



Shared Health Summary

CDA Implementation Guide

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1 Introduction

This implementation guide is an [HL7 Clinical Document Architecture \[HL7CDAR2\]](#) specification to represent a Shared Health Summary. A shared health summary is a record, authored by a practitioner, that contains key summaries of an individual's health information and status that is useful to a wide range of practitioners in delivering care.

1.1 Document purpose and scope

The primary aim of the implementation guide is to take implementers step by step through mapping each element of the Shared Health Summary (SHS) model ([Shared Health Summary FHIR Implementation Guide \[DH2020i\]](#)) to a corresponding CDA attribute or element. The resulting CDA document can be used for the electronic exchange of SHS information between healthcare providers.

This implementation guide is not to be used as a guide to presentation (or rendering) of the data. Beyond defining conformance requirements on CDA narratives it contains no information as to how the data described by it should be displayed and no such guidance should be inferred from This implementation guide.

Reference has been made to International and Australian Standards, and to Standards from Health Level Seven. The following standard is referred to in the text in such a way that some or all of its content constitutes requirements for the purposes of this specification: [HL7 Clinical Document Architecture \[HL7CDAR2\]](#).

Wherever possible, material in this specification is based on existing standards. All efforts have been made to minimise divergence from the HL7 Australia profiles of HL7 International standards ([Australian Base Implementation Guide \(AU Base 1.1.1\) \[HL7AUF3B2\]](#)) to provide for system interoperability and compatibility with other profiles. Issues of an editorial nature in the source material (such as spelling or punctuation errors) are intentionally reproduced.

1.2 Context and use

A CDA implementation guide is part of a package of documents and files that support the development of software to exchange a type of clinical document, an end-product clinical specification package.

An Agency end-product clinical specification package supports software developers to create and interpret instances of a clinical document. The core of each package is a specification of the information content of instances of the clinical document.

Supplementary contents of the package include statements of scenarios for which the specification is appropriate, guidance on implementing the specification, and guidance on testing purported instances.

The contents may include:

- statement of requirements
- CDA implementation guide – a statement of constraints and custom extensions on [HL7 Clinical Document Architecture \[HL7CDAR2\]](#)
- FHIR implementation guide – a statement of constraints and custom extensions on [FHIR Release 3 \(STU\) \[HL7FHIR3\]](#)
- template package library – a set of Schematron schema to test conformance of CDA documents with the specification
- conformance profile – a statement of conformance requirements for exchanging documents within a particular scenario such as the My Health Record
- release notes

Clinical specification packages contain only files relevant to the particular clinical document. Specifications that are common to many clinical documents and should be considered part of the specification package, as directed by the relevant release note and conformance profile, are contained in the [Common - Clinical Document \[DH2019a\]](#).

1.3 How to read this document

This implementation guide contains descriptions of both constraints on HL7 CDA and, where necessary, custom extensions to the HL7 CDA, for the purposes of fulfilling the requirements for Australian implementations of shared health summaries. These constraints are defined as a set of templates.

For implementers, the starting point for the CDA templates is [ClinicalDocument \(Shared Health Summary\)](#), which references the additional templates necessary to assert conformance for this implementation guide.

Chapters that may be of primary interest are organised as follow:

- [3 Conformance](#) - defines the conformance requirements applicable to a clinical document instance claiming conformance to a ClinicalDocument template defined in this implementation guide or any derived conformance profile.
- [4 Shared Health Summary hierarchy](#) - hierarchical overview of the model for this document-level usage scenario.
- [5 CDA Header templates](#) - contains the CDA Header templates that apply across all of the supported usage scenarios in this implementation guide.
- [6 Document CDA templates](#) - defines the ClinicalDocument template for each logical model of a document-level usage scenario, e.g. Shared Health Summary, in this implementation guide.
- [7 Section CDA templates](#) - defines the section templates referenced by a ClinicalDocument template in this implementation guide.
- [8 Participation CDA templates](#) - defines the templates for individuals and organisations, called participations, referenced by other templates in this implementation guide.
- [9 Entity CDA templates](#) - defines the templates for entities referenced by a participation template in this implementation guide.
- [10 Act CDA templates](#) - defines the templates for entry-level classes, called acts, referenced by other templates in this implementation guide.
- [Appendix B, Examples](#) - provides examples demonstrating a document-level usage model, e.g. Shared Health Summary, and that conform to the CDA templates defined in this implementation guide.

1.4 Editorial note

This implementation guide is an early working specification that is available for comment and review. It may be used to solicit feedback and to provide insight as to the expected content in a forthcoming stable and approved version of the specification.

This implementation guide may not be considered to be complete enough or sufficiently reviewed to be safe for implementation and use in production systems. It may have known issues and still be in development.

It is intended to supersede [Shared Health Summary Structured Content Specification \[NEHT2015d\]](#) and [Shared Health Summary CDA Implementation Guide \[NEHT2015c\]](#). This new, backwards incompatible version, is intended to address alignment to HL7 FHIR and is the result of work undertaken in conjunction with HL7 Australia.

1.5 Intended audience

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

This implementation guide and related artefacts are technical in nature and the audience is expected to be familiar with the language of health data specifications and to have some familiarity with health information standards and specifications, such

as [HL7 Clinical Document Architecture \[HL7CDAR2\]](#) and Standards Australia IT-014 documents. Definitions and examples are provided to clarify relevant terminology usage and intent.

