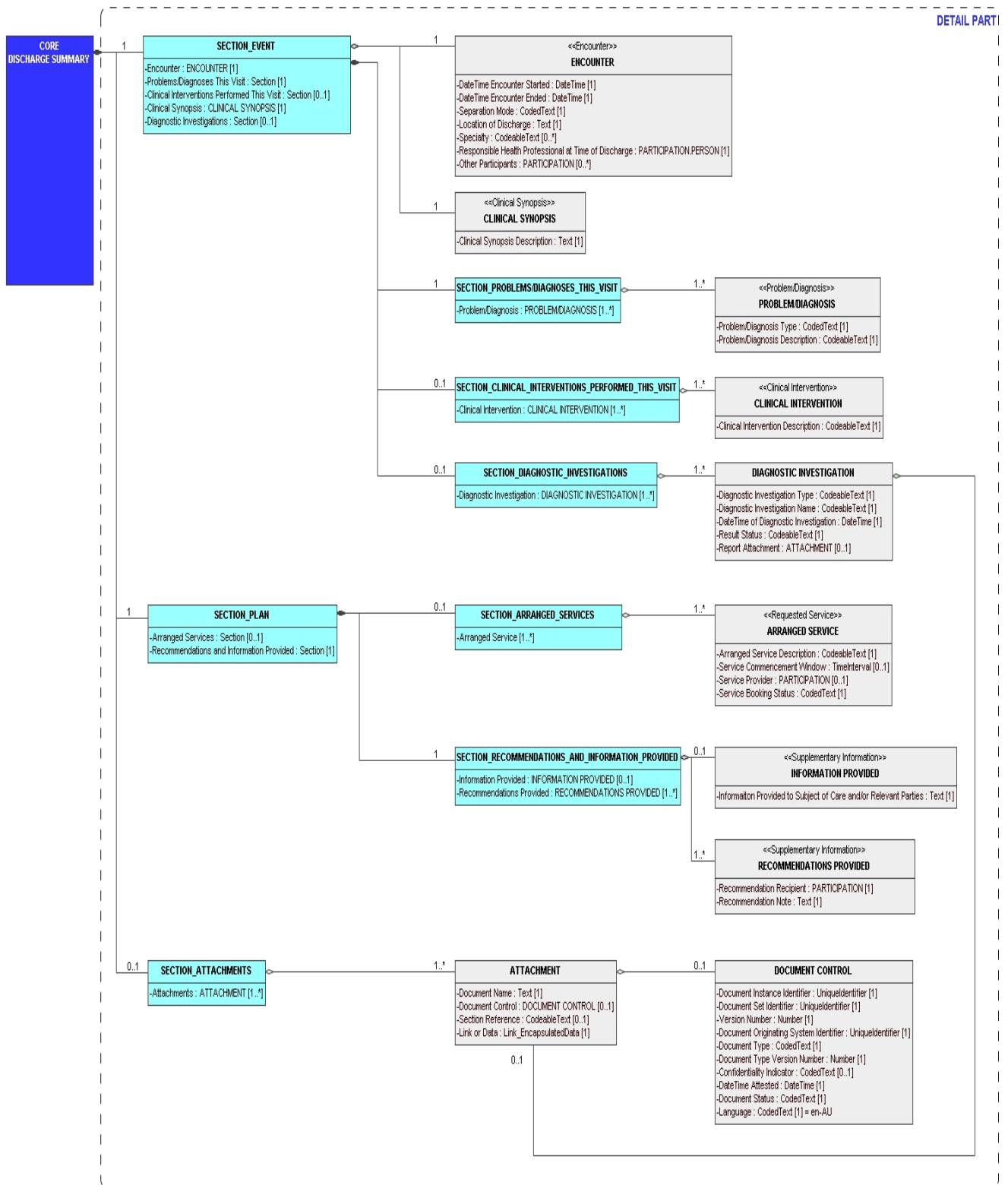
- Nominated Primary Healthcare Provider;
- Diagnostic Investigations;
- Clinical Interventions;
- Alerts;
- Arranged Services;
- Information Provided to Subject of Care and/or Relevant Parties;
- Attachments;

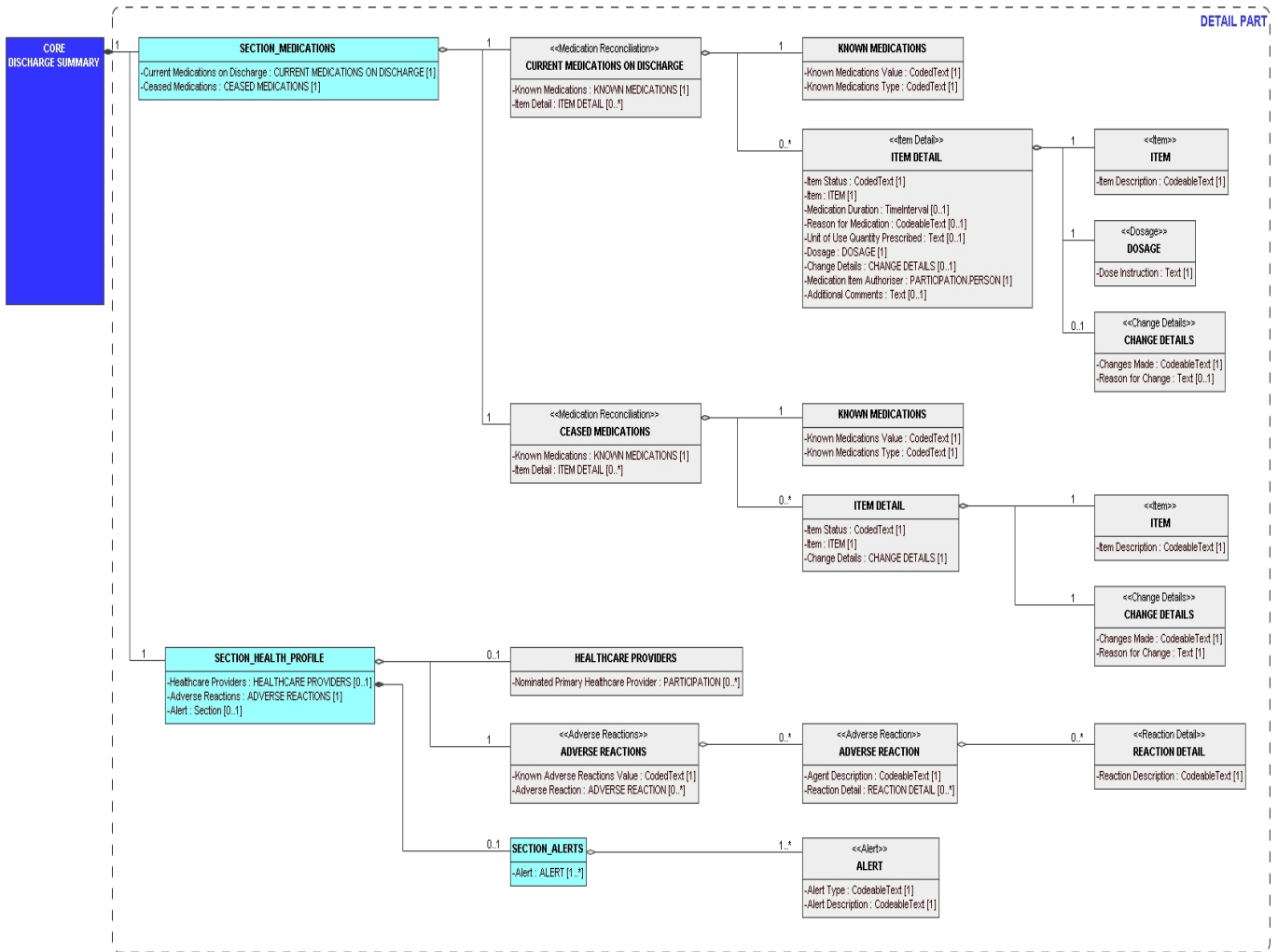
Information which is optional to implement and is not necessarily included in all discharge summaries, is not included in this release of the Discharge Summary SDT.

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* [[DSPBRS2009](#)].

# 2 UML Diagram














### 3 Discharge Summary Header


The data hierarchy below provides a logical representation of the data structure of the discharge summary information components. This data hierarchy is not intended to represent how the data contents are visually displayed in a discharge summary authoring application or a clinical desktop environment.

Within this SDT information components in upper case are sections and data groups and information components in lower case are individual data elements.

Individual data elements associated with the Participation data group are not displayed in the data hierarchy to improve its readability. The data elements of the PARTICIPATION data group and their hierarchical structure can be found in the related document *Data Specification – Participation* [DS-PART]. 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 use of the header in a discharge summary, are explained later in this section.

		<b>Discharge Summary</b>		
<b>HEADER</b>				
	HEALTH EVENT CONTEXT			!
	PATIENT [SUBJECT OF CARE] (PARTICIPATION.PERSON)			!
	FACILITY (PARTICIPATION.ORGANISATION)			!
	DOCUMENT CONTEXT			!
	DOCUMENT CONTROL			!
	<b>ID</b>	Document Instance Identifier		!
	<b>ID</b>	Document Set Identifier		!
	<b>1<sup>23</sup></b>	Version Number		!
	<b>ID</b>	Document Originating System Identifier		!
	<b>T<sub>010</sub></b>	Document Type		!
	<b>1<sup>23</sup></b>	Document Type Version Number		!
	<b>T<sub>010</sub></b>	Confidentiality Indicator		O
		DateTime Attested		!
	<b>T<sub>010</sub></b>	Document Status		!
	<b>T<sub>010</sub></b>	Language (default to en-AU)		!
	DOCUMENT AUTHOR (PARTICIPATION.PERSON)			!
	DOCUMENT RECIPIENTS			! ↻

		<b>T</b> <sub>010</sub>	Document Recipient Type	!
			DOCUMENT RECIPIENT (PARTICIPATION)	!

Each of the key data groups in the header is described in the following sections, including specific constraints on the information that apply in the context of a discharge summary.

### 3.1 Patient (Subject of Care)

The patient (or 'Subject of Care') data group identifies the person about whom the healthcare event/encounter/clinical interaction has been captured and/or interchanged, that led to the creation of the document, i.e. the subject of the information.

