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## **ePrescription**

### **Structured Document Template**

Version 1.0 — 20091120

Release: 1

Draft for Comment

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# 1 Introduction

This document is a Structured Document Template (SDT) that specifies the content of an ePrescription that can be created by an electronic prescribing system (EPS) that is forwarded and stored in a Prescription Exchange Service (PES) for subsequent retrieval by a community pharmacy for the purpose of dispensing against a prescribed item.

Essential information about Structured Document Templates can be found in *NEHTA Data Specification and Structured Document Template Guide for Use* [[NEHT2009b](#)].

This release is intended to inform and seek feedback from prospective software system designers and their clinical consultants. The content of this release is not suitable for implementation in live clinical systems.

The National Clinical Terminology and Information Service (NCTIS) values your questions, comments and suggestions about this document. Please direct your questions or feedback to <[clinicalinfo@nehta.gov.au](mailto:clinicalinfo@nehta.gov.au)>.

## 1.1 Document Purpose

This SDT is a specification for an ePrescription. Its content is based on requirements described in four documents:

- *ETP Business Process and Requirements Specification – Release 1* [[NEHT2009d](#)];
- *ETP Technical Requirements Specification – Release 1* [[NEHT2009g](#)];
- *ETP Logical Information Model – Release 1* [[NEHT2009e](#)].
- *ETP Technical Architecture – Release 1* [[NEHT2009f](#)].

The development of this specification was influenced primarily by the *ETP Logical Information Model – Release 1* [[NEHT2009e](#)] with the remaining documents used as secondary references.

The content of the SDT will form the basis of mapping to the Clinical Document Architecture (CDA) standard adopted in Australia for transmission of electronic clinical documents. These mappings will form the primary content of the *ePrescription SDT Release 1 Implementation Guide*. The SDT can also, on a stakeholder needs basis, be used to map to other electronic message standards such as HL7 v2.x. Background information on the HL7 clinical document architecture (CDA) can be found at the HL7 web site [[HL72008](#)].

Through this standards-based approach NEHTA will deliver implementable design specifications. The aim is to realise maximum value from systems through interoperating (sharing information) between systems and so contribute towards improving the quality and efficiency of healthcare delivery.

(For information on the subject of 'interoperating' refer to the *Interoperability Maturity Model* [[NEHT2007](#)], which is available on the NEHTA website).

## 1.2 Intended Audience

This document is intended to be read and understood by:

1. IT-aware clinicians who wish to evaluate the clinical suitability of NEHTA-endorsed standards.
2. Software development teams:
  - a. To plan, architect or implement:

- clinical applications, infrastructure components or messaging interfaces
  - the facilitation of semantic interoperability
  - 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
3. Researchers who wish to explore certain aspects of NEHTA-endorsed standards

This document is reasonably technical in nature and so it is advisable that the readers of it are familiar with the language of health data specifications and have some familiarity with health information standards and specifications such as HL7 CDA and [\[AS2007\]](#).

## 1.3 Overview

The key features of the solution proposed for Electronic Transfer of Prescriptions (ETP) Release 1 are:

- An Electronic Prescribing System (EPS) used by a General Practitioner will create an electronic version of a prescription, an ePrescription, containing at least one prescribed item and related dosage and dispensing instructions.

An electronic prescription used to request pharmaceutical benefits must fulfil the requirements of Regulation 5 of the National Health (Pharmaceutical Benefits) Regulations 1960 and be prepared in accordance with Regulation 19 of the same set of regulations. (For further elaboration refer to the requirements document (*ETP Logical Information Model (LIM) Release 1*) for ETP Release 1 [\[NEHT2009e\]](#)).

- The Subject of Care (also known as the patient) will be provided with a paper copy of that ePrescription.
- That ePrescription will be transmitted to and stored in, one Prescription Exchange Service (PES) – a web-based service operated by a PES provider. The PES will be accessible by any Electronic Dispensing System (EDS) in use in a community pharmacy.
- The Subject of Care will present at a community pharmacy of their choice with the paper prescription which the dispenser at that pharmacy will use as the basis of identifying and retrieving the related ePrescription from the PES.
- Dispensing takes place which may entail a number of tasks including further interaction between the dispenser and the Subject of Care, between the dispenser and the prescriber or other authorities such as the Pharmaceuticals Benefits Scheme.
- At the conclusion of the dispensing event, an electronic dispense record, called the PES-DR, containing information pertinent to that event is created and stored in the PES.

As stated in the requirements document (*ETP Logical Information Model (LIM) Release 1*) for ETP Release 1 [\[NEHT2009e\]](#):

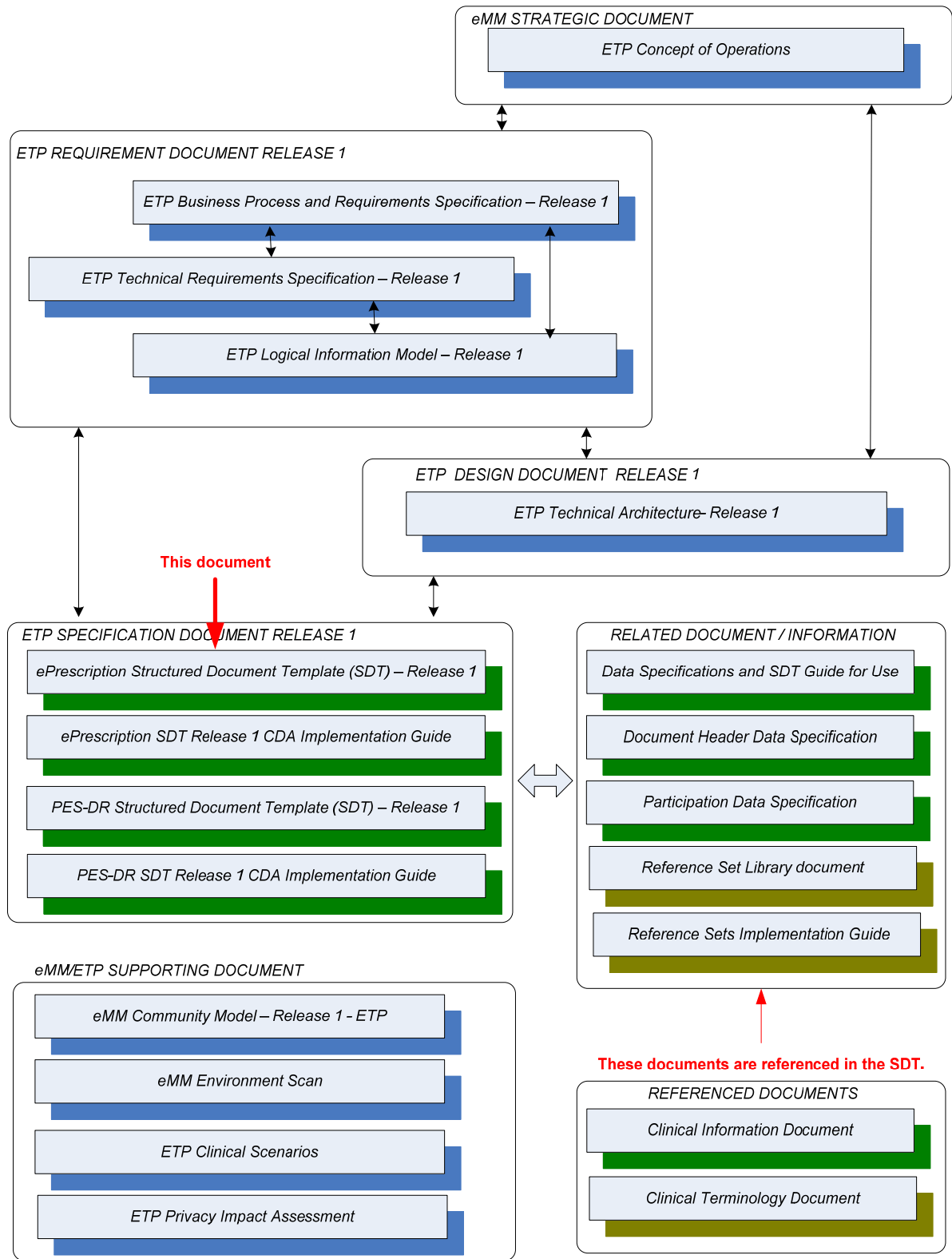
“The Dispense Record is the encapsulation of all activity associated with the dispensing of a single ePrescription Item within a single dispensing event. More specifically, a Dispense Record instance may exist for each ePrescription Item. A single Dispense Event may be associated with many Dispense Records, each of which encapsulates the dispensing information associated with a single ePrescription Item.”

In ETP Release 1, each PES-DR is a record of a dispensing outcome against one prescribed item that is associated with an ePrescription in the PES.

By nature of this relationship, familiarity with the content of this document is essential, prior to reading the NEHTA publication *PES-DR Structured Document Template (SDT) Release 1* [[NEHT2009j](#)].

## 1.4 Document Map

[Figure 1](#) below identifies documents prepared for ETP Release 1 and indicates their relationship to each other.



**Figure 1: Document Map**

This specification is indicated in Figure 1. Development of the complementary *ePrescription SDT Release 1 CDA Implementation Guide* may require some refinement to this SDT – refinements that align with the detail of the standard for Clinical Data Architecture.

### 1.4.1 Related Documents

Related documents are also indicated in this document map. Amongst these are documents that are common to all SDTs, and provide information that will contribute to understanding the content in this SDT. These common documents are as follows:

- *Data Specifications – Guide for Use* [NEHT2009b] – which describes the generic data structures, data types, keywords and icons used within this Structured Document Template.
- *Document Header Data Specification* [NEHT2009a] – which contains the full specification of the standardised header used across all NEHTA Structured Document Templates. The major constructs are based on the concept of 'Participation' modelled fully in the Participation Data Specification referenced below.
- *Participation Data Specification* [NEHT2009c] – which contains the full specification of the standardised header used across all NEHTA Structured Document Templates.

Participation is defined in the HL7 Reference Information Model (RIM) specification [HL72009] as "An association between an Act and a Role. The Entity playing the Role is the actor."

The association between an Act and a Role is called a Participation in the RIM and, each A has one or many Participations. Each instance of a Participation expresses an aspect of context for an Act in terms of either who performed it, or for whom it was done, or where it was done etc. (Please refer to the HL7 RIM specification [HL72009] for more details).

### 1.4.2 Reference Sets

Additionally, implementation of an operational ETP solution requires specification of Reference Sets for defining specific codes. Publications relevant to this subject matter are:

- *Reference Set Library* [NEHT2009i]. This a register of reference sets developed for use by the SNOMED CT-AU<sup>®</sup> community of practice.<sup>1</sup> It contains information about the development and author/s of the reference sets. (See the Australian Medicines Terminology (AMT) page [NEHT2009k] on the NEHTA web site for more information.)
- *Reference Sets Implementation Guide* [NEHT2009h]. This basic information and guidance for the implementation of terminology reference sets.

## 1.5 Document Scope

For the required data elements of an ePrescription, this SDT includes their organisation (grouping), definition, datatype and constraints (including occurrence frequency, value domain and conditions of use).

This specification is designed to record the following types of prescription:

- PBS/RPBS prescriptions;
- PBS/RPBS authority prescriptions; and
- Non-PBS prescriptions (private prescriptions).

These are described in the Glossary [NEHT2008].

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<sup>1</sup> SNOMED CT is a registered trademark of the International Health Terminology Standards Development Organisation.

The following is a summary of the organisation and scope of the content in this document.

The data organisation and details of an ePrescription for ETP Release 1 are presented as header information and prescription details. The former identifies the Subject of Care for whom the prescription is raised, the healthcare provider organisation (General Practice) where the prescribing occurred, identity of the healthcare provider person (General Practitioner) that authored the prescription and, control data.

The latter includes the identity and basic details of the prescription that guide dispensing as well as details of the therapeutic good prescribed including dosage instructions.

For each of the data groups and data elements specified for an ePrescription, a detailed definition is provided.

(Note: the equivalent details for the header are included in *Document Header Data Specification* [[NEHT2009a](#)]).

Two UML diagrams are included, one that models the information Classes that make up the Header of an ePrescription and the other that models the information Classes that make up the details of an ePrescription. These models are a commonly used method for representing data structures and content; they are full representation of the data hierarchies presented in the SDT. Their inclusion offers an alternative means by which the reader can gain an understanding of the organisation and detail of an ePrescription as specified in this SDT.

## 1.6 ePrescription Life Cycle.

During a healthcare encounter between a General Practitioner (GP) and a Subject of Care, the GP may use an Electronic Prescribing Systems (EPS). Consequently, an ePrescription and a paper copy of it is issued to the Subject of Care or the person accompanying them, for example a parent. An ePrescription is created with content that is considered important for safe and effective dispensing of a prescription and essential as per legislative requirements.

An ePrescription is a record that fulfils the requirements of National, State or Territory legislation. Some of this information is considered to be critical to any ePrescription and such information is given an Obligation of 'Essential'. Examples of such information are:

- Subject of Care
- Facility
- Document Author
- Document Control
- Prescribed Item
- Item Detail
- Benefit Category Type

Other types of information may also be recorded in an ePrescription depending on a variety of circumstances that prevail at the time the prescription is being raised. Such information is included in the SDT with an Obligation of 'optional'. Examples include:

- Authority Approval Number
- State Authority Number

In summary, the information content of an ePrescription published in the SDT is intended to convey accurate context and instructions that enable a pharmacist to correctly dispense. During a GP and Subject of Care healthcare encounter, other additional information is likely to be recorded by a GP; that additional information is not included in this specification.

An ePrescription may go through several iterations of Dispensing before all the prescribed items are fully dispensed. For each Dispense action, a Dispense Record is created that is linked to the ePrescription.

### **1.6.1 Cancelling and Replacing an ePrescription**

The ePrescription can also be cancelled, for example, when an adverse reaction to the prescribed medication occurs during the course of taking the medication.

- An ePrescription can be cancelled by creating a copy of it and denoting the status of the copy as 'Withdrawn' and inserting a Prescription Note that states 'Cancelled'. This preserves the principle that an original clinical document cannot be edited once lodged as a record of the event.
- Once cancelled, no other 'documents' (e.g. a replacement prescription) can be associated with it. Additionally, no dispensing can take place against a cancelled ePrescription.

Whilst not strictly related to the lifecycle of an ePrescription, the information included in the 'Document Control' section in the SDT supports the following:

- Tracking of versions including attestation per version.
- A trail of linked ePrescriptions and dispense activity against each ePrescription.
- Grouping of related documents (initially prescriptions and dispense records) applicable to a specific clinical process.

For more details on the lifecycle of an ePrescription please refer to the *ETP Business Process and Requirements Specification – Release 1* [[NEHT2009d](#)].

## 2 ePrescription Header

This section identifies those data elements that comprise a standard ePrescription 'header' that is created by a computer application used by the prescriber (an Electronic Prescribing System or EPS). The header is designed to define the context of the prescribing event as well as control information of the document itself.









The data hierarchy below provides a logical representation of the data elements that make up the header. This data hierarchy is not intended to represent how the data contents are visually displayed in an ePrescription authoring or reviewing Electronic Prescribing System.






Within this SDT, information components that are in upper case are sections or data groups, while information components in title case are individual data elements.

Definitions of the data types, obligations and all icons used in this SDT can be found in the *NEHTA Data Specification and Structured Document Templates Guide for Use* [NEHT2009b].

The document header is generic to all Structured Document Templates and is defined in detail in the Document Header Data Specification [NEHT2009a]. Specific constraints, related to the use of the header in a dispense record, are explained in sections 2.1 and 2.2 of this section.

Individual data elements associated with the Participation data group are not displayed in the data hierarchy in order to improve readability. The data elements of the Participation data group and their hierarchical structure can be found in the related document *Data Specification – Participation* [NEHT2009c].

	<b>EPRESCRIPTION HEADER</b>		
	HEALTH EVENT CONTEXT		!
	SUBJECT OF CARE		!
	FACILITY		!
	HEALTH EVENT IDENTIFICATION		0
	<b>ID</b>	Health Event Identifier	!
		DateTime Health Event Started	!
	DOCUMENT CONTEXT		!
	DOCUMENT CONTROL		!
	<b>ID</b>	Document Instance Identifier	!
	<b>ID</b>	Document Set Identifier	!

	<b>EPRESCRIPTION HEADER</b>		
	<b>123</b>	Version Number	!
	<b>ID</b>	Document Originating System Identifier	!
	<b>T<sub>010</sub></b>	Business Document Type	!
	<b>123</b>	Business Document Type Version Number	!
		DateTime Attested	!
	<b>T<sub>010</sub></b>	Document Status	!
	<b>T<sub>010</sub></b>	Language (default to en-AU)	!
	DOCUMENT AUTHOR		!
	DOCUMENT RECIPIENT DETAIL		! ↻
	<b>T<sub>010</sub></b>	Document Recipient Type	!
		DOCUMENT RECIPIENT	!

## 2.1 HEALTH EVENT CONTEXT

### Usage

<b>Conditions of Use</b>	<p>This includes a reuse of HEALTH EVENT CONTEXT.</p> <p>On this reuse, the following constraints apply:</p> <ul style="list-style-type: none"> <li>• HEALTH EVENT IDENTIFICATION: Occurrence changes from Multiple to Single.</li> <li>• Health Event Identifier: Obligation changes from Optional to Essential.</li> <li>• DateTime Clinical Process Ended: Occurrence changes from Single to Zero.</li> </ul>
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<b>Data Element</b>	<b>Use in Prescription</b>
SUBJECT OF CARE	The person the prescription is for.
FACILITY	The organisation that the prescriber is working for when they write the prescription.
Health Event Identifier	This is used to tie a prescription and dispense record together.
DateTime Health Event Started	The date (and optionally time) when the prescription is signed.