Mandatory details of this data group are listed below, with the allowable range of values in square brackets.

This data group must include the following participation details:

- Participation Type [1] – The value must indicate 'Subject of Care'
- Entity Identifier [1 to many]
- Address [1 to many] – This may indicate that the patient has no known address
- Person Name [1 to many]
- Date of Birth [1] – This may be an approximate date where the date is not known – the DateTime data type includes a flag that explicitly states whether or not the value is an estimation
- Sex [1]

### 3.2 Facility

The facility data group identifies a healthcare organisation involved in or associated with the delivery of the healthcare services to the subject of care.

Mandatory details of this data group are listed below, with the allowable range of values in square brackets.

This data group must include the following participation details:

- Participation Type [1] – The value must indicate 'Facility'
- Entity Identifier [1 to many]
- Address [1 to many]
- Electronic Communication Details [1 to many]
- Organisation Name [1]

### 3.3 Document Control

Holds versioning information about the document instance that belongs to the same logical document set, i.e. that are related to the same healthcare encounter.

The Document Type, which is the name of the Structured Document Template used to create the document instance, is "Discharge Summary", and the Document Type Version Number, which is the identifier of the version of the Structured Document Template used to create the document instance, is "2".

### 3.4 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 for inpatient encounters in Australia is that this is the current intern or resident of the senior clinician responsible for the patient).

Mandatory details of this data group are listed below, with the allowable range of values in square brackets.

This data group must include the following participation details:

- Participation Type [1] – The value must indicate 'Document Author'
- Entity Identifier [1 to many]
- Person Name [1]

### 3.5 Document Recipients

The Document Recipients are the persons and/or organisations who are designated to receive a copy of the document. A healthcare provider (person or organisation), who is involved in the care of the patient, may receive the discharge summary either via electronic or manual means. Recipients of a discharge summary may include the patient's nominated GP or GP practice, the referring clinician, the residential aged care facility at which the patient usually resides, other healthcare professionals/organisations who will be involved in the patient's post-discharge care, the community pharmacy which dispenses their medications, the patient themselves, and the patient's carer.

Mandatory details of this data group are listed below, with the allowable range of values in square brackets.















This data group must include the following details:


















- Document Recipient Type [1] – e.g. 'Primary recipient', 'CC recipient'
- Participation Type [1] – The value must indicate 'Document Recipient'
- Entity Identifier [1 to many] – May be a person or an organisation



















# 4 Discharge Summary Detail






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

Note that the definitions for the Document Control data group are found in the Document Header Data Specification [\[DS-DH\]](#).

		<b>Discharge Summary</b>		
<b>DETAIL</b>				
	EVENT			!
	ENCOUNTER			!
		DateTime Encounter Started		!
		DateTime Encounter Ended		!
	<b>T</b> <sub>010</sub>	Separation Mode		!
	<b>T/T</b> <sub>0</sub>	Specialty		o ↻
	<b>T</b>	Location of Discharge		!
		RESPONSIBLE HEALTH PROFESSIONAL AT TIME OF DISCHARGE (PARTICIPATION.PERSON)		!
		OTHER PARTICIPANT (PARTICIPATION)		o ↻
	PROBLEMS/DIAGNOSES THIS VISIT			!
		PROBLEM/DIAGNOSIS		! ↻
		<b>T</b> <sub>010</sub>	Problem/Diagnosis Type	!
		<b>T/T</b> <sub>010</sub>	Problem/Diagnosis Description	!
	CLINICAL INTERVENTIONS PERFORMED THIS VISIT			o
		CLINICAL INTERVENTION		! ↻
		<b>T/T</b> <sub>010</sub>	Clinical Intervention Description	!
		CLINICAL SYNOPSIS		!
		<b>T</b>	Clinical Synopsis Description	!
	DIAGNOSTIC INVESTIGATIONS			o
		DIAGNOSTIC INVESTIGATION		! ↻
		<b>T/T</b> <sub>010</sub>	Diagnostic Investigation Type	!
		<b>T/T</b> <sub>010</sub>	Diagnostic Investigation Name	!

			DateTime of Diagnostic Investigation		!
			<b>T/T</b> <sub>010</sub>	Result Status	!
			REPORT ATTACHMENT (ATTACHMENT)		o
	MEDICATIONS				!
		CURRENT MEDICATIONS ON DISCHARGE (MEDICATION RECONCILIATION)			!
			KNOWN MEDICATIONS		!
			<b>T</b> <sub>010</sub>	Known Medications Type	!
			<b>T</b> <sub>010</sub>	Known Medications Value	!
			ITEM DETAIL		o 
			<b>T</b> <sub>010</sub>	Item Status	!
			ITEM		!
			<b>T/T</b> <sub>01</sub>	Item Description	!
			Medication Duration		o
			<b>T/T</b> <sub>010</sub>	Reason for Medication	o
			<b>T</b>	Unit of Use Quantity Dispensed	o
			DOSAGE		!
			<b>T</b>	Dose Instruction	!
			CHANGE DETAILS		o
			<b>T/T</b> <sub>01</sub>	Changes Made	!
			<b>T</b>	Reason for Change	o
			MEDICATION ITEM AUTHORISER (PARTICIPATION.PERSON)		!
			<b>T</b>	Additional Comments	o
		CEASED MEDICATIONS (MEDICATION RECONCILIATION)			!
			KNOWN MEDICATIONS		!
			<b>T</b> <sub>010</sub>	Known Medications Type	!
			<b>T</b> <sub>010</sub>	Known Medications Value	!
			ITEM DETAIL		o 
			<b>T</b> <sub>010</sub>	Item Status	!
			ITEM		!

			<b>T/T<sub>010</sub></b>	Item Description	!
				CHANGE DETAILS	!
			<b>T/T<sub>010</sub></b>	Changes Made	!
			<b>T</b>	Reason for Change	!
	HEALTH PROFILE				!
		HEALTHCARE PROVIDERS			o
			NOMINATED PRIMARY HEALTHCARE PROVIDER (PARTICIPATION)		o ↻
		ADVERSE REACTIONS			!
		<b>T<sub>010</sub></b>	Known Adverse Reactions Value		!
			ADVERSE REACTION		o ↻
			<b>T/T<sub>010</sub></b>	Agent Description	!
				REACTION DETAIL	o ↻
			<b>T/T<sub>010</sub></b>	Reaction Description	!
		ALERTS			o
			ALERT		! ↻
			<b>T/T<sub>010</sub></b>	Alert Type	!
			<b>T/T<sub>010</sub></b>	Alert Description	!
	PLAN				!
		ARRANGED SERVICES			o
			ARRANGED SERVICE		! ↻
			<b>T/T<sub>010</sub></b>	Arranged Service Description	!
			Service Commencement Window		o
			SERVICE PROVIDER (PARTICIPATION)		o
			<b>T/T<sub>010</sub></b>	Service Booking Status	!
		RECOMMENDATIONS AND INFORMATION PROVIDED			!
			INFORMATION PROVIDED (SUPPLEMENTARY INFORMATION)		o
			<b>T</b>	Information Provided to Subject of Care and/or Relevant Parties	!
			RECOMMENDATIONS PROVIDED (SUPPLEMENTARY INFORMATION)		! ↻
			RECOMMENDATION RECIPIENT (PARTICIPATION)		!


		<b>T</b>	Recommendation Note	!
	ATTACHMENTS			o
		ATTACHMENT		! ↻
		<b>T</b>	Document Name	!
			DOCUMENT CONTROL (see [DS-DH] DOCUMENT CONTROL)	o
		<b>ID</b>	Document Instance Identifier	!
		<b>ID</b>	Document Set Identifier	!
		<b>123</b>	Version Number	!
		<b>ID</b>	Document Originating System Identifier	!
		<b>T</b> <sub>010</sub>	Document Type	!
		<b>123</b>	Document Type Version Number	!
		<b>T</b> <sub>010</sub>	Confidentiality Indicator	o
			DateTime Attested	!
		<b>T</b> <sub>010</sub>	Document Status	!
		<b>T</b> <sub>010</sub>	Language	!
		<b>T/T</b> <sub>01</sub>	Section Reference	o
		Link or Data		!

# 5 Data Specifications

The following part of the document expands on the details for each section, data group and data element shown in the Discharge Summary Data Hierarchy. Definition of the table layout used 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, which is released when the patient is discharged from the care of the provider 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 from a provider facility/organisation includes information summarising the care given to the patient during the stay and additional information considered relevant to the ongoing care of the patient.</p> <p>This version of the Discharge Summary SDT is primarily intended to define the detailed logical data structure required by the core information components, which have been recommended for use when exchanging discharge summaries in Australia.</p>


### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
	HEALTH EVENT CONTEXT (see <a href="#">[DS-DH]</a> )	2.0	Essential		1
	DOCUMENT CONTEXT see <a href="#">[DS-DH]</a>	2.0	Essential		1
	EVENT		Essential		1
	MEDICATIONS		Essential		1
	HEALTH PROFILE		Essential		1
	PLAN		Essential		1
	ATTACHMENTS	1.0	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 encounter which instigated the creation of the discharge summary.
<b>Synonymous Names</b>	Encounter
<b>Notes</b>	This section is for the logical grouping of data elements relating to the healthcare event.