## 2.2 DOCUMENT CONTEXT

### Usage














<b>Conditions of Use</b>	<p>This includes a reuse of DOCUMENT CONTEXT.</p> <p>On this reuse, the following constraints apply:</p> <ul style="list-style-type: none"> <li>• Confidentiality Indicator: Occurrence changes from Single to Zero</li> <li>• DOCUMENT AUTHORISER/APPROVER: Occurrence changes from Single to Zero</li> </ul>
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





















<b>Data Element</b>	<b>Use in Prescription</b>
Document Instance Identifier	Unique identifier of an instance of the document being created. The value is globally unique and generally not for human consumption.
Document Set Identifier	The Prescription Identifier.
Version Number	Identifier of a document within a document set, it is used to version successive replacement documents. There is no concept of major and minor versions.
Document Originating System Identifier	Unique identifier of the system used to create the document.
Business Document Type	The value is 'ePrescription'.
Business Document Type Version Number	The value is '1.0'.
DateTime Attested	The date (and optionally time) when the prescription is signed.
Document Status	'Final' for the first prescription, 'Withdrawn' for the document that cancels a prescription.
Language	The value defaults to 'en-AU'.
DOCUMENT AUTHOR	The prescriber.
Document Recipient Type	The value is 'Primary'.
DOCUMENT RECIPIENT	The organisation that owns the Prescription Exchange System that the prescription is sent to.




# 3 ePrescription Detail

This section describes the structure and data elements that make up the body of an ePrescription. It contains information regarding the item(s) prescribed for the subject of care, instructions on how those items should be administered and instructions for dispensing the items, as represented in the data hierarchy below.

The definition of each data element of the body is presented in Section 4 below.

	<b>EPRESCRIPTION DETAIL</b>		
	PRESCRIPTION		!
	DateTime Prescription Written		!
	DateTime Prescription Expires		0
<b>ID</b>	Prescription Identifier		!
	PRESCRIBER		!
<b>T/T<sub>010</sub></b>	Concession or Safety Net Type		!
	PRESCRIPTION NOTE DETAIL		<i>a→b</i> 
	<b>T</b>	Prescription Note	!
		DateTime Prescription Note Created	!
		PRESCRIPTION NOTE AUTHOR	0
	PRESCRIBED ITEM		! 
	<b>ID</b>	Prescribed Item Instance Identifier	!
	<b>T/T<sub>010</sub></b>	PBS/RPBS Benefit Category Type	!
		PBS/RPBS ITEM CODE DETAIL	<i>a→b</i>
	<b>ID</b>	PBS/RPBS Item Code	!
	<b>T/T<sub>010</sub></b>	Manufacturer Code	!
		DISPENSING INSTRUCTION	!

	<b>EPRESCRIPTION DETAIL</b>				
				Pursuant to Regulation 24	
				Brand Substitute Allowed	
				Maximum Number of Repeats	
				Minimum Interval between Repeats	0
			PRESCRIBED ITEM NOTE DETAIL		0
			<b>T</b>	Prescribed Item Note	
				DateTime Prescribed Item Note Created	
				PRESCRIBED ITEM NOTE AUTHOR	0
		<b>T</b>	Authority Approval Number		0
		<b>T</b>	State Authority Number		0
			ITEM DETAIL		
			<b>T/T<sub>010</sub></b>	Item Description	
				Medication Duration	0
			<b>T</b>	Quantity of Medication	0
				DOSAGE	0
			<b>T</b>	Dose Instruction	
	<b>BODY WEIGHT MEASUREMENT</b>				0
	<b>T/T<sub>010</sub></b>	Observation Description			
		Body Weight Value			
		DateTime of Observation			
	<b>T/T<sub>010</sub></b>	State of the Subject of Care			0 
	<b>BODY HEIGHT MEASUREMENT</b>				0

	<b>EPRESCRIPTION DETAIL</b>		
	<b>T/T</b> <sub>010</sub>	Observation Description	!
		Body Height Value	!
		DateTime of Observation	!
	<b>T/T</b> <sub>010</sub>	State of the Subject of Care	O ↻

The definition of each data element of the body is presented in Section 4 below.

# 4 Data Specifications

This section provides a definition of each data group or data element that forms the body of the ePrescription. The layout of the definition is as published in the *NEHTA Data Specification and Structured Document Templates Guide for Use* [NEHT2009b].

## 4.1 PRESCRIPTION

### Identification






<b>Name</b>	PRESCRIPTION
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-10101
<b>Version</b>	2.0

### Definition


<b>Definition</b>	A formal Medication Order (printed or electronic) complying with all regulatory requirements.
<b>Source</b>	AS4700.3-2007
<b>Synonymous Names</b>	
<b>Notes</b>	For the purposes of this SDT, an ePrescription is a precise written order or instruction, issued by a general medical practitioner with prescribing authority, authorising a pharmacist or other authorised dispenser to dispense one or more prescribed items for use/consumption by a subject of care. The ePrescription will include, when necessary, instructions for the preparation, use and administration of the item. The prescribed item may be a drug, appliance, dressing or reagent.

## Relationships

### Children


Type	Name	Obligation	Condition	Occurrence
	DateTime Prescription Written	Essential		Single
	DateTime Prescription Expires	Optional		Single
<b>ID</b>	Prescription Identifier	Essential		Single
	PRESCRIBER	Essential		Single
<b>T/T</b> <sub>010</sub>	Concession or Safety Net Type	Essential		Single
	PRESCRIPTION NOTE DETAIL	Conditional	Essential if Document Status value equals 'Withdrawn' otherwise it is optional.	Multiple
	PRESCRIBED ITEM	Essential		Multiple

### Parent

Type	Name	Obligation	Condition	Occurrence
	ePrescription Detail	Essential		Single

## 4.2 DateTime Prescription Written

### Identification

 <b>Name</b>	DateTime Prescription Written
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	To Be Allocated

### Definition


<b>Definition</b>	Date (and optionally time) of the completion of the writing of the prescription.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	<p>In common practice this is the date the prescription was signed by the prescriber.</p> <p>This is typically the date from which it could be filled. If the prescriber wishes the prescription to take effect from a later date, this can be stated as text in a prescription note.</p> <p><b>Business Rule</b></p> <p>If the value of the Benefit Category Type is PBS or RPBS, the value of this data element must be the DateTime Attested from the document header.</p>
<b>Datatype</b>	DateTime

### Usage

<b>Examples</b>	See: <i>Data Specifications – Guide for Use</i> [ <a href="#">NEHT2009b</a> ]
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### Relationships

#### Parent

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

## 4.3 DateTime Prescription Expires

### Identification

 <b>Name</b>	DateTime Prescription Expires
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	To Be Allocated

### Definition


<b>Definition</b>	The date (and optionally time) after which the prescription can no longer be dispensed against.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	<p>The prescription expiry date will be dependent on local, national rules and controlled by protocols. As an example, the prescriptions issued under the Pharmaceutical Benefits Schedule usually expire after 12 months. Local policy may shorten this timeframe (e.g. to 6 months for Schedule 8 drugs).</p> <p>Prescriber may pre-set an expiry date that falls within the default expiry period.</p> <p>The expiry of the prescription allows for appropriate and regular assessment and follow-up of long-term medication and the chronic or other condition for which the medication has been prescribed. This usually requires complex decisions and a thorough evaluation of the subject of care.</p> <p><b>Business rules</b></p> <ol style="list-style-type: none"> <li>1. The value of this data element must be greater than the <a href="#">DateTime Prescription Written</a>.</li> <li>2. For PBS and RPBS items, the value of this data element must not be after 12 months from the <a href="#">DateTime Prescription Written</a>.</li> <li>3. Must be populated if the prescription duration is intended to be longer than the default duration allowed by Medicare/PBS regulation.</li> </ol>
<b>Datatype</b>	DateTime

### Usage

<b>Examples</b>	See: <i>Data Specifications – Guide for Use</i> [ <a href="#">NEHT2009b</a> ]
-----------------	---

## Relationships

### Parent

Type	Name	Obligation	Condition	Occurrence
	PRESCRIPTION	Optional		Single

## 4.4 Prescription Identifier

### Identification

ID

<b>Name</b>	Prescription Identifier
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	To Be Allocated

### Definition


<b>Definition</b>	A number generated by an EPS (Electronic Prescribing System) to uniquely identify a prescription.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	This represents the unique identifier assigned by Prescriber desktop software and as such, the number is unique ONLY to the EPS that issues it. This is the same as <a href="#">Document Set Identifier</a> .
<b>Datatype</b>	UniqueIdentifier

### Usage

<b>Examples</b>	
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### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	<a href="#">PRESCRIPTION</a>	Optional		Single

## 4.5 PRESCRIBER

### Identification



<b>Name</b>	PRESCRIBER
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	To Be Allocated
<b>Version</b>	2.0

### Definition

<b>Definition</b>	The healthcare provider who wrote the prescription.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	This will be the same as the <a href="#">DOCUMENT AUTHOR</a> .