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
	ENCOUNTER	1.0	Essential		1
	PROBLEMS/DIAGNOSES THIS VISIT		Essential		1
	CLINICAL INTERVENTIONS PERFORMED THIS VISIT		Optional		0..1
	CLINICAL SYNOPSIS	2.0	Essential		1
	DIAGNOSTIC INVESTIGATIONS		Optional		0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY	2.0	Essential		1

## 5.2.1 ENCOUNTER

### Identification





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

### Definition


<b>Definition</b>	Describes the general details about a stay in a healthcare facility as an admitted or non-admitted patient.
<b>Synonymous Names</b>	Admission
<b>Notes</b>	

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
	DateTime Encounter Started		Essential		1
	DateTime Encounter Ended		Essential		1
<b>T</b> <sub>010</sub>	Separation Mode		Essential		1
<b>T/T</b> <sub>010</sub>	Specialty		Optional		0..*
<b>T</b>	Location of Discharge		Essential		1
	RESPONSIBLE HEALTH PROFESSIONAL AT TIME OF DISCHARGE	1.0	Essential		1
	OTHER PARTICIPANT	1.0	Optional		0..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	EVENT		Essential		1

## 5.2.2 DateTime Encounter Started

### Identification

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

### Definition


<b>Definition</b>	The date (and optionally time) of the start of the encounter that this discharge summary refers to. In the case of admitted patients, this is the date/time of their admission to the healthcare facility.
<b>Synonymous Names</b>	Admission Date Admission Date and Time Encounter Start Date Encounter Start 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>Examples</b>	2008-10-3011:20
-----------------	-----------------


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ENCOUNTER	1.0	Essential		1

## 5.2.3 DateTime Encounter Ended

### Identification

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

### Definition


<b>Definition</b>	The date (and optionally time) of the end of the encounter that this discharge summary refers to. In the case of admitted patients, this is the date/time of their discharge.
<b>Synonymous Names</b>	Discharge Date Discharge Date and Time Separation Date Separation Date and Time Encounter DateTime Ended
<b>Notes</b>	This item denotes the date or date and time at which the patient is released/discharged from the healthcare facility at completion of the healthcare encounter. Must include a date component and may include a time component if available.
<b>Datatype</b>	DateTime

### Usage

<b>Examples</b>	2008-11-1709:30
-----------------	-----------------

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ENCOUNTER	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 patient (e.g. discharge/transfer/death) and place to which person is released (e.g. home).
<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>Examples</b>	Discharge/transfer to a residential aged care service, unless this is the usual place of residence. Left against medical advice/discharge at own risk. Discharge to usual residence. Discharge to welfare institution (e.g. prisons, hostels and group homes providing primarily welfare services).
-----------------	--

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ENCOUNTER	1.0	Essential		1

## 5.2.5 Specialty

### Identification



<b>Name</b>	Specialty
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16028

### Definition


<b>Definition</b>	A reverse chronological list of the clinical specialties under which the patient was treated during the encounter (i.e. the last specialty appears first). Each specialty should only appear once in the list, in its first (i.e. most recent) position.
<b>Synonymous Names</b>	
<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

#### Examples

### Relationships

#### Parent

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

## 5.2.6 Location of Discharge

### Identification

<b>T</b>	<b>Name</b>	LOCATION OF DISCHARGE
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-16040

### Definition


<b>Definition</b>	The name or identifier of the physical location from which the patient was discharged. In the case of admitted patients, this should be the ward in which they were located at the time of discharge. For non-admitted patients, this may be the department in which the encounter occurred.
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	Text

### Usage

<b>Examples</b>	Emergency Department Cardiac Ward Oncology Ward
-----------------	---


### Relationships

#### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	ENCOUNTER	1.0	Essential		1

## 5.2.7 RESPONSIBLE HEALTH PROFESSIONAL AT TIME OF DISCHARGE

### Identification



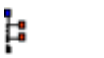
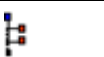
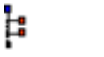
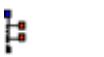
	<b>Name</b>	RESPONSIBLE HEALTH PROFESSIONAL (PARTICIPATION.PERSON)
	<b>Metadata Type</b>	Data Group (reuse of PARTICIPATION.PERSON, refer to the PARTICIPATION Data Specification <a href="#">[DS-PART]</a> for more detail).
	<b>Identifier</b>	DG-10296
	<b>Version</b>	1.0

### Definition


<b>Definition</b>	The healthcare provider who has the overall responsibility for the care given to the patient at the time of discharge.
<b>Synonymous Names</b>	Consultant Specialist Nurse Practitioner
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Condition	Occurrence
	Participation Type	Participation Type.description="Responsible Health Professional"	1
	Healthcare Role	<b>Must</b> be included	1
	ENTITY IDENTIFIER	<b>Must</b> contain the Healthcare Provider Identifier – Individual (HPI-I).	1
	PERSON NAME	<b>Must</b> contain name details and name usage type.	1
	HEALTHCARE PROVIDER FIELD OF PRACTICE DETAILS	<b>Should</b> be included	0..*
	ELECTRONIC COMMUNICATION DETAILS	<b>Should</b> include at least one method of electronic communication.	0..*

#### Parent

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

## 5.2.8 OTHER PARTICIPANT

### Identification



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

### Definition

<b>Definition</b>	Other healthcare providers who were involved in the encounter, or individuals associated with the patient at the time of the encounter, and the role that they played – e.g. registrar, referred specialist, referring clinician, emergency contact.
<b>Synonymous Names</b>	
<b>Notes</b>	Only those participants whose involvement in the healthcare encounter is considered to be relevant to the ongoing care of the patient should be included.

### Relationships

#### Children


Type	Name	Condition	Occurrence
T/T <sub>010</sub>	Participation Type	Participation Type.description="Other Participant"	1
T/T <sub>010</sub>	Healthcare Role	<b>Must</b> be included	1
	ENTITY IDENTIFIER	<b>Must</b> contain the Healthcare Provider Identifier – Individual (HPI-I).	1
	PERSON NAME	<b>Must</b> contain name details and name usage type.	1
	HEALTHCARE PROVIDER FIELD OF PRACTICE DETAILS	<b>Should</b> be included	0..*
	ELECTRONIC COMMUNICATION DETAILS	<b>Should</b> include at least one method of electronic communication.	0..*

#### Parent

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

## 5.2.9 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 or health/medical problems relevant to the patient during the encounter. This must include at least one problem/diagnosis whose type is "Principal".
<b>Synonymous Names</b>	Problems/Diagnoses This Admission Problems/Diagnoses During This Visit Problems/Diagnosis This Encounter Principal Problem/Diagnosis Complications Co-morbidities
<b>Notes</b>	This section specifically relates to the problems relevant to this healthcare encounter and should not include details of unrelated historical problems.

### Relationships

#### Children

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

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	EVENT		Essential		1

## 5.2.10 PROBLEM/DIAGNOSIS

### Identification

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

### Definition

<b>Definition</b>	Describes a diagnostic label or problem statement assigned by the healthcare provider to describe the diagnoses or health/medical problems relevant to the patient during the encounter.
<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.</p> <p>Should only include problems/diagnoses related to the healthcare encounter 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

#### Parent

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

## 5.2.11 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 used to categorise the problem/diagnosis. The supported Problem/Diagnosis Types must include "Principal", "Complication" and "Co-morbidity".
<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

#### Examples

### Relationships

#### Parent

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

## 5.2.12 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>	A description of the problem/diagnosis, which may or may not be coded.
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	NEHTA SCT-AU Problem/Diagnosis Description Reference Set

### Usage

#### Examples


### Relationships

#### Parent

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

## 5.2.13 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 the clinical interventions (including operations, procedures and relevant nursing and allied health interventions) performed on the patient during the healthcare encounter.
<b>Synonymous Names</b>	Procedures Performed This Visit
<b>Notes</b>	

### 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

## 5.2.14 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 patient, 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>	Procedure Treatment 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 encounter.  This item is repeated for every instance of a clinical intervention. It 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>	Clinical Intervention Description		Essential		1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
<b>S</b> <sub>==</sub>	CLINICAL INTERVENTIONS PERFORMED THIS VISIT		Essential		1..*

## 5.2.15 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 patient.
<b>Synonymous Names</b>	
<b>Notes</b>	A separate description should be included for each Clinical Intervention performed.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	NEHTA SCT-AU Clinical Intervention Reference Set

### Usage

<b>Examples</b>	Creation of Arterio-venous shunt for haemodialysis Peritoneal Dialysis
-----------------	---

### Relationships

#### Parent

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

## 5.2.16 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>	The clinical synopsis contains summary information or comments about the clinical management of the patient, and the prognosis of diagnoses/ problems identified during the healthcare encounter. It may also include health-related information pertinent to the patient, and a clinical interpretation of relevant investigations and observations performed on the patient (including pathology and diagnostic imaging). Please note that pathology and diagnostic imaging reports referred to in the clinical synopsis should be included in full as an attachment to the Discharge Summary. These attached investigation reports should be referenced and listed in the Investigation results section.
<b>Synonymous Names</b>	Clinical Comment Clinical Notes 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 Description</a>		Essential		1

#### Parent

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

## 5.2.17 Clinical Synopsis Description

### Identification

**T**

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

### Definition


<b>Definition</b>	The clinical synopsis, written in free text. The description may include a summary of the issues/problems, management strategies, outcomes/progress and possible prognosis.
<b>Synonymous Names</b>	Clinical Synopsis Comment Clinical Summary Description
<b>Notes</b>	
<b>Datatype</b>	Text

### Usage

<b>Examples</b>	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. 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.
-----------------	--


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	CLINICAL SYNOPSIS	2.0	Essential		1

## 5.2.18 DIAGNOSTIC INVESTIGATIONS

### Identification


	<b>Name</b>	DIAGNOSTIC INVESTIGATIONS
	<b>Metadata Type</b>	Section
	<b>Identifier</b>	S-20117

### Definition


<b>Definition</b>	Describes the diagnostic investigations performed on the patient during the healthcare event, that are considered to be relevant to the patient's ongoing care.
<b>Synonymous Names</b>	Pathology/Diagnostic Imaging Results Investigations Performed
<b>Notes</b>	This allows the results to be included as an attached report, or as a reference (i.e. link) to where the results are located. Pending results can be indicated using a Result Status of 'pending'.

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
	DIAGNOSTIC INVESTIGATION	1.0	Essential		1..*

#### Parent

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

## 5.2.19 DIAGNOSTIC INVESTIGATION

### Identification






 <b>Name</b>	DIAGNOSTIC INVESTIGATION
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-16029
<b>Version</b>	1.0

### Definition


<b>Definition</b>	Describes a single diagnostic investigation.
<b>Synonymous Names</b>	
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
 <b>T/T</b> <sub>010</sub>	<a href="#">Diagnostic Investigation Type</a>		Essential		1
 <b>T/T</b> <sub>010</sub>	<a href="#">Diagnostic Investigation Name</a>		Essential		1
	<a href="#">DateTime of Diagnostic Investigation</a>		Essential		1
 <b>T/T</b> <sub>010</sub>	<a href="#">Result Status</a>		Essential		1
	<a href="#">REPORT ATTACHMENT</a>		Optional		0..1

#### Parent

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

## 5.2.20 Diagnostic Investigation Type

### Identification

T/T<sub>010</sub>

<b>Name</b>	Diagnostic Investigation Type
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16030

### Definition


<b>Definition</b>	The type or category of diagnostic investigation performed on the patient.
<b>Synonymous Names</b>	
<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>Examples</b>	Pathology Diagnostic Imaging
-----------------	---------------------------------

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DIAGNOSTIC INVESTIGATION	1.0	Essential		1

## 5.2.21 Diagnostic Investigation Name

### Identification

T/T<sub>010</sub>

<b>Name</b>	Diagnostic Investigation Name
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-20190

### Definition


<b>Definition</b>	The name of the diagnostic investigation performed on the patient.
<b>Synonymous Names</b>	
<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>Examples</b>	INR Chest X-ray
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### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DIAGNOSTIC INVESTIGATION	1.0	Essential		1

## 5.2.22 DateTime of Diagnostic Investigation

### Identification



<b>Name</b>	DateTime of Diagnostic Investigation
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16031

### Definition

<b>Definition</b>	The date and/or time that the diagnostic investigation was performed (in the case of diagnostic imaging investigations), or the specimen was taken (in the case of pathology investigations).
<b>Synonymous Names</b>	DateTime Specimen Collected Investigation Date
<b>Notes</b>	
<b>Datatype</b>	DateTime

### Usage

#### Examples

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DIAGNOSTIC INVESTIGATION	1.0	Essential		1

## 5.2.23 Result Status

### Identification

T/T<sub>010</sub>

<b>Name</b>	Result Status
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-11029

### Definition


<b>Definition</b>	The status of the test result as indicated by the performing pathologist or laboratory scientist, detailing the stage at which the pathology testing has reached.
<b>Synonymous Names</b>	
<b>Notes</b>	<p>Allows a report with more than one result to be issued and for each result to have a different status associated with it.</p> <p>The status of a result is included within the report to inform the requester or receiver whether it is final or there is more to expect, or if amendments have been made. This indicates whether the results are able to be acted upon by the clinician.</p>
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	HL7 v2.4 Table 0123

### Usage

<b>Examples</b>	<p>A – Some, but not all results available</p> <p>C – Correction to results</p> <p>F – Final results</p>
-----------------	--


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DIAGNOSTIC INVESTIGATION	1.0	Essential		1

## 5.2.24 REPORT ATTACHMENT

### Identification



	<b>Name</b>	Report Attachment (reuse of ATTACHMENT)
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DG-16033

### Definition


<b>Definition</b>	The investigation results report, included as an attachment, using either a link (reference to an external repository) or data (the actual content of the report itself).
<b>Synonymous Names</b>	
<b>Notes</b>	The Report Attachment should only be included if the Result Status is not 'Pending'.  Please refer to the definition of 'Attachment' for more information about its children.

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
<b>T</b>	<a href="#">Document Name</a>		Essential		1
	<a href="#">DOCUMENT CONTROL</a>	1.0	Optional		0..1
<b>T/T</b> <sub>010</sub>	<a href="#">Section Reference</a>		Optional		0..1
	<a href="#">Link or Data</a>		Essential		1

#### Parent

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

## 5.2.25 MEDICATIONS

### Identification

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

### Definition



**Definition** Describes relevant medication information for the patient to be communicated to the general practitioner. Includes sections on current medications on discharge and ceased medications.

**Synonymous Names**


**Notes** This section outlines the data groups and data elements for Current and Ceased Medications for the discharge summary.

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
	CURRENT MEDICATIONS ON DISCHARGE (MEDICATION RECONCILIATION)	1.0	Essential		1
	CEASED MEDICATIONS (MEDICATION RECONCILIATION)	1.0	Essential		1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY		Essential		1

## 5.2.26 CURRENT MEDICATIONS ON DISCHARGE

### Identification



	<b>Name</b>	CURRENT MEDICATIONS ON DISCHARGE (reuse of MEDICATION RECONCILIATION)
	<b>Metadata Type</b>	Data Group
	<b>Identifier</b>	DG-16026

### Definition


<b>Definition</b>	Medications that the patient will continue or commence 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 the encounter, which are to be 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> The Status of the Item Detail must not equal "Ceased".</p>

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
	KNOWN MEDICATIONS	1.0	Essential		1
	ITEM DETAIL	2.0	Conditional	If the Known Medications Value is equivalent to "Known", then there must be medication item details recorded.	0..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	MEDICATIONS		Essential		1

## 5.2.27 KNOWN MEDICATIONS

### Identification



 <b>Name</b>	KNOWN MEDICATIONS
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-16034
<b>Version</b>	1.0

### Definition


<b>Definition</b>	Indicates: (a) Whether or not the patient is known to be taking any medication; and (b) Whether medications known to be taken are continued or ceased.
<b>Synonymous Names</b>	
<b>Notes</b>	This data group is used to determine the Medications to be included in the Current Medications on Discharge data group.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
 T <sub>010</sub>	<a href="#">Known Medications Type</a>		Essential		1
 T <sub>010</sub>	<a href="#">Known Medications Value</a>		Essential		1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	<a href="#">CURRENT MEDICATIONS ON DISCHARGE</a>	1.0	Essential		1

## 5.2.28 Known Medications Type

### Identification

T<sub>010</sub>

<b>Name</b>	Known Medications Type
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16035

### Definition


<b>Definition</b>	The type of Known Medications Value. This is used to determine which set the Medication belong to.
<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>Examples</b>	Current Medications on Discharge
-----------------	----------------------------------

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	KNOWN MEDICATIONS	1.0	Essential		1

## 5.2.29 Known Medications Value

### Identification

T<sub>010</sub>

<b>Name</b>	Known Medications Value
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16036

### Definition


<b>Definition</b>	Whether or not any relevant medications are known to exist.
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	CodedText
<b>Value Domain</b>	

### Usage

<b>Examples</b>	Known Unknown
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### Relationships

#### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	KNOWN MEDICATIONS	1.0	Essential		1

## 5.2.30 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>	Item Status		Essential		1
	ITEM	1.0	Essential		1
	Medication Duration		Optional		0..1
<b>T/T</b> <sub>010</sub>	Reason for Medication		Optional		0..1
<b>T</b>	Unit of Use Quantity Dispensed		Optional		0..1
	DOSAGE	1.0	Essential		1
	CHANGE DETAILS	1.0	Optional		0..1
	MEDICATION ITEM AUTHORISER	1.0	Essential		1
<b>T/T</b> <sub>010</sub>	Additional Comments		Optional		0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	CURRENT MEDICATIONS ON DISCHARGE	1.0	Conditional	If the Known Medications Value is equivalent to "Known", then there must be medication item details recorded.	0..*

## 5.2.31 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.
<b>Synonymous Names</b>	
<b>Notes</b>	Status must not equal 'Ceased' for any Item 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>Examples</b>	New Unchanged Dose Changed Withheld
-----------------	--


### Relationships

#### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	ITEM DETAIL	2.0	Essential		1

### 5.2.32 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> / <b>T</b> <sub>010</sub>	<a href="#">Item Description</a>		Essential		1

##### Parent

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

## 5.2.33 Item Description

### Identification



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

### Definition


<b>Definition</b>	The details that fully describe a medication, including the name of the medication (active ingredients or brand name), strength and dose form, where appropriate.
<b>Synonymous Names</b>	Drug name; Medication name
<b>Notes</b>	
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	MPUU, MPP, TPUU, TPP or CTPP from the Australian Medicines Terminology

### Usage

<b>Examples</b>	<p>Paracetamol 500mg + codeine phosphate 30 mg tablet (MPUU – Medicinal Product Unit of Use)</p> <p>Paracetamol 500mg + codeine phosphate 30 mg tablet, 20 (MPP – Medicinal Product)</p> <p>Panadeine Forte tablet: uncoated, 20 tablets (TPP – Trade Product Pack)</p> <p>Panadeine Forte (paracetamol 500 mg + codeine phosphate 30mg) tablet: uncoated, 1 tablet (TPUU – Trade Product Unit of Use)</p> <p>Panadeine Forte tablet: uncoated, 20 tablets, blister pack (CTPP – Containered trade product pack)</p>
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### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ITEM	1.0	Essential		1

## 5.2.34 Medication Duration

### Identification



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

### Definition

<b>Definition</b>	The time period (optionally including start date, end date and length of time) that the patient has taken or will take the prescribed medication. If no end date is supplied, then the medication is ongoing. If the length of time post discharge is required, then this can be derived for display.
<b>Synonymous Names</b>	
<b>Notes</b>	Should be expressed as a time interval with a start and/or end date (Note, if an end date is recorded, it should be after the discharge date). May also be expressed as a total prescribed duration, which indicates the elapsed time between start date and anticipated end date.
<b>Datatype</b>	TimeInterval

### Usage

<b>Examples</b>	2005 to 2008-05-18 3 months
-----------------	--------------------------------

### Relationships

#### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	ITEM DETAIL	2.0	Optional		0..1

## 5.2.35 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 (e.g. specific therapeutic effect intended) for this patient's use of the medication. For inpatient discharge summaries, this should always be recorded.
<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>Examples</b>	Long-term maintenance treatment of bronchospasm and dyspnoea.
-----------------	---

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ITEM DETAIL	2.0	Optional		0..1

## 5.2.36 Unit of Use Quantity Dispensed

### Identification

**T**

<b>Name</b>	Unit of Use Quantity Dispensed
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10145

### Definition


<b>Definition</b>	The quantity of medication prescribed or dispensed/supplied to the patient.
<b>Synonymous Names</b>	Quantity Prescribed Quantity Ordered Unit of Use Quantity Prescribed Quantity Supplied Unit of Use Quantity Supplied Dispensed Unit of Use Quantity
<b>Notes</b>	In a discharge summary, this is the quantity of medication supplied by the facility to the patient, with which the patient is discharged.
<b>Datatype</b>	Text

### Usage

<b>Examples</b>	25 tablets 500 mL
-----------------	----------------------


### Relationships

#### Parent

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

## 5.2.37 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 medication is being taken by the patient.
<b>Synonymous Names</b>	
<b>Notes</b>	In a discharge summary, this data group describes how a particular medication is being taken by the patient as at the date of discharge or is intended to be taken immediately following discharge.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T</b>	<a href="#">Dose Instruction</a>		Essential		1