### Usage

<b>Conditions of Use</b>	This is a reuse of the PARTICIPATION BY HEALTHCARE PROVIDER (PERSON) data group. On this reuse, no additional constraints apply.
--------------------------	---

### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	<a href="#">PRESCRIPTION</a>	Optional		Single

## 4.6 Concession or Safety Net Type

### Identification

T/T<sub>010</sub>

<b>Name</b>	Concession or Safety Net Type
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	To Be Allocated

### Definition


<b>Definition</b>	The type of concession or safety net benefit granted by a government agency to an eligible subject of care or family, which qualifies eligible persons to pay concessional rates for their PBS medicines.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	<p>It may be one of the Commonwealth and state &amp; territory concession/health benefit, Repatriation Health Card, or PBS (pharmaceutical benefits scheme) safety net benefits.</p> <p>This Replicates the check boxes provided on paper prescriptions. Check box values influence Dispenser driven PBS/RPBS billing and claiming processes.</p> <p>Safety Net types can be Safety Net Entitlement Card Holders or Concessional Card Holders. If a person holds neither of these cards, the safety net type is Not Applicable.</p> <p>Concessional subjects of care hold a Medicare card and one of the following cards from Centrelink or the DVA :</p> <ul style="list-style-type: none"> <li>• Pensioner Concession Card</li> <li>• Commonwealth Seniors Health Card</li> <li>• Health Care Card</li> <li>• Repatriation Health Card (Gold)</li> <li>• Repatriation Health Card (White)</li> <li>• Repatriation Health Card (Orange)</li> <li>• Safety Net Concession Card</li> </ul>
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified – Use existing code sets until NEHTA determines a suitable common reference set.

## Usage

<b>Examples</b>	<ul style="list-style-type: none"><li>• Safety Net Entitlement Card Holder</li><li>• Concessional Card Holder</li><li>• Not Applicable</li></ul>
-----------------	--

## Relationships

### Parent

Type	Name	Obligation	Condition	Occurrence
	PRESCRIPTION	Essential		Single

## 4.7 PRESCRIPTION NOTE DETAIL

### Identification

<b>Name</b>	PRESCRIPTION NOTE DETAIL
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	To Be Allocated
<b>Version</b>	V1.0

### Definition



<b>Definition</b>	Details pertinent to additional or supplementary information about the prescription, which is not captured by other information structures contained in the prescription.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	Clinical Note
<b>Notes</b>	<p>For an ePrescription, this data group contains details of information/note at the prescription level.</p> <p>It must contain a note with details of the information (such as counselling instructions or reason for cancellation of a prescription) and the DateTime of the creation of the note.</p> <p>Provides for capture of general Prescriber remarks that target the Dispenser and may include things like :</p> <ul style="list-style-type: none"> <li>• Subject of Care does not speak English, provide appropriate counselling</li> <li>• Subject of Care has arthritis of the hands, please use appropriate containers</li> </ul> <p>Also used to capture rationale associated with ePrescription cancellation.</p> <p><b>Misuse:</b></p> <p>Not to be used to provide additional information about any prescribed item. Such information is to be captured using <a href="#">PRESCRIBED ITEM NOTE DETAIL</a>.</p>

## Usage


<b>Conditions of Use</b>	<p>This is a reuse of the SUPPLEMENTARY INFORMATION data group.</p> <ul style="list-style-type: none"> <li>• On this reuse, the following constraints apply:</li> <li>• Supplementary Information Recipient: Occurrence changes from Multiple to Zero</li> <li>• Supplementary Information Note: Is renamed to Prescription Note, Obligation changes from Optional to Essential</li> <li>• DateTime Note Created: Is renamed to DateTime Prescription Note Created, Obligation changes from Optional to Essential</li> <li>• Supplementary Information Author: Is renamed Prescription Note Author, Occurrence changes from Multiple to Single</li> </ul>
--------------------------	---

## Relationships

### Children

Type	Name	Obligation	Condition	Occurrence
<b>T</b>	Prescription Note	Essential		Single
	DateTime Prescription Note Created	Essential		Single
	PRESCRIPTION NOTE AUTHOR	Optional		Single

### Parent

Type	Name	Obligation	Condition	Occurrence
	PRESCRIPTION	Conditional	Essential if Document Status value equals 'Withdrawn' otherwise it is optional	Multiple

## 4.8 Prescription Note

### Identification

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

### Definition


<b>Definition</b>	Free text comments (by the prescriber) providing extra details relevant to the prescription.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	Advice to Subject of Care
<b>Notes</b>	In the case of an ePrescription, a note may contain details for counselling instructions, Adverse Drug Reaction (ADR), explanation regarding activities such as brand substitution.  In case of replacement or withdrawal of a prescription, the details and reason should be entered here.
<b>Datatype</b>	Text

### Usage

<b>Examples</b>	Please counsel carer on how to administer these medications.
-----------------	--


### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	PRESCRIPTION NOTE DETAIL	Essential		Single

## 4.9 DateTime Prescription Note Created

### Identification

 <b>Name</b>	DateTime Prescription Note Created
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	To Be Allocated

### Definition


<b>Definition</b>	The date (and optionally time) that the Supplementary or additional information pertinent to the prescription was written.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	DateTime

### Usage

<b>Examples</b>	See: <i>Data Specifications – Guide for Use</i> [ <a href="#">NEHT2009b</a> ]
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### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	<a href="#">PRESCRIPTION NOTE DETAIL</a>	Essential		Single

## 4.10 PRESCRIPTION NOTE AUTHOR

### Identification



<b>Name</b>	PRESCRIPTION NOTE AUTHOR
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	To Be Allocated
<b>Version</b>	2.0

### Definition

<b>Definition</b>	The healthcare provider who wrote the prescription note.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	This will typically be the same as the <a href="#">DOCUMENT AUTHOR</a> .

### Usage

<b>Conditions of Use</b>	This is a reuse of the PARTICIPATION BY HEALTHCARE PROVIDER (PERSON) data group. On this reuse, no additional constraints apply.
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### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	<a href="#">PRESCRIPTION NOTE DETAIL</a>	Optional		Single

## 4.11 PRESCRIBED ITEM

### Identification





<b>Name</b>	PRESCRIBED ITEM
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	To Be Allocated

### Definition


<b>Definition</b>	Details of a single, unique therapeutic good or medicinal product which is included in a prescription as an item to be supplied to (and administered to/by) the subject of care.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	Prescription Item
<b>Notes</b>	<p>The items within the scope of Phase 1 ePrescription implementation are the following:</p> <ul style="list-style-type: none"> <li>• An item on the PBS/RPBS.</li> <li>• An item on the PBS/RPBS requiring authority.</li> <li>• A non-PBS item – medication or other prescribed item not on the PBS.</li> </ul> <p>There are rules governing the allowable number of items in a prescription and rules governing combining PBS and non-PBS items on a single script. These rules described are below under the Implementation Rules heading.</p> <p><b>Business Rules:</b></p> <ol style="list-style-type: none"> <li>1. For PBS/RPBS items, if Authority Approval Number and State Authority Number are not populated, there can be a maximum of 3 occurrences of this data group.</li> <li>2. For PBS/RPBS items, if Authority Approval Number and State Authority Number are populated, there can only be a maximum of 1 occurrence of this data group.</li> <li>3. Pharmaceutical benefits and non-pharmaceutical benefits should not be listed together on one PBS prescription form.</li> </ol>

## Relationships

### Children

Type	Name	Obligation	Condition	Occurrence
<b>ID</b>	Prescribed Item Instance Identifier	Essential		Single
<b>T/T<sub>010</sub></b>	PBS/RPBS Benefit Category Type	Essential		Single
	PBS/RPBS ITEM CODE DETAIL	Conditional	Essential if value equals 'PBS' or 'RPBS' otherwise it is not allowed.	Single
	DISPENSING INSTRUCTION	Essential		Single
	PRESCRIBED ITEM NOTE DETAIL	Optional		Single
<b>T</b>	Authority Approval Number	Optional		Single
<b>T</b>	State Authority Number	Optional		Single
	ITEM DETAIL	Essential		Single

### Parent

Type	Name	Obligation	Condition	Occurrence
	PRESCRIPTION	Essential		Multiple

## 4.12 Prescribed Item Instance Identifier

### Identification

ID

<b>Name</b>	Prescribed Item Instance Identifier
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	To Be Allocated

### Definition


<b>Definition</b>	A number generated by an EPS (Electronic Prescribing System) to uniquely identify information about a therapeutic good that is included within a prescription.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	UniqueIdentifier

### Usage

<b>Examples</b>	No example available for this data element.
-----------------	---

### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	PRESCRIBED ITEM	Essential		Single

## 4.13 PBS/RPBS Benefit Category Type

### Identification

T/T<sub>010</sub>

<b>Name</b>	PBS/RPBS Benefit Category Type
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	To Be Allocated

### Definition


<b>Definition</b>	Indicates the category of subsidy appropriate to the item being prescribed.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	<p>The primary purpose of this data element is to indicate how payment for the item is to be made.</p> <ul style="list-style-type: none"> <li>• Non-PBS: Items on these prescriptions are not covered by a PBS or RPBS subsidy.</li> <li>• PBS: A range of medications which may be prescribed at a subsidised cost for all Australian residents and eligible overseas visitors under the Pharmaceutical Benefits Scheme.</li> <li>• RPBS: Through the Veterans' Entitlements Act 1986 the Department of Veterans' Affairs provides programs of compensation, income support and treatment for eligible veterans and their dependants. One of the defined benefits for eligible veterans is the Repatriation Pharmaceutical Benefits Scheme. This range of medications and dressings is more comprehensive than is available through the Pharmaceutical Benefits Scheme.</li> </ul> <p>This data element should not to be confused with <a href="#">Concession or Safety Net Type</a>.</p>
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified – Use existing code sets until NEHTA determines a suitable common reference set.