#### Parent

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

## 5.2.38 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 description of how a particular product is being taken by the patient as at the date of discharge, or is intended to be taken. This must include the route, dose quantity, frequency and any additional instructions required to safely describe the appropriate dosage. This should also include the administration schedule. In discharge summary systems, which support atomic dosage instructions, this item only needs to be populated when the atomic dosage items are not.
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	Text

### Usage

#### Examples

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DOSAGE	1.0	Essential		1

## 5.2.39 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 relevant changes made to the medication item during the patient's healthcare encounter, and the reason for that change.
<b>Synonymous Names</b>	
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T/T</b> <sub>010</sub>	<a href="#">Changes Made</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

## 5.2.40 Changes Made

### Identification



<b>Name</b>	Changes Made
<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 the end of the healthcare encounter.
<b>Synonymous Names</b>	
<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>Examples</b>	Dose increased to 10mg. Correction of prescription error.
-----------------	--

### Relationships

#### *Parent*

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

## 5.2.41 Reason for Change

### Identification

**T**

<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 in medication.
<b>Synonymous Names</b>	
<b>Notes</b>	Should be completed if a change has been made.
<b>Datatype</b>	Text

### Usage

<b>Examples</b>	Optimise drug therapy. Intolerable side effect of dizziness.
-----------------	---


### Relationships

#### *Parent*

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

## 5.2.42 MEDICATION ITEM AUTHORISER

### Identification







	<b>Name</b>	MEDICATION ITEM AUTHORISER (PARTICIPATION.PERSON)
	<b>Metadata Type</b>	Data Group (reuse of PARTICIPATION.PERSON, refer to the PARTICIPATION 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 authorised for this item to be added to the Current Medications list, and the role they played in the patient's healthcare (e.g. 'Pharmacist').
<b>Synonymous Names</b>	Pharmacist Authorised By
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Condition	Occurrence
	Participation Type	Participation Type.description="Medication Item Authoriser"	1
	Healthcare Role	<b>Must</b> be included	1
	ENTITY IDENTIFIER	<b>Should</b> contain the Healthcare Provider Identifier – Individual (HPI-I), if this is a healthcare provider (when available).	0..1
	PERSON NAME	<b>Must</b> contain name details and name usage type.	1
	HEALTHCARE PROVIDER FIELD OF PRACTICE DETAILS	<b>Should</b> be included, if available	0..*
	ELECTRONIC COMMUNICATION DETAILS	<b>Should</b> include at least one method of electronic communication.	0..*

#### Parent

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

## 5.2.43 Additional Comments

### Identification

<b>T</b>	<b>Name</b>	Additional Comments
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-16009

### Definition


<b>Definition</b>	Any additional information that may be needed to ensure the continuity of supply, continued proper use, or appropriate medication management.
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	Text

### Usage

<b>Examples</b>	<p>Patient requires an administration aid</p> <p>Patient will require new script in 3 days of discharge</p> <p>Dosage to be reviewed in 10 days</p> <p>Target INR for warfarin management</p> <p>Recommence post-discharge (for medications with Status of 'Withheld').</p>
-----------------	---


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ITEM DETAIL	1.0	Optional		0..1

## 5.2.44 CEASED MEDICATIONS

### Identification



	<b>Name</b>	CEASED MEDICATIONS (reuse of MEDICATION RECONCILIATION)
	<b>Metadata Type</b>	Data Group
	<b>Identifier</b>	DG-16026

### Definition


<b>Definition</b>	Medications that the patient was taking at the start of the healthcare encounter (e.g. on admission), that have been stopped during the encounter or on discharge, and that are not expected to be recommenced.
<b>Synonymous Names</b>	Medications Ceased This Visit Medications Ceased This Admission
<b>Notes</b>	<u>Conditions</u> The Medication Duration's End Date is on or prior to the Discharge Date.

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
	KNOWN MEDICATIONS	1.0	Essential		1
	ITEM DETAIL	2.0	Conditional	If the Known Medications Value is equivalent to "Known", then there must be medication item details recorded.	0..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	MEDICATIONS		Essential		1

## 5.2.45 KNOWN MEDICATIONS

### Identification



 <b>Name</b>	KNOWN MEDICATIONS
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-16034
<b>Version</b>	1.0

### Definition


<b>Definition</b>	Indicates: (a) Whether or not the patient is known to be taking any medication; and (b) Whether medications known to be taken are continued or ceased.
<b>Synonymous Names</b>	
<b>Notes</b>	This data group is used to determine the Medications to be included in the Ceased Medications data group.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
 T <sub>010</sub>	<a href="#">Known Medications Type</a>		Essential		1
 T <sub>010</sub>	<a href="#">Known Medications Value</a>		Essential		1

#### Parent

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

## 5.2.46 Known Medications Type

### Identification

T<sub>010</sub>

<b>Name</b>	Known Medications Type
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16035

### Definition


<b>Definition</b>	The type of Known Medications Value. This is used to determine which set the Medication belong to.
<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>Examples</b>	Ceased Medication
-----------------	-------------------

### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	KNOWN MEDICATIONS	1.0	Essential		1

## 5.2.47 Known Medications Value

### Identification

T<sub>010</sub>

<b>Name</b>	Known Medications Value
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16036

### Definition


<b>Definition</b>	The value of the Known Medications indicator.
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	CodedText
<b>Value Domain</b>	

### Usage

<b>Examples</b>	Known None Known
-----------------	---------------------


### Relationships

#### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	KNOWN MEDICATIONS	1.0	Essential		1

## 5.2.48 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
 T <sub>010</sub>	Item Status		Essential		1
	ITEM	1.0	Essential		1
	CHANGE DETAILS	1.0	Essential		1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	CEASED MEDICATIONS	1.0	Conditional	If the Known Medications Value is equivalent to "Known", then there must be medication item details recorded.	0..*

## 5.2.49 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 a specific point in time , e.g. at discharge.
<b>Synonymous Names</b>	
<b>Notes</b>	Status must equal 'Ceased' for any Item 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>Examples</b>	Ceased
-----------------	--------


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ITEM DETAIL	2.0	Essential		1

### 5.2.50 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/T</b> <sub>010</sub>	<a href="#">Item Description</a>		Essential		1

##### Parent

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

## 5.2.51 Item Description

### Identification



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

### Definition

<b>Definition</b>	The details that fully describe a medication, including the name of the medication (active ingredients or brand name), strength and dose form, where appropriate.
<b>Synonymous Names</b>	Drug name; Medication name
<b>Notes</b>	
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	MP, TP, MPUU, MPP, TPUU, TPP or CTPP from the Australian Medicines Terminology.

### Usage

<b>Examples</b>	<p>Paracetamol 500mg + codeine phosphate 30 mg tablet (MPUU – Medicinal Product Unit of Use)</p> <p>Paracetamol 500mg + codeine phosphate 30 mg tablet, 20 (MPP – Medicinal Product)</p> <p>Panadeine Forte tablet: uncoated, 20 tablets (TPP – Trade Product Pack)</p> <p>Panadeine Forte (paracetamol 500 mg + codeine phosphate 30mg) tablet: uncoated, 1 tablet (TPUU – Trade Product Unit of Use)</p> <p>Panadeine Forte tablet: uncoated, 20 tablets, blister pack (CTPP – Containered trade product pack)</p> <p>Nexium Hp7</p>
-----------------	--


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ITEM	1.0	Essential		1

## 5.2.52 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 relevant changes made to the medication item during the patient's healthcare encounter, and the reason for that change.
<b>Synonymous Names</b>	
<b>Notes</b>	In this section of the discharge summary, Change Details will always refer to the cessation of this medication item.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T</b> / <b>T</b> <sub>010</sub>	<a href="#">Changes Made</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

## 5.2.53 Changes Made

### Identification



<b>Name</b>	Changes Made
<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.
<b>Synonymous Names</b>	
<b>Notes</b>	For ceased medications this must always be "Medication Ceased".
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified – Use existing reference sets until NEHTA determines a suitable common reference set.

### Usage

<b>Examples</b>	Medication Ceased
-----------------	-------------------

### Relationships

#### Parent

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

## 5.2.54 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 in medication.
<b>Synonymous Names</b>	
<b>Notes</b>	This is the reason for the cessation of the medication. This should always be included for Ceased Medications.
<b>Datatype</b>	Text

### Usage

<b>Examples</b>	Optimise drug therapy. Intolerable side effect of dizziness.
-----------------	---


### Relationships

#### *Parent*

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

## 5.3 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 patient that is not specific to the healthcare encounter described by 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 patient overall. For example, the patient's nominated primary healthcare provider is not specifically related to the encounter. Similarly the patient's adverse reactions are likely to be applicable after the event.</p>

### Relationships

#### Children


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

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY	2.0	Essential		1

### 5.3.1 HEALTHCARE PROVIDERS

#### Identification


 <b>Name</b>	HEALTHCARE PROVIDERS
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-20102
<b>Version</b>	1.0

#### Definition


<b>Definition</b>	Contains details of the patient's healthcare providers.
<b>Synonymous Names</b>	
<b>Notes</b>	<p>This item currently only includes the Nominated Primary Healthcare Provider, but may include other providers in the future.</p> <p>It is recognised that not all subjects will have a Nominated Primary Healthcare Provider, 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
	NOMINATED PRIMARY HEALTHCARE PROVIDER	1.0	Optional		0..*

##### Parent

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

## 5.3.2 NOMINATED PRIMARY HEALTHCARE PROVIDER

### Identification



<b>Name</b>	NOMINATED PRIMARY HEALTHCARE PROVIDER (PARTICIPATION)
<b>Metadata Type</b>	Data Group (reuse of PARTICIPATION, refer to the PARTICIPATION 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 providers (person or organisation) nominated by the patient as being primarily responsible for their ongoing healthcare. It is expected that in many cases there will only be one nominated primary healthcare provider, and that this will be a General Practitioner or General Practice. If the nominated primary healthcare provider is an individual, then Person Identifier and Name must be recorded. If the nominated primary healthcare provider is or has an organisation, then Organisation Identifier and Organisation Name must be recorded.
<b>Synonymous Names</b>	Usual General Practitioner Usual Healthcare Provider Nominated Primary Healthcare Provider
<b>Notes</b>	


### Relationships

#### Children

Type	Name	Condition	Occurrence
	Participation Type	Participation Type.description="Nominated Primary Healthcare Provider"	1
	Healthcare Role	<b>Must</b> be included	1
	ENTITY IDENTIFIER	<b>Must</b> contain the Healthcare Provider Identifier – Individual (HPI-I), if the Nominated Primary Healthcare Provider is a PARTICIPATION.PERSON (if available). <b>Must</b> contain the Healthcare Provider Identifier – Organisation (HPI-O) if Primary Healthcare Provider is a PARTICIPATION.ORGANISATION (if available).	0..*
	PERSON NAME	<b>Must</b> contain person name details and name usage type if Nominated Primary Healthcare Provider is a PARTICIPATION.PERSON.	0..1


Type	Name	Condition	Occurrence
	ORGANISATION NAME	<b>Must</b> contain organisation name details and name usage type if Nominated Primary Healthcare Provider is a PARTICIPATION.ORGANISATION.	0..1
	EMPLOYER ORGANISATION DETAIL.ENTITY IDENTIFIER	<b>Should</b> contain the Healthcare Provider Identifier – Organisation (HPI-O), if available, and if the Nominated Primary Healthcare Provider is a PARTICIPATION.HPI.	0..*
	EMPLOYER ORGANISATION DETAIL.ORGANISATION NAME	<b>Should</b> contain organisation name details if Nominated Primary Healthcare Provider is a PARTICIPATION.HPI. <b>Must</b> contain employer organisation name details if employer organisation identifier is recorded.	0..1
	ADDRESS	<b>Must</b> contain address details	1..*
	ELECTRONIC COMMUNICATION DETAILS	<b>Must</b> include at least one method of electronic communication.	1..*

### Parent

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

### 5.3.3 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 patient (including allergies and intolerances), and any relevant reaction details.
<b>Synonymous Names</b>	Allergies/Adverse Reactions
<b>Notes</b>	

#### Relationships

##### Children

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

##### Parent

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

### 5.3.4 Known Adverse Reactions Value

#### Identification

T<sub>010</sub>

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

#### Definition


<b>Definition</b>	Indicates the status of knowledge about the patient’s Adverse Reactions.
<b>Synonymous Names</b>	Adverse Reactions Indicator
<b>Notes</b>	This item is applicable to the patient 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>Examples</b>	Known None Known Asked But Not Known Not asked
-----------------	---

#### Relationships

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ADVERSE REACTIONS	2.0	Essential		1

### 5.3.5 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 Allergy/Adverse Reaction
<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
	<a href="#">REACTION DETAIL</a>	2.0	Optional		0..*

##### Parent

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

### 5.3.6 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 patient.
<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>	NEHTA SCT-AU Agent Description Reference Set

#### Usage

<b>Examples</b>	Peanut Penicillin Bee venom Animal protein Latex
-----------------	--


#### Relationships

##### *Parent*

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

## 5.3.7 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
 <b>T/T</b> <sub>010</sub>	<a href="#">Reaction Description</a>		Essential		1

#### Parent

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

### 5.3.8 Reaction Description

#### Identification

T/T<sub>010</sub>

<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 patient as a consequence of the adverse reaction to the specific agent/substance. The severity of the reaction and certainty may be included in this description, where appropriate.
<b>Synonymous Names</b>	Reaction
<b>Notes</b>	The signs, symptoms, severity and/or certainty 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. Given that an adverse reaction has occurred, it is important to determine the manifestations of that reaction.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	NEHTA SCT-AU Reaction Description Reference Set

#### Usage

<b>Examples</b>	Itchy eyes Dysphagia Tinnitus
-----------------	-------------------------------------


#### Relationships

##### Parent

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

### 5.3.9 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 patient that may require special consideration or action by the recipients.
<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

### 5.3.10 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 patient 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 patient, 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 patient.</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

##### Parent

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

### 5.3.11 Alert Type

#### Identification

T/T<sub>010</sub>

<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. infection risk, special needs, clinical, discharge circumstances, vulnerable families, psychosocial alerts etc).
<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>Examples</b>	Administrative Clinical or Medical Home environment Infection risk Safety and security Special mental health Special needs and/or preferences Psychosocial
-----------------	---

#### Relationships

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ALERT	2.0	Essential		1

### 5.3.12 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>Examples</b>	Animals present at patient's home Anaesthetic risk Pacemaker present Patient is a risk to others Patient speaks no English
-----------------	--


#### Relationships

##### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	ALERT	2.0	Essential		1

## 5.4 PLAN

### Identification



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

### Definition


<b>Definition</b>	Describes the services requested for the patient and the recommendations to the recipient healthcare providers and/or the patient.
<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 specialists. 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 providers (at the time of discharge).

### Relationships

#### Children


Type	Name	Version	Obligation	Condition	Occurrence
	ARRANGED SERVICES		Optional		0..1
	RECOMMENDATIONS AND INFORMATION PROVIDED	1.0	Optional		1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	DISCHARGE SUMMARY		Optional		1

### 5.4.1 ARRANGED SERVICES

#### Identification


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

#### Definition


<b>Definition</b>	Describes clinical services that have been provided for or arranged for the patient.
<b>Synonymous Names</b>	
<b>Notes</b>	

#### Relationships

##### *Children*


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

##### *Parent*

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

## 5.4.2 ARRANGED SERVICE

### Identification





 <b>Name</b>	ARRANGED SERVICE (reuse of REQUESTED SERVICE)
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-20158
<b>Version</b>	1.0

### Definition


<b>Definition</b>	Describes the types of service requested for, or provided to, the subject of care. If the service provision has not been confirmed then, the service date and/or provider may not be recorded.
<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 providers (at the time of discharge).

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
 <b>T/T</b> <sub>010</sub>	<a href="#">Arranged Service Description</a>		Essential		1
	<a href="#">Service Commencement Window</a>		Optional		0..1
	<a href="#">SERVICE PROVIDER</a>	1.0	Optional		0..1
 <b>T/T</b> <sub>010</sub>	<a href="#">5.4.6Service Booking Status</a>		Essential		1

#### Parent

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

### 5.4.3 Arranged Service Description

#### Identification

T/T<sub>010</sub>

<b>Name</b>	Arranged Service Description (renamed from Requested Service Description)
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-20117

#### Definition


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

#### Usage

<b>Examples</b>	Elective Orthopaedic surgery for TKR Dialysis. Adjustment of heart failure/hypertensive medications. Adjust INR to therapeutic range, etc.
-----------------	---

#### Relationships

##### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ARRANGED SERVICE	1.0	Essential		1

## 5.4.4 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>	The datetime or date range at/during which the arranged service is scheduled to be provided to the patient.
<b>Synonymous Names</b>	Service Commences
<b>Notes</b>	This item specifies the range of time within which the requesting provider is expected the arranged service to be provided to the patient.
<b>Datatype</b>	TimeInterval

### Usage

<b>Examples</b>	2009-03-31 to 2009-04-15
-----------------	--------------------------

### Relationships

#### Parent

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

## 5.4.5 SERVICE PROVIDER

### Identification



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




### Definition

<b>Definition</b>	The provider (individual or organisation) that has been arranged 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 arranged to provide a service after discharge of the patient from the healthcare facility at which the healthcare encounter has been completed.


### Relationships

#### Children

Type	Name	Condition	Occurrence
	Participation Type	Participation Type.description="Service Provider"	1
	Healthcare Role	<b>Must</b> be included	1
	ENTITY IDENTIFIER	<b>Must</b> contain the Healthcare Provider Identifier – Individual (HPI-I), if the Nominated Primary Healthcare Provider is a PARTICIPATION.PERSON (if available). <b>Must</b> contain the Healthcare Provider Identifier – Organisation (HPI-O) if Primary Healthcare Provider is a PARTICIPATION.ORGANISATION (if available).	0..*
	PERSON NAME	<b>Must</b> contain person name details and name usage type if Nominated Primary Healthcare Provider is a PARTICIPATION.PERSON.	0..1
	ORGANISATION NAME	<b>Must</b> contain organisation name details and name usage type if Nominated Primary Healthcare Provider is a PARTICIPATION.ORGANISATION.	0..1
	EMPLOYER ORGANISATION DETAIL.ENTITY IDENTIFIER	<b>Should</b> contain the Healthcare Provider Identifier – Organisation (HPI-O), if available, and if the Nominated Primary Healthcare Provider is a PARTICIPATION.HPI.	0..*

Type	Name	Condition	Occurrence
	EMPLOYER ORGANISATION DETAIL.ORGANISATION NAME	<b>Should</b> contain organisation name details if Nominated Primary Healthcare Provider is a PARTICIPATION.HPI. <b>Must</b> contain employer organisation name details if employer organisation identifier is recorded.	0..1
	ADDRESS	<b>Should</b> contain address details	0..*
	ELECTRONIC COMMUNICATION DETAILS	<b>Must</b> include at least one method of electronic communication.	1..*

**Parent**

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

## 5.4.6 Service Booking Status

### Identification

T/T<sub>010</sub>

<b>Name</b>	Service Booking Status
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16039

### Definition


<b>Definition</b>	An indication of the booking status of the arranged service.
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Data Type</b>	Text

### Usage

<b>Examples</b>	Requested Tentative Confirmed
-----------------	-------------------------------------


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	ARRANGED SERVICE	1.0	Optional		0..*

## 5.4.7 RECOMMENDATIONS AND INFORMATION PROVIDED

### Identification



<b>Name</b>	RECOMMENDATIONS AND INFORMATION PROVIDED
 <b>Metadata Type</b>	Section
<b>Identifier</b>	S-20016

### Definition


<b>Definition</b>	Recommendations and information provided to a patient and/or recipient healthcare provider, which are relevant to the continuity of care and management of the patient after discharge.
<b>Synonymous Names</b>	
<b>Notes</b>	Recommendations may include reminders to the GP on special management strategies.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
	INFORMATION PROVIDED	1.0	Optional		0..1
	RECOMMENDATIONS PROVIDED	1.0	Essential		1..*