### Usage

<b>Examples</b>	<ul style="list-style-type: none"> <li>• PBS</li> <li>• RPBS</li> <li>• Non PBS</li> </ul>
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## Relationships

### Parent

Type	Name	Obligation	Condition	Occurrence
	PRESCRIBED ITEM	Essential		1

## 4.14 PBS/RPBS ITEM CODE DETAIL

### Identification

 <b>Name</b>	PBS/RPBS ITEM CODE DETAIL
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	To Be Allocated

### Definition


<b>Definition</b>	A collection of data elements that identify a therapeutic good listed within the Pharmaceutical Benefit Scheme (PBS) or the Repatriation Pharmaceutical Benefits Scheme (RPBS).
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	PBS ITEM CODE DETAIL RPBS ITEM CODE DETAIL
<b>Notes</b>	This is only relevant to PBS and RPBS items.

### Relationships

#### Children

Type	Name	Obligation	Condition	Occurrence
<b>ID</b>	PBS/RPBS Item Code	Essential		Single
<b>T/T<sub>010</sub></b>	Manufacturer Code	Essential		Single

#### Parent

Type	Name	Obligation	Condition	Occurrence
	PRESCRIBED ITEM	Conditional	Essential if value equals 'PBS' or 'RPBS' otherwise it is not allowed.	Single

## 4.15 PBS/RPBS Item Code

### Identification

<b>ID</b>	<b>Name</b>	PBS/RPBS Item Code
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	To Be Allocated

### Definition


<b>Definition</b>	Identifier assigned by Medicare Australia to therapeutic goods listed in the Pharmaceutical Benefit Scheme (PBS) or the Repatriation Pharmaceutical Benefits Scheme (RPBS).
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	PBS Item Code RPBS Item Code
<b>Notes</b>	
<b>Datatype</b>	UniqueIdentifier
<b>Value Domain</b>	The code set is determined by Medicare Australia.

### Usage

<b>Examples</b>	4411E
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### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	<a href="#">PBS/RPBS ITEM CODE DETAIL</a>	Essential		Single

## 4.16 Manufacturer Code

### Identification

T/T<sub>010</sub>

<b>Name</b>	Manufacturer Code
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	To Be Allocated

### Definition


<b>Definition</b>	<p>A code assigned by Medicare Australia, for use within the Schedule of Pharmaceutical Benefits, to identify either:</p> <ul style="list-style-type: none"> <li>a party (organisation or person) who imports, or arranges the importation of, the goods into Australia; or</li> <li>a party (organisation or person) who, in Australia, manufactures the goods, or arranges for another person to manufacture the goods, for supply (whether in Australia or elsewhere).</li> </ul>
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	<p>PBS Item Manufacturer Code</p> <p>Manufacturer Code</p>
<b>Notes</b>	This is distinct from the Sponsor ID used in the Australian Register of Therapeutic Goods (ARTG).
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	The code set is determined by Medicare Australia.

### Usage

<b>Examples</b>	PF
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
### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	PBS/RPBS ITEM CODE DETAIL	Essential		Single

## 4.17 DISPENSING INSTRUCTION

### Identification





 <b>Name</b>	DISPENSING INSTRUCTION
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	To Be Allocated

### Definition


<b>Definition</b>	Details, provided by the prescriber, that are of relevance to the dispensing of a prescribed item.
<b>Source</b>	NEHTA
<b>Notes</b>	<p>The collection of information relevant to the dispenser for dispensing the prescription.</p> <p>These include the regulation requirements, number of repeats, brand substitution instructions and minimum amount of time between dispense.</p>

### Relationships

#### Children

Type	Name	Obligation	Condition	Occurrence
	Pursuant to Regulation 24	Essential		Single
	Brand Substitute Allowed	Essential		Single
	Maximum Number of Repeats	Essential		Single
	Minimum Interval between Repeats	Optional		Single

#### Parent

Type	Name	Obligation	Condition	Occurrence
	PRESCRIBED ITEM	Essential		Single

## 4.18 Pursuant to Regulation 24

### Identification




<b>Name</b>	Pursuant to Regulation 24
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16017

### Definition

<b>Definition</b>	Indicates whether or not the item is being prescribed within the terms of Regulation 24 whereby, in essence, the original and all repeats of a PBS medicine ordered on a prescription may be supplied at the one time.
<b>Source</b>	Medicare Australia
<b>Synonymous Names</b>	
<b>Notes</b>	<p>Generally, a pharmaceutical benefit may not be supplied to the same person more than once in any four clear days (or 20 clear days for items listed in the Schedule with five repeats or more). Under Regulation 24, a prescriber can direct that the original and all repeats of a PBS medicine ordered on a prescription be supplied at the one time, provided that the prescriber is satisfied that all of the following circumstances apply:</p> <ul style="list-style-type: none"> <li>• The maximum quantity or number of units applicable in relation to the pharmaceutical benefit is insufficient for the treatment of the person for whom the prescription is written.</li> <li>• The person requires the pharmaceutical benefit for the treatment of a chronic illness or is residing in a place remote from the approved pharmacist nearest to that person's place of residence.</li> <li>• The person could not, without great hardship, obtain the required quantity or number of units of the pharmaceutical benefit by means of repeated supplies on separate occasions.</li> </ul> <p>A PBS prescription must be endorsed by the prescriber with 'Regulation 24' as certification that all the above conditions apply.</p> <p>An example of where a prescription would need to be endorsed as Regulation 24 for each item would be where a Subject of Care taking antihypertensive medicine plans to travel overseas and requires the dispensing of the original and repeats at one time. <a href="#">[MA2009a]</a></p> <p>This is only relevant to PBS and RPBS prescriptions.</p>
<b>Datatype</b>	Boolean

## Relationships

### Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSING INSTRUCTION	Essential		Single

## 4.19 Brand Substitute Allowed

### Identification



<b>Name</b>	Brand Substitute Allowed
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10107

### Definition

<b>Definition</b>	Indicates whether or not the substitution of a prescribed medication with a different brand name drug is allowed when the medication is dispensed/supplied.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	Allow substitutions
<b>Notes</b>	<p>PBS prescriptions must not be prepared using a computer prescribing program that contains a default which would result in all prescriptions being indicated as Brand Substitution Not Permitted. [DHA2009]</p> <p>The default value should therefore be to allow substitutions, with the ability for the prescriber to override the default if necessary. Processes may be implemented to disallow substitution when the pharmacodynamic and pharmacokinetic properties of different branded drugs are known to be different (i.e. their bioequivalence and therapeutic equivalence cannot be established), e.g. Coumadin and Marevan in Warfarin prescribing.</p>
<b>Datatype</b>	Boolean

### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSING INSTRUCTION	Essential		Single

## 4.20 Maximum Number of Repeats

### Identification

123

<b>Name</b>	Maximum Number of Repeats
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10169

### Definition


<b>Definition</b>	The number of times the supply of the prescribed item may be repeated under the terms of this prescription.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	<p>Note that the initial supply under the prescription is not counted as a repeat.</p> <p>PBS and RPBS items specify a maximum number of permitted repeats within the Schedules. This number must not be exceeded on a prescription without the appropriate authorisation.</p> <p>When a prescription for a PBS medicine asks for repeat supplies, the pharmacist shall prepare a Repeat Authorisation Form to be attached to the 'Pharmacist/Subject of Care' copy. An exception to this is when the prescription is marked 'Regulation 24', where all repeats are supplied at once with the original prescription. The Repeat Authorisation is to be detailed in a separate Structured Document Template.</p> <p><b>Implementation Rules:</b></p> <ol style="list-style-type: none"> <li>1. The default value is '0'.</li> <li>2. If the value of 'Pursuant to Regulation 24' is 'True', the value of this data element must be greater than '0'</li> </ol>
<b>Datatype</b>	Integer

### Usage

<b>Examples</b>	<ul style="list-style-type: none"> <li>• 2</li> <li>• 4</li> </ul>
-----------------	--


## Relationships

### Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSING INSTRUCTION	Essential		Single

## 4.21 Minimum Interval between Repeats

### Identification

 <b>Name</b>	Minimum Interval Between Repeats
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10164

### Definition


<b>Definition</b>	The minimum time before the medication can be dispensed again.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	<p>Where the prescription is for a Schedule 8 medicine and the dispensing of the prescription is authorised to be repeated, the minimum intervals at which it may be dispensed must be written on the prescription by the prescriber.</p> <p>The dispensing interval for other scripts is a dispensing issue and is governed by PBS rules.</p> <p>However, there may be other situations where a prescriber may want to limit access – i.e. if there are safety concerns or if the Subject of Care is taking greater than the prescribed dose.</p>
<b>Datatype</b>	Duration

### Usage

<b>Examples</b>	20 days
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### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	DISPENSING INSTRUCTION	Optional		Single

## 4.22 PRESCRIBED ITEM NOTE DETAIL

### Identification

<b>Name</b>	PRESCRIBED ITEM NOTE DETAIL
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	To Be Allocated
<b>Version</b>	V1.0

### Definition



<b>Definition</b>	Supplementary information about the prescribed item, which is not captured by other information structures contained in the prescription.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	For an ePrescription, this data group contains details of information at the prescribed item level provided by the prescriber to the dispenser that provides additional dispensing instructions which are not included in the Prescription Note Detail and Dispensing Instruction data groups.

### Usage


<b>Conditions of Use</b>	<p>This is a reuse of the SUPPLEMENTARY INFORMATION data group.</p> <p>On this reuse, the following constraints apply:</p> <ul style="list-style-type: none"> <li>• Supplementary Information Recipient: Occurrence changes from Multiple to Zero;</li> <li>• Supplementary Information Note: Is renamed to Dispense Item Note, Obligation changes from Optional to Essential;</li> <li>• DateTime Note Created: Is renamed to DateTime Dispense Item Note Created, Obligation changes from Optional to Essential;</li> <li>• Supplementary Information Author: Is renamed Dispense Item Note Author, Occurrence changes from Multiple to Single.</li> </ul>
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## Relationships

### Children

Type	Name	Obligation	Condition	Occurrence
<b>T</b>	Prescribed Item Note	Essential		Single
	DateTime Prescribed Item Note Created	Essential		Single
	PRESCRIBED ITEM NOTE AUTHOR	Optional		Single

### Parent

Type	Name	Obligation	Condition	Occurrence
	PRESCRIBED ITEM	Optional		Single

## 4.23 Prescribed Item Note

### Identification

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

### Definition


<b>Definition</b>	Supplementary note regarding the item being prescribed which the prescriber deems to be clinically relevant.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	Prescription Item Note Advice to Subject of Care
<b>Notes</b>	<p>Information provided by the prescriber to the dispenser that provides more detail or guidance about how the item should be dispensed. May include information for the subject of care.</p> <p><b>Use:</b> May also be used when justifying prescribing an item without an authority number. For example, in NSW, 'Issued under clause 37 of the Poisons and Therapeutic Goods Regulation'.</p> <p><b>Misuse:</b> Not to be used for dispensing instructions or details captured elsewhere in the prescription.</p>
<b>Datatype</b>	Text

### Usage

<b>Examples</b>	<ul style="list-style-type: none"> <li>• This item replaces the Subject of Care's normal prescription for XXX.</li> <li>• Dispense all repeats at once.</li> <li>• Dispense daily dose for Schedule 8 drug.</li> <li>• Issued under clause 37 of the Poisons and Therapeutic Goods Regulation</li> </ul>
-----------------	--


## Relationships

### Parent

Type	Name	Obligation	Condition	Occurrence
	PRESCRIBED ITEM NOTE DETAIL	Essential		Single

## 4.24 DateTime Prescribed Item Note Created

### Identification

 <b>Name</b>	DateTime Prescribed Item Note Created
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	To Be Allocated

### Definition


<b>Definition</b>	The date (and optionally time) that the Supplementary or additional information about the prescribed item was written.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	
<b>Datatype</b>	DateTime

### Usage

<b>Examples</b>	See: <i>Data Specifications – Guide for Use</i> [ <a href="#">NEHT2009b</a> ]
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### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	<a href="#">PRESCRIBED ITEM NOTE DETAIL</a>	Essential		Single

## 4.25 PRESCRIBED ITEM NOTE AUTHOR

### Identification

 <b>Name</b>	PRESCRIBED ITEM NOTE AUTHOR
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	To Be Allocated
<b>Version</b>	2.0

### Definition


<b>Definition</b>	The healthcare provider who wrote the prescribed item note.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	This will typically be the same as the <a href="#">DOCUMENT AUTHOR</a> .

### Usage

<b>Conditions of Use</b>	This is a reuse of the PARTICIPATION BY HEALTHCARE PROVIDER (PERSON) data group. On this reuse, no additional constraints apply.
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### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	<a href="#">PRESCRIBED ITEM NOTE DETAIL</a>	Optional		Single

## 4.26 Authority Approval Number

### Identification

<b>T</b>	<b>Name</b>	Authority Approval Number
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-10159

### Definition

<b>Definition</b>	An identification number obtained by the prescriber and included in the prescription to show that the prescription meets agreed prescribing requirements and has authority to prescribe the medication and/or the quantity of the medication.
<b>Source</b>	Medicare Australia
<b>Synonymous Names</b>	


<b>Notes</b>	<p>Each authority prescription requires a unique approval number provided by Medicare Australia.</p> <p>Authority required benefits fall into two categories – Authority required and Authority required (STREAMLINED).</p> <p>The process in which an Authority PBS prescription can be prescribed will depend on the category.</p> <p><b>Authority Required</b></p> <p>The format of the approval will depend on how the approval was obtained. One of the following markings should be on the prescription:</p> <ul style="list-style-type: none"> <li>• Telephone approval – Z1234AB – there may also be a prefix of TPX, SPX, HSD, CAP or PLC;</li> <li>• Online approval – 1234AAA;</li> <li>• Written approval – a stamp or perforation, the quantity and number of repeats authorised and a signature from the delegate;</li> <li>• DVA approval – will have the prefix 'DVA'.</li> </ul> <p>To obtain PBS/RPBS benefits for medicines listed as 'authority required', approval must be sought by the prescribing doctor.</p> <p>NEHTA is to seek clarification from Medicare Australia as to how these authorities should be recorded electronically.</p> <p><b>Authority Required (STREAMLINED)</b></p> <p>Represented by a 4 digit streamlined authority code (format is 1234). <a href="#">[MA2009c]</a></p> <p><b>Implementation Rules</b></p> <ol style="list-style-type: none"> <li>1. This <b>MUST</b> be populated if: <ul style="list-style-type: none"> <li>– The Benefit Category type is PBS or RPBS; and</li> <li>– The item is listed as 'authority required'.</li> </ul> </li> <li>2. This <b>MUST NOT</b> be populated if the Benefit Category type is not PBS or RPBS or if the item is not listed as 'authority required'</li> </ol> <p><b>Context:</b></p> <p>Authority prescriptions are required for certain PBS medicines, and where the doctor feels the patient requires an increased number of repeats or a quantity greater than the maximum listed in the Schedule of Pharmaceutical Benefits. (Medicare Australia)</p>
<b>Datatype</b>	Text

## Usage

<b>Examples</b>	<ul style="list-style-type: none"> <li>• Authority Required Z1234AB</li> <li>• Authority Required (Streamlined) 9876.</li> </ul>
-----------------	--

## Relationships

### Parent

Type	Name	Obligation	Condition	Occurrence
	PRESCRIBED ITEM	Optional		Single

## 4.27 State Authority Number

### Identification

**T**

<b>Name</b>	State Authority Number
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16018

### Definition

<b>Definition</b>	An identification number issued by an Australian State or Territory health authority as proof that the prescriber has obtained written authority to prescribe drugs of dependence for a drug-dependent person, or for the treatment of a person with drug addiction for a period in accordance with State or Territory regulations.
<b>Source</b>	Medicare Australia
<b>Synonymous Names</b>	

<b>Notes</b>	<p>The PBS refers to the requirement to also observe State legislation when prescribing Schedule 8 medicines. For example, South Australia has additional controls for drugs of dependence from Regulations under the Controlled Substances Act of South Australia 1984:</p> <p>"Medical Practitioners may not prescribe or supply a drug of dependence (a schedule 8 Medicine) unless Authorised by the Minister for Mental Health and Substance Abuse</p> <ul style="list-style-type: none"> <li>- To treat a spouse, parent, grandparent, child, grandchild, brother or sister. [REGULATION 31B]</li> <li>- To a Subject of Care where the Medical Practitioner knows or has reason to believe the Subject of Care is drug dependent [SECTION 18A]</li> <li>- For a Subject of Care who has received a drug of dependence for more than two months [SECTION 18A]"</li> </ul> <p>These authority numbers may be required in addition to a PBS Authority Approval Number.</p> <p>There are state regulations when prescribing dexamphetamine, methylphenidate, clomiphene and isotretinoin in NSW. To meet the legal requirement under the Poisons and Therapeutic Goods Regulation, prescriptions for dexamphetamine and methylphenidate are only eligible for dispensing when the prescriber has included one of the following New South Wales Health Department State Authority reference numbers on the prescription:</p> <ul style="list-style-type: none"> <li>• CNS xxxxxx (e.g. CNS 123654); or</li> <li>• S28c xxxxxx( e.g. S28c 132465); or</li> <li>• Ref. No: xxxxxx-MM-20YY (i.e. unique patient number-month-year e.g. 123658-10-2009)</li> </ul> <p>To be eligible for dispensing clomiphene, the authorised prescriber must include an authority number with the prefix CL/xxxxxx (e.g. CL/24586) on the prescription.</p> <p>To be eligible for dispensing isotretinoin, the authorised prescriber must include an authority number with the prefix RA/xxxxxx (e.g. RA/34536) on the prescription.</p> <p><b>Implementation Rules</b></p> <p>If State authorisation is required to prescribe this item, this information must be provided in the ePrescription.</p>
<b>Datatype</b>	Text


## Usage

<b>Examples</b>	<ul style="list-style-type: none"> <li>• S18A0812</li> <li>• CNS 123654</li> <li>• S28c 132465</li> <li>• 123658-10-2009</li> </ul>
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	<ul style="list-style-type: none"><li>• CL/24586</li><li>• RA/34536</li></ul>
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## Relationships

### Parent

Type	Name	Obligation	Condition	Occurrence
	PRESCRIBED ITEM	Optional		Single

## 4.28 ITEM DETAIL

### Identification

<b>Name</b>	ITEM DETAIL
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-10120
<b>Version</b>	3.0

### Definition



<b>Definition</b>	Information, including dosage instruction, about a single, unique therapeutic good that is listed as an item within a prescription.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	Medication Item Prescribed Item Detail
<b>Notes</b>	It is intended to enable correct dispensing of the item to the subject of care.  Details of the item include a description, duration and quantity of the medication and the dosage which should be administered.