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	PLAN		Optional		1

## 5.4.8 INFORMATION PROVIDED

### Identification

<b>Name</b>	INFORMATION PROVIDED (reuse of Supplementary Information data group)
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-20116
<b>Version</b>	1.0

### Definition

<b>Definition</b>	Information that has or has not been provided, including information provided to the subject of care and/or relevant parties.
<b>Synonymous Names</b>	
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T</b>	<a href="#">Information Provided to Subject of Care and/or Relevant Parties</a>		Optional		0..1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
<a href="#"><u>S</u></a>	<a href="#">RECOMMENDATIONS AND INFORMATION PROVIDED</a>		Essential		1..*

## 5.4.9 Information Provided to Subject of Care and/or Relevant Parties

### Identification

<b>T</b>	<b>Name</b>	Information Provided to Subject of Care and/or Relevant Parties
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-20175

### Definition


<b>Definition</b>	Details of the information and education that has been provided to and discussed with the patient, their family, carer and/or other relevant parties, including awareness or lack of awareness of diagnosed conditions, and relevant health management. An indication of whether or not the patient or carer has understood the information or instructions provided may also be relevant.
<b>Synonymous Names</b>	Information Provided to Patient and/or Relevant Parties Information Provided to Patient
<b>Notes</b>	
<b>Datatype</b>	Text

### Usage

<b>Examples</b>	Diagnosis has not been discussed with patient. Gentle physiotherapy exercises have been provided to patient.
-----------------	---


### Relationships

#### *Parent*

Type	Name	Version	Obligation	Condition	Occurrence
	INFORMATION PROVIDED	1.0	Essential		1

## 5.4.10 RECOMMENDATIONS PROVIDED

### Identification


 <b>Name</b>	RECOMMENDATIONS PROVIDED (reuse of Supplementary Information data group)
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-20116
<b>Version</b>	1.0

### Definition


<b>Definition</b>	Recommendations to a recipient healthcare provider and/or patient which are relevant to the continuity of care and management of the patient after discharge.
<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
	RECOMMENDATION RECIPIENT		Essential		1
<b>T</b>	Recommendation Note		Essential		1

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	RECOMMENDATIONS PROVIDED		Essential		1..*

## 5.4.11 RECOMMENDATION RECIPIENT

### Identification



<b>Name</b>	Recommendation Recipient (reuse of Participation data group)
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-10296

### Definition


<b>Definition</b>	The individual or organisation to which the recommendation is directed.
<b>Synonymous Names</b>	
<b>Notes</b>	

### Relationships

#### Children

Type	Name	Condition	Occurrence
T/T <sub>010</sub>	Participation Type	Participation Type.description="Recommendation To"	1
T/T <sub>010</sub>	Healthcare Role	<b>Must</b> be included	1
	ENTITY IDENTIFIER	<b>Must</b> contain the Healthcare Provider Identifier – Individual (HPI-I), if the Nominated Primary Healthcare Provider is a PARTICIPATION.PERSON (if available). <b>Must</b> contain the Healthcare Provider Identifier – Organisation (HPI-O) if Primary Healthcare Provider is a PARTICIPATION.ORGANISATION (if available).	0..*
	PERSON NAME	<b>Must</b> contain person name details and name usage type if Nominated Primary Healthcare Provider is a PARTICIPATION.PERSON.	0..1
	ORGANISATION NAME	<b>Must</b> contain organisation name details and name usage type if Nominated Primary Healthcare Provider is a PARTICIPATION.ORGANISATION.	0..1
	EMPLOYER ORGANISATION DETAIL.ENTITY IDENTIFIER	<b>Should</b> contain the Healthcare Provider Identifier – Organisation (HPI-O), if available, and if the Nominated Primary Healthcare Provider is a PARTICIPATION.HPI.	0..*
	EMPLOYER ORGANISATION DETAIL.ORGANISATION NAME	<b>Should</b> contain organisation name details if Nominated Primary Healthcare Provider is a PARTICIPATION.HPI. <b>Must</b> contain employer organisation name details if employer organisation identifier is recorded.	0..1
	ADDRESS	<b>Should</b> contain address details	0..*
	ELECTRONIC COMMUNICATION DETAILS	<b>Must</b> include at least one method of electronic communication.	1..*

**Parent**

Type	Name	Version	Obligation	Condition	Occurrence
	RECOMMENDATIONS PROVIDED	1.0	Essential		1

## 5.4.12 Recommendation Note

### Identification

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

### Definition


<b>Definition</b>	Details of the recommendation given to the recipient.
<b>Synonymous Names</b>	Advice to Patient
<b>Notes</b>	The relevant recommendation is important for the continuity of care and management of the patient after discharge. This item does not include referral details or information specific to a requested service.
<b>Datatype</b>	Text

### Usage

<b>Examples</b>	<p>GP to remove the staples on day 10-14.</p> <p>Aspirin to recommence at GP's discretion.</p> <p>Please arrange a follow-up appointment with a community physiotherapist in one week to ensure that post-surgical mobility outcomes are being met.</p>
-----------------	---


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	RECOMMENDATIONS PROVIDED	1.0	Essential		1

## 5.5 ATTACHMENTS

### Identification


 <b>Name</b>	ATTACHMENTS
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-16032

### Definition


<b>Definition</b>	Documents that have been attached to the discharge summary (as a link or as data), because they are relevant to the ongoing care of the patient. For example a care plan, or a health assessment.
<b>Synonymous Names</b>	
<b>Notes</b>	Only attachments that are considered relevant to the ongoing care of the patient should be included.

### Relationships

#### Children


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

#### Parent

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

## 5.5.1 ATTACHMENT

### Identification



 <b>Name</b>	ATTACHMENT
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-16033

### Definition


<b>Definition</b>	A single document that has been attached to the discharge summary (as a link or as data), because it is relevant to the ongoing care of the patient. For example a care plan, or a health assessment.
<b>Synonymous Names</b>	
<b>Notes</b>	This data group should be repeated for each attachment.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>T</b>	<a href="#">Document Name</a>		Essential		1
	<a href="#">DOCUMENT CONTROL</a>	1.0	Optional		0..1
<b>T/T</b> <sub>010</sub>	<a href="#">Section Reference</a>		Optional		0..1
	<a href="#">Link or Data</a>		Essential		1

#### Parent

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

## 5.5.2 Document Name

### Identification

<b>T</b>	<b>Name</b>	Document Name
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-10345

### Definition



<b>Definition</b>	The name of the attached document, to be used when referencing the attachment.
<b>Synonymous Names</b>	Report Type
<b>Notes</b>	
<b>Datatype</b>	Text

### Usage

<b>Examples</b>	Care Plan
-----------------	-----------


### Relationships

#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	REPORT ATTACHMENT	1.0	Essential		1
	ATTACHMENT	1.0	Essential		1

## 5.5.3 DOCUMENT CONTROL

### Identification


 <b>Name</b>	Document Control
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-20101

### Definition



<b>Definition</b>	Information about the attachment (such as the version number, identifiers, document type and date attested) that will assist in the processing and document management of the attachment.
<b>Synonymous Names</b>	Document Management Details
<b>Notes</b>	Please refer to the 'Document Control' data group defined in the <i>Document Header Data Specification</i> <a href="#">[DS-DH]</a> for more information.

### Relationships

#### Children

Type	Name	Version	Obligation	Condition	Occurrence
<b>ID</b>	<a href="#">Document Instance Identifier</a>		Essential		1
<b>ID</b>	<a href="#">Document Set Identifier</a>		Essential		1
<b>123</b>	<a href="#">Version Number</a>		Essential		1
<b>ID</b>	<a href="#">Document Originating System Identifier</a>		Essential		1
<b>T<sub>010</sub></b>	<a href="#">Document Type</a>		Essential		1
<b>123</b>	<a href="#">Document Type Version Number</a>		Essential		1
<b>T<sub>010</sub></b>	<a href="#">Confidentiality Indicator</a>		Optional		0..1
	<a href="#">DateTime Attested</a>		Essential		1
<b>T<sub>010</sub></b>	<a href="#">Document Status</a>		Essential		1
<b>T<sub>010</sub></b>	<a href="#">Language</a>		Essential		1

#### Parent

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

### 5.5.4 Section Reference

#### Identification

T/T<sub>010</sub>

<b>Name</b>	Document Name
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16037

#### Definition



<b>Definition</b>	The section in the discharge summary from which the attachment should be referenced.
<b>Synonymous Names</b>	Report Category
<b>Notes</b>	This information may be used to organise references to the attachments into appropriate groups.
<b>Datatype</b>	Codeable Text

#### Usage

<b>Examples</b>	Physical Assessments Diagnostic Investigations
-----------------	---

#### Relationships

##### Parent

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

## 5.5.5 Link or Data

### Identification



<b>Name</b>	Link or Data
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16038

### Definition



<b>Definition</b>	Either a link – i.e. a reference to an external repository where the attachment is stored – or the actual data contents of the attachment.
<b>Synonymous Names</b>	Report Type
<b>Notes</b>	The attachment may use one of a variety of formats (as indicated in the Document Control details), including PDF, structured text or XML structured using a NEHTA-defined template.
<b>Datatype</b>	Link or Encapsulated Data

### Usage

#### Examples

### Relationships


#### Parent

Type	Name	Version	Obligation	Condition	Occurrence
	REPORT ATTACHMENT	1.0	Essential		1
	ATTACHMENT	1.0	Essential		1