### Usage


<b>Conditions of Use</b>	<p>This is a reuse of the ITEM DETAIL data group.</p> <p>On this reuse, the following constraints apply:</p> <ul style="list-style-type: none"> <li>• Item Status: Occurrence changes from Single to Zero</li> <li>• Reason for Medication: Occurrence changes from Single to Zero</li> <li>• Delivery Compliance Aid Description: Occurrence changes from Single to Zero</li> <li>• Cautionary Advice: Occurrence changes from Single to Zero</li> <li>• QUANTITY OF MEDICATION DETAIL: Occurrence changes from Single to Zero</li> <li>• CHANGE DETAIL: Occurrence changes from Single to Zero</li> <li>• MEDICATION ITEM AUTHORISER: Occurrence changes from Single to Zero</li> <li>• Additional Comments: Occurrence changes from Single to Zero</li> </ul>
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## Relationships

### Children

Type	Name	Obligation	Condition	Occurrence
<b>T</b> / <b>T</b> <sub>010</sub>	Item Description	Essential		Single
	Medication Duration	Optional		Single
<b>T</b>	Quantity of Medication	Optional		Single
	DOSAGE	Optional		Single

### Parent

Type	Name	Obligation	Condition	Occurrence
	PRESCRIBED ITEM	Essential		Single

## 4.29 Item Description

### Identification

T/T<sub>010</sub>

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

### Definition


<b>Definition</b>	The description of the therapeutic good as described by the prescriber.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	Drug Medication Medication Item Description
<b>Notes</b>	This data element is designed to carry a concept from a terminology with a description of the prescribed item. The description should include the name of the item and for a medicinal item, may also contain the active ingredients, strength, form, pack size as part of the term (if applicable).  In the Australian Medicines Terminology (AMT), this is done by binding to a MPUU, MPP, TPUU, TPP or CTPP concept.  The concept reference set specifying the list of permissible values is not yet available.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified – Use existing code sets until NEHTA determines a suitable common reference set.

### Usage

<b>Examples</b>	<ul style="list-style-type: none"> <li>paracetamol 500mg + codeine phosphate 30 mg tablet (MPUU – Medicinal Product Unit of Use)</li> <li>paracetamol 500mg + codeine phosphate 30 mg tablet, 20 (MPP – Medicinal Product Pack)</li> <li>Panadeine Forte tablet: uncoated, 20 tablets (TPP – Trade Product Pack)</li> <li>Panadeine Forte (paracetamol 500 mg + codeine phosphate 30mg) tablet: uncoated, 1 tablet (TPUU – Trade Product Unit of Use)</li> <li>Panadeine Forte tablet: uncoated, 20 tablets, blister pack (CTPP – Containered trade product pack)</li> <li>Bandage compression 10 cm x 3.5 m bandage: high stretch, 1 bandage (MPP – Medicinal Product Pack).</li> </ul>
-----------------	--

## Relationships

### Parent

Type	Name	Obligation	Condition	Occurrence
	ITEM DETAIL	Essential		Single

## 4.30 Medication Duration

### Identifications



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

### Definition


<b>Definition</b>	The length of time the course of medication has continued since it first commenced and should be continued by the subject of care.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	<p>This relates to the entire course of medication, not just the course which is the subject of the current prescription, and may therefore have a start date prior to the current prescription date if this is a repeat prescription.</p> <p>Capture of this data element may be helpful in the following circumstances:</p> <ul style="list-style-type: none"> <li>• Some medications may recommend that subjects of care on long term therapy should be reviewed on a regular basis to assess for any change in risk/benefit balance.</li> <li>• Some drugs may recommend a maximum length of time for which they should be continuously taken.</li> <li>• Legislation mandates that certain drugs (drugs of dependency) can only be made available for continuous use for a prescribed maximum period.</li> </ul> <p>The period of time may be expressed as a duration (e.g. 2 months) or as a time interval with a start and/or end date.</p>
<b>Datatype</b>	TimeInterval

### Usage

<b>Examples</b>	<ul style="list-style-type: none"> <li>• 2005 – 12/5/2008</li> <li>• 3 months</li> </ul>
-----------------	--

## Relationships

### Parent

Type	Name	Obligation	Condition	Occurrence
	ITEM DETAIL	Optional		Single

## 4.31 Quantity of Medication

### Identification

**T**

<b>Name</b>	Quantity of Medication
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-10145

### Definition


<b>Definition</b>	A statement of the total number of doses or physical amount of the prescribed therapeutic good that is supplied to the subject of care.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	Quantity of Medication Prescribed
<b>Notes</b>	<p>Current regulation requires that Schedule 8 drug prescriptions contain quantity in both numeric and in full text formats in paper prescription to prevent unauthorised alteration of the quantity.</p> <p>In the electronic environment, quantity recorded in only numeric format should suffice if security features are properly implemented.</p>
<b>Datatype</b>	Text

### Usage

<b>Examples</b>	<ul style="list-style-type: none"> <li>• If prescribing 2 packs of 20 tablets: '40 tablets'.</li> <li>• If prescribing 1 box of 10 vials of an injection (e.g. Injection 600 micrograms in 1 mL 10 Injection): '10 vials'.</li> </ul>
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
### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	ITEM DETAIL	Optional		Single

## 4.32 DOSAGE

### Identification

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

### Definition


<b>Definition</b>	Details of the amount of therapeutic substance/medicine to be administered to the subject of care at one time or during one continuous time interval.
<b>Source</b>	NEHTA
<b>Notes</b>	<p>This data group is used to provide details of dose instructions for medication administration. Instruction on use/administration of non-medication items can be recorded in text in the data element <a href="#">Prescribed Item Note</a>.</p> <p>The dosage data group in this release of the SDT is designed to support simple dosage instructions. Clinical input is being sought to modify the data group in order to support more complex dosing instructions such as variable and alternate dosing and multi-component medicines. This is an evolving process and will be supported by the development of an implementation guide outlining how the dosage group is to be implemented.</p> <p>In the meantime, implementers may be interested in reading information on the NHS Dose Syntax Model. <a href="#">[NHS2009]</a>. That model, whilst different to this data group, provides many similarities.</p>

### Relationships

#### Children

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

#### Parent

Type	Name	Obligation	Condition	Occurrence
	<a href="#">ITEM DETAIL</a>	Optional		Single

## 4.33 Dose Instruction

### Identification

T

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

### Definition


<b>Definition</b>	A description of the dose quantity, frequency and route instruction that determines how the prescribed therapeutic substance is intended to be correctly administered to/taken by the subject of care.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	Dosage instruction
<b>Notes</b>	<p>It should be ensured that the instructions for the Subject of Care are as specific as possible. For example, 'Take as directed', can be confusing and dangerous to the Subject of Care and is illegal in some states. <a href="#">[MA2009b]</a></p> <p><b>Scope:</b></p> <p>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.</p>
<b>Datatype</b>	Text

### Usage

<b>Examples</b>	<ul style="list-style-type: none"> <li>One tablet twice a day every 12 hours, before or with the first mouthful of food.</li> <li>Apply thin layer to affected area 3-4 times daily; reassess after 7 days if no response.</li> </ul>
-----------------	---

### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	DOSAGE	Essential		Single

## 4.34 BODY WEIGHT MEASUREMENT

### Identification

<b>Name</b>	BODY WEIGHT MEASUREMENT
<b>Metadata Type</b>	Data Group
<b>Identifier</b>	DG-15529
<b>Version</b>	3.0

### Definition




<b>Definition</b>	Details pertinent to the physical measurement of the weight (mass) of a Subject of Care's body.
<b>Source</b>	Adapted from AIHW/METeOR definition of 'body weight (measured) in Kilogram'
<b>Synonymous Names</b>	Body Weight
<b>Notes</b>	<p>The weight of a Subject of Care is a key observation used for dosage calculation for paediatric and chemotherapy prescriptions.</p> <p>Business Rules:</p> <p>For children 12 years old or younger a body weight must be recorded.</p>

### Usage


<b>Conditions of Use</b>	<p>This is a reuse of the OBSERVATION data group.</p> <p>On this reuse, the following constraints apply:</p> <ul style="list-style-type: none"> <li>• Observation Result: renamed to 'Body Weight'.</li> <li>• Reference Range: Occurrence changes from Single to Zero.</li> <li>• Observation Abnormal Indicator: Occurrence changes from Single to Zero.</li> <li>• Observation Note: Occurrence changes from Single to Zero.</li> <li>• DateTime of Observation: Obligation changes from Optional to Essential.</li> <li>• Information Provided By: Occurrence changes from Single to Zero.</li> <li>• Observer: Occurrence changes from Single to Zero.</li> </ul>
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### Relationships

#### Children

Type	Name	Obligation	Condition	Occurrence
 $T/T_{010}$	Observation Description	Essential		Single
	Body Weight Value	Essential		Single
	DateTime of Observation	Essential		Single
$T/T_{010}$	State of the Subject of Care	Optional		Multiple

**Parent**

Type	Name	Obligation	Condition	Occurrence
	ePrescription Detail	Optional		Single

## 4.35 Observation Description

### Identification

T/T<sub>010</sub>

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

### Definition


<b>Definition</b>	Descriptive text of the type of measurement or observation that is performed on the subject of care.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	The value of this data element should be 'Body Weight'.
<b>Datatype</b>	CodeableText

### Usage

<b>Examples</b>	Body Weight
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### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	BODY WEIGHT MEASUREMENT	Essential		Single

## 4.36 Body Weight Value

### Identification



<b>Name</b>	Body Weight Value
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15516

### Definition


<b>Definition</b>	The weight (body mass) of a person.
<b>Source</b>	Based on Australian Institute of Health and Welfare [AIHW2009]
<b>Synonymous Names</b>	Person weight
<b>Notes</b>	Includes the unit of measurement.
<b>Datatype</b>	Quantity

### Usage

<b>Examples</b>	<ul style="list-style-type: none"> <li>• 15.5 Kg</li> <li>• 2000 g</li> <li>• 110 lb</li> </ul>
-----------------	---


### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	BODY WEIGHT MEASUREMENT	Essential		Single

## 4.37 DateTime of Observation

### Identification

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

### Definition


<b>Definition</b>	The date (and optionally time) that an observation value is taken.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	DateTime of Body Weight Observation
<b>Notes</b>	This item must include a date component and may include a time component if it is known and relevant to record.
<b>Datatype</b>	DateTime

### Usage

<b>Examples</b>	See: <i>Data Specifications – Guide for Use</i> [ <a href="#">NEHT2009b</a> ]
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### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	<a href="#">BODY WEIGHT MEASUREMENT</a>	Essential		Single

## 4.38 State of the Subject of Care

### Identification

T/T<sub>010</sub>

<b>Name</b>	State of the Subject of Care
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16051

### Definition


<b>Definition</b>	Description of the physical and/or mental state of the Subject of Care when an observation is performed.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	In the context of body weight measurements, the State is used to describe the physical and/or mental status of the Subject of Care at the time when the measurement is taken. It provides the contextual information for determining the accuracy of the measurement taken.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified – Use existing code sets until NEHTA determines a suitable common reference set.

### Usage

<b>Examples</b>	<ul style="list-style-type: none"> <li>Fully clothed</li> <li>Diapers on only</li> <li>Subject of Care agitated and restless</li> <li>Standing without footwear</li> <li>Agitated</li> </ul>
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### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	BODY WEIGHT MEASUREMENT	Optional		Multiple

## 4.39 BODY HEIGHT MEASUREMENT

### Identification

Name	BODY HEIGHT MEASUREMENT
Metadata Type	Data Group
Identifier	DG-15529
Version	3.0

### Definition





<b>Definition</b>	Details pertinent to the physical measurement of the height <u>or</u> length of a Subject of Care's body.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	Body Length
<b>Notes</b>	The height of a subject of care enables derivation of Body Mass Index (BMI) which is a key observation that may be used for dosage calculation for certain medication prescription protocols, such as chemotherapy.

### Usage


<b>Conditions of Use</b>	<p>This is a reuse of the OBSERVATION data group.</p> <p>On this reuse, the following constraints apply:</p> <ul style="list-style-type: none"> <li>• Observation Result: Is renamed to Body Height</li> <li>• Reference Range: Occurrence changes from Single to Zero</li> <li>• Observation Abnormal Indicator: Occurrence changes from Single to Zero</li> <li>• Observation Note: Occurrence changes from Single to Zero</li> <li>• DateTime of Observation: Obligation changes from Optional to Essential</li> <li>• Information Provided By: Occurrence changes from Single to Zero</li> <li>• Observer: Occurrence changes from Single to Zero</li> </ul>
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## Relationships

### Children

Type	Name	Obligation	Condition	Occurrence
	Observation Description	Essential		Single
	Body Height Value	Essential		Single
	DateTime of Observation	Essential		Single
	State of the Subject of Care	Optional		Multiple

### Parent

Type	Name	Obligation	Condition	Occurrence
	ePrescription Detail	Optional		Single

## 4.40 Observation Description

### Identification

<b>T/T</b> <sub>010</sub>	<b>Name</b>	Observation Description
	<b>Metadata Type</b>	Data Element
	<b>Identifier</b>	DE-15515

### Definition


<b>Definition</b>	Descriptive text of the type of measurement or observation that is performed on the subject of care.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	
<b>Notes</b>	The value of this data element should be 'Body Height'.
<b>Datatype</b>	CodeableText

### Usage

<b>Examples</b>	Body Height
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### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	BODY HEIGHT MEASUREMENT	Essential		Single

## 4.41 Body Height Value

### Identification



<b>Name</b>	Body Height Value
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-15516

### Definition

<b>Definition</b>	The height or length of a person.
<b>Source</b>	Based on Australian Institute of Health and Welfare [AIHW2009]
<b>Synonymous Names</b>	Body Length Person height
<b>Notes</b>	Includes the unit of measurement. Using the synonym Body Length may indicate that the observation is for an infant or possibly someone who cannot stand for some reason.
<b>Datatype</b>	Quantity

### Usage

<b>Examples</b>	<ul style="list-style-type: none"> <li>• 1.20 m</li> <li>• 120 cm</li> <li>• 59 in</li> </ul>
-----------------	---


### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	BODY HEIGHT MEASUREMENT	Essential		Single

## 4.42 DateTime of Observation

### Identification

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

### Definition


<b>Definition</b>	The date (and optionally time) that an observation value is taken.
<b>Source</b>	NEHTA
<b>Synonymous Names</b>	DateTime of Height Observation
<b>Notes</b>	This item must include a date component and may include a time component if it is known and relevant to record.
<b>Datatype</b>	DateTime

### Usage

<b>Examples</b>	See: <i>Data Specifications – Guide for Use</i> [ <a href="#">NEHT2009b</a> ]
-----------------	---

### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	<a href="#">BODY HEIGHT MEASUREMENT</a>	Essential		Single

## 4.43 State of the Subject of Care

### Identification

T/T<sub>010</sub>

<b>Name</b>	State of the Subject of Care
<b>Metadata Type</b>	Data Element
<b>Identifier</b>	DE-16051

### Definition


<b>Definition</b>	Description of the physical and/or mental state of the Subject of Care when an observation is performed.
<b>Synonymous Names</b>	
<b>Notes</b>	In the context of body height measurements, the state is used to describe the physical and/or mental status of the Subject of Care at the time when the measurement is taken. It provides the contextual information for determining the accuracy of the measurement taken.
<b>Datatype</b>	CodeableText
<b>Value Domain</b>	Not specified – Use existing code sets until NEHTA determines a suitable common reference set.

### Usage

<b>Examples</b>	<ul style="list-style-type: none"> <li>• Supine position</li> <li>• Standing without footwear</li> <li>• Agitated</li> </ul>
-----------------	--

### Relationships

#### Parent

Type	Name	Obligation	Condition	Occurrence
	BODY HEIGHT MEASUREMENT	Optional		Multiple

## 5 UML Diagram

The overall structure of all structured document templates is described in *NEHTA Data Specification and Structured Document Templates Guide for Use* [[NEHT2009b](#)].

This section contains a UML 2.0 class diagram of the detail part of the structured document template.

Class diagrams for the standard document header are found in *Document Header Data Specification* [[NEHT2009a](#)]. Class diagrams for participation are found in *Participation Data Specification* [[NEHT2009c](#)].

The following diagram represents the data elements with their names, data types, multiplicities and groupings into data groups. Data elements are modelled as attributes and data groups as classes. Participation data groups are modelled with all of their attributes suppressed; this is to simplify the diagram.



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# 7 Appendix A. Known Issues

This appendix lists known issues for this document. The identified issues will be addressed in subsequent releases.

Reference	Description
<a href="#">ePrescription Header</a> , <a href="#">ePrescription Detail</a>	The uses of the participation data groups SUBJECT OF CARE, FACILITY, DOCUMENT AUTHOR, DOCUMENT RECIPIENT, PRESCRIPTION NOTE AUTHOR and PRESCRIBED ITEM NOTE AUTHOR need to be added.
<a href="#">PRESCRIPTION NOTE DETAIL</a> , <a href="#">PRESCRIBED ITEM NOTE DETAIL</a>	All multiple occurring data groups and data elements are implicitly ordered (see the 'Guide for Use' in <a href="#">[NEHT2009b]</a> , page 15). As such it is the responsibility of the sender to insert the items into the document in the correct order and the receiver to extract them in the correct order. However, we are concerned that this mechanism may not have sufficient clinical safety in the case of the NOTES data group. Consequently we are investigating changes to the mechanism to further reduce the risk that items in lists may be ordered incorrectly.

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