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

 GOOD HEALTH HOSPITAL  <b>DISCHARGE SUMMARY</b>  Summary Status: AMENDED Final Version Number: 2 Date completed: 20/10/2008 11:05		<b>PATIENT</b> Name: Mr William SMITH Mr Bill SMITH (preferred) MRN: 542181 IHI: 8003610200002375 Date of Birth: 01/01/1946 (63 years) Sex: Male Address: 140 Satellite St, Melbourne, VIC, 3001 Contact: Home: 03 3988 7156 Mobile: 0411 378 942											
<b>FACILITY DETAILS</b> Name: The Good Health Hospital HPI-O: 8003630000007319 Address: 67 Brisbane St, MELBOURNE, VIC, 3001 PO Box 5, MELBOURNE, VIC, 3001 Contact: Phone: 03 3378 9322 Fax: 03 3378 9399		<b>ENCOUNTER</b> Start Date: Friday 10/10/2008 End Date: Friday 17/10/2008 Separation Mode: To Home Location of Discharge: Ward 3A Specialty: Respiratory Orthopaedic Surgery											
<b>DOCUMENT AUTHOR</b> Name: Dr Peter INTERN (HPI: 8003620000000111) Contact: Phone: 03 3378 9322 Pager: 5555													
<b>ALERTS</b> <table border="1"> <thead> <tr> <th>Type</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>Clinical</td> <td>At risk of pressure sores due to easily damaged skin</td> </tr> <tr> <td>Social</td> <td>Single parent looking after intellectually disabled son.</td> </tr> </tbody> </table>				Type	Description	Clinical	At risk of pressure sores due to easily damaged skin	Social	Single parent looking after intellectually disabled son.				
Type	Description												
Clinical	At risk of pressure sores due to easily damaged skin												
Social	Single parent looking after intellectually disabled son.												
<b>ALLERGIES AND ADVERSE REACTIONS</b> <table border="1"> <thead> <tr> <th>Agent</th> <th>Reaction description</th> </tr> </thead> <tbody> <tr> <td>Penicillin</td> <td>Severe urticaria on trunk and legs Nausea and vomiting</td> </tr> <tr> <td>Metoprolol</td> <td>Acute exacerbation of Chronic Obstructive Airways Disease</td> </tr> </tbody> </table>				Agent	Reaction description	Penicillin	Severe urticaria on trunk and legs Nausea and vomiting	Metoprolol	Acute exacerbation of Chronic Obstructive Airways Disease				
Agent	Reaction description												
Penicillin	Severe urticaria on trunk and legs Nausea and vomiting												
Metoprolol	Acute exacerbation of Chronic Obstructive Airways Disease												
<b>PROBLEMS/DIAGNOSES THIS VISIT</b> <table border="1"> <thead> <tr> <th>Type</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>Principal Diagnosis</td> <td>Osteoarthritis of right knee</td> </tr> <tr> <td>Complications</td> <td>Post-operative pneumonia Intra operative haemorrhage</td> </tr> <tr> <td>Comorbidities</td> <td>Chronic Obstructive Airways Disease Anaemia</td> </tr> <tr> <td>Past History</td> <td>Chronic radiation cystitis for bladder TCC in 2004</td> </tr> </tbody> </table>				Type	Description	Principal Diagnosis	Osteoarthritis of right knee	Complications	Post-operative pneumonia Intra operative haemorrhage	Comorbidities	Chronic Obstructive Airways Disease Anaemia	Past History	Chronic radiation cystitis for bladder TCC in 2004
Type	Description												
Principal Diagnosis	Osteoarthritis of right knee												
Complications	Post-operative pneumonia Intra operative haemorrhage												
Comorbidities	Chronic Obstructive Airways Disease Anaemia												
Past History	Chronic radiation cystitis for bladder TCC in 2004												
<b>CLINICAL SYNOPSIS</b> Admitted for elective, right TKR (cemented prosthesis). Day 3, developed bilateral basal atelectasis. The CBC showed high WCC (20.0) and high neutrophils (16.0). Commenced on doxycycline and chest physio. Due to mild anaemia prior to surgery and subsequent operative blood loss, required a blood transfusion of three units. Subsequently made steady progress, regaining good mobility in his knee and is able to mobilise with the aid of a stick. Right knee Xray showed no fracture or dislocation, with the total knee prosthesis well positioned post surgery.													
<b>CLINICAL INTERVENTIONS PERFORMED THIS VISIT</b> Primary cemented total knee replacement (R) Lumbar epidural block Transfusion of packed red blood cells, post-op Physiotherapy													
<b>INFORMATION PROVIDED TO PATIENT and/or RELEVANT PARTIES</b> Patient was given a brochure explaining the expected post-op recovery following a total knee replacement. The physiotherapist provided a list of home exercises. The good prognosis for return to activity was discussed with the patient – likely to be able to walk with a stick at six weeks.													
<b>RECOMMENDATIONS</b> <table border="1"> <thead> <tr> <th>To</th> <th>Note</th> </tr> </thead> <tbody> <tr> <td>Dr Mary MOULD (General Practitioner)</td> <td>Please remove the staples on 22nd October. Please ensure aspirin is recommenced 3 days post discharge. Please follow-up anaemia.</td> </tr> <tr> <td>Mr William SMITH (Patient)</td> <td>Return to GP on 22nd October to have the staples removed. Keep up regular mobility routine as guided by physiotherapist. Please recommence aspirin 3 days post discharge.</td> </tr> </tbody> </table>				To	Note	Dr Mary MOULD (General Practitioner)	Please remove the staples on 22nd October. Please ensure aspirin is recommenced 3 days post discharge. Please follow-up anaemia.	Mr William SMITH (Patient)	Return to GP on 22nd October to have the staples removed. Keep up regular mobility routine as guided by physiotherapist. Please recommence aspirin 3 days post discharge.				
To	Note												
Dr Mary MOULD (General Practitioner)	Please remove the staples on 22nd October. Please ensure aspirin is recommenced 3 days post discharge. Please follow-up anaemia.												
Mr William SMITH (Patient)	Return to GP on 22nd October to have the staples removed. Keep up regular mobility routine as guided by physiotherapist. Please recommence aspirin 3 days post discharge.												

NEHTA does not promote this document as the prescribed display format but one EXAMPLE ONLY of the many possible presentation permutations.

<b>IHI:</b> 8003610200002375		<b>Patient:</b> Mr William SMITH			<b>DOB:</b> 01/01/1946		
<b>CURRENT MEDICATIONS ON DISCHARGE</b>							
Status	Item	Dose Instructions	Reason for Medication	Duration	Change made (+ reason)	Quantity supplied	Authoriser
New	Doxycycline 100 mg tablet	Oral 1 tablet Once daily	Pneumonia	12/10/2008 to 19/10/2008 (8 days)		3 tablets	John SMITH (pharmacist)
New	Paracetamol 500mg + codeine phosphate 30mg tablet	Oral 1-2 tablets As required (maximum of 8 per day)	Pain management	Ongoing		20 tablets	John SMITH (pharmacist)
Altered	Fruzemide 40 mg tablet	Oral 1 tablet Once daily	Fluid retention	Ongoing	Dose decreased from 1 tablet Twice a day (Due to hypotension)	100 tablets	John SMITH (pharmacist)
With-held	Cardiprin (aspirin) 100 mg tablet	Oral 1 tablets Once daily	Cardiovascular prophylaxis	Ongoing	Withheld (due to surgery)	30 tablets	Mary BROWN (pharmacist)
<b>Additional comments</b>			Please recommence 3 days after discharge				
<b>CEASED MEDICATIONS</b>							
Item Description	Reason for Ceasing						
Oxycodone hydrochloride 5mg capsule	No longer required						
Celebrex (celecoxib) 200mg capsule hard	Ceased due to scheduled surgery						
<b>DIAGNOSTIC INVESTIGATIONS</b>							
Type	Date	Investigation Name	Result Status	Result			
<b>Pathology</b>	12/10/2008 14:31	Complete Blood Count	Final	Report attached			
	12/10/2008 14:06	Biochemistry Battery Tests	Final	Report attached			
	12/10/2008 14:06	Hepatic Function Panel	Pending				
<b>Radiology</b>	10/10/2008 13:54	Right knee x-ray	Final	Report attached			
	12/10/2008 09:28	X-Ray of chest	Final	Report attached			
<b>ARRANGED SERVICES</b>							
Service Date	Provider	Description					Status
28/11/2008	Dr Horace MOORCROFT (Orthopaedic Surgeon) Ph 03 3023 7777	Orthopaedic outpatient clinic appointment for 6 weeks post-discharge progress review					Confirmed
<b>NOMINATED PRIMARY HEALTHCARE PROVIDER</b>							
Name	Organisation	Address			Contact		
Dr Mary MOULD General Practitioner <small>HPI-I: 8003620000000922</small>	Jaydon Oak GP Practice <small>HPI-O: 8003630000000178</small>	22 Low Street, Melbourne, VIC, 3001			Phone: 03 4923 1989 Email: records@jaydonoak.com.au		
<b>OTHER PARTICIPANTS</b>							
Role	Name	Specialty	Organisation			Contact	
<b>Responsible Health Professional at Time of Discharge</b>	Dr Jeremy SPECIALIST <small>HPI-I: 8003620000000677</small>	Respiratory	The Good Health Hospital <small>HPI-O: 8003630000001456</small>			Phone: 03 3378 9322 Pager: 3585	
<b>Registrar</b>	Dr Janice REGISTRAR <small>HPI-I: 8003620000000789</small>	Orthopaedics	The Good Health Hospital <small>HPI-O: 8003630000001456</small>			Phone: 03 3378 9322 Pager: 8888	
<b>Pharmacist</b>	Mr Toby MEDICINE <small>HPI-I: 8003620000000074</small>	Pharmacy	The Good Health Hospital <small>HPI-O: 8003630000001456</small>			Phone: 03 3378 9334	
<b>Physiotherapist</b>	Miss Kathryn PHYSIO <small>HPI-I: 8003620000000915</small>	Physiotherapy	The Good Health Hospital <small>HPI-O: 8003630000001456</small>			Phone: 03 3378 9311	
<b>PRIMARY RECIPIENT</b>							
Name (& role)	Organisation	Address			Contact		
Dr Mary MOULD (General Practitioner) <small>HPI-I: 8003620000000922</small>	Jaydon Oak GP Practice <small>HPI-O: 8003630000000178</small>	22 Low Street, Melbourne, VIC, 3001			Phone: 03 4923 1989 Email: records@jaydonoak.com.au		
<b>OTHER RECIPIENTS</b>							
(Community Physiotherapy)	PhysioCare Pty Ltd <small>HPI-O: 8003630000000999</small>	5 Physio Ave, Melbourne, VIC, 3001			Phone: 03 3032 5555 Fax: 03 3032 5554		
<b>Mr William SMITH (Patient)</b> <small>HPI-I: 8003620000002375</small>		14 Satellite St, Melbourne, VIC, 3001			Home: 03 3988 7156 Mobile: 0411 378 942		

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