1.6 Known issues

This section lists known issues with this specification at the time of publishing. We are working on solutions to these issues and encourage comments to help us develop these solutions.

Reference	Description
Placeholder logical type icons	<p>There is ongoing discussion on the use of icons as a visual aid denoting different logical types in a hierarchical view in implementation guides.</p> <p>Feedback on the work in progress FHIR-driven CDA implementation guides has included consistent feedback that a logical hierarchy with icons was a key piece of informative material – the old NEHTA developed logical data types had their own icons, FHIR does not provide a similar type of icons for its types so this would need to be a piece of work to develop a set of meaningful icons to be used in a FHIR logical hierarchy in the CDA implementation guides.</p> <p>In the interim a placeholder set of icons from the Digital Health Icon Library v1.0 have been used in this implementation guide (and some others) to elicit further feedback and provide a baseline from which a useful set of icons may be developed.</p>
Source material errors	<p>Material in this specification is based on existing standards and all efforts have been made to minimise divergence. Issues of an editorial nature in the source material (such as spelling or punctuation errors in an element description) are intentionally reproduced.</p>
Shared Health Summary CDA implementation guide roadmap	<p>The objective of this specification is to provide guidance on the implementation in HL7 CDA Release 2 of shared health summary documents (defined in HL7 FHIR).</p> <p>The current guide covers implementation in HL7 CDA Release 2 of the shared health summary model defined in FHIR Release 3 (STU) (Shared Health Summary FHIR Implementation Guide [DH2020i]).</p> <p>The model is in transition to a FHIR Release 4 representation in collaboration with HL7 Australia. This move has normative implications to the CDA representation that are expected to result in major version incrementation to accommodate backwards incompatible changes. Widespread changes to terminology, including code system and value set identifiers, are expected to make up the bulk of the backwards incompatible changes. Where possible, FHIR Release 4 terminology has been pre-adopted in this implementation guide.</p>
PractitionerRole > healthcareService	<p>PractitionerRole > healthcareService is not currently mapped into CDA. Future releases of this implementation guide are expected to include a CDA template for the concept of a HealthcareService.</p>
AllergyIntolerance > onset[x]	<p>onset[x] as a Range is not currently mapped to CDA. Future releases of this implementation guide are expected to include one or more mappings to support a Range.</p>
Resolving URLs to Agency logical models (FHIR profiles) – not available	<p>Direct links to the Agency logical models (published as FHIR profiles) referenced throughout this implementation guide are not available. It is intended that logical models, e.g. “Patient with Mandatory Identifier”, will be published at a resolvable address. Future releases of this implementation guide are expected to hyperlink all references to logical models.</p> <p>At this time the Agency logical models are only available via the Shared Health Summary FHIR Implementation Guide [DH2020i].</p>

Reference	Description
PBS Medicine Item Codes	The PBS Medicines Item Codes value set, originating from the HL7 AU Base Medication profile, is a placeholder resource. Forthcoming work is expected to result in an authoritative value set published in the National Clinical Terminology Service (NCTS) with the following canonical URL: https://healthterminologies.gov.au/fhir/ValueSet/australian-pbs-item-1 . Implementers are to make use of the value set served via the NCTS when available.
GTIN for Medicines	No expansion is available for this value set using the associated code system published in the HL7 AU Base material. None of the concepts defined by the code system are included in the code system resource. Implementers are expected to have available an expansion that defines what codes are in the value sets to make use of this terminology.
MIMS Terminology	No expansion is available for this value set using the associated code system published in the HL7 AU Base material. None of the concepts defined by the code system are included in the code system resource. Implementers are expected to have available an expansion that defines what codes are in the value sets to make use of this terminology.
Appendix B. Examples	Alignment with examples between the CDA-IG and FHIR-IG is not yet complete.

2 Guidance

2.1 Clinical Document Architecture Release 2

A CDA document is an XML document built following the rules described in the CDA specification, which conforms to the HL7 CDA schema provided by HL7. The CDA document is based on the semantics provided by the HL7 V3 RIM, Data types and Vocabulary standards [\[HL7V3\]](#).

A CDA document has two main parts: the header and the body.

The CDA document header is consistent across all CDA documents, regardless of document type. The header identifies and classifies the document and provides information on authentication, the encounter, the patient, and the involved providers.

The body contains the clinical report. The body can be marked-up text (narrative, renderable text) or a combination of both marked-up text and structured data. The marked-up text can be transformed to XHTML and displayed to a human. The structured data allows machine processing of the information shown in the narrative section.

All clinical information is required to be marked up in CDA narratives. These narratives are CDA-defined hypertext, able to be rendered in web browsers with only a standard accompanying transformation. This transformation is produced and distributed by HL7.

The rendered narrative can stand alone as a source of authenticated information for consuming parties. Content from the CDA body is not to be omitted from the narrative.

Further information and conformance requirements on the CDA narrative is available in [CDA narrative conformance requirements](#).

The following references are recommended to gain a better understanding of CDA:

- [HL7 Clinical Document Architecture \[HL7CDAR2\]](#)
- [HL7 Version 3 Standard \[HL7V3\]](#)
- [CDA Examples \[RING2009\]](#)
- [CDA Validation Tools: infoway_release_2_2X_18.zip \[INFO2009\]](#)

2.2 Australian Digital Health Agency CDA extensions

As part of the CDA, standard extensions are allowed as follows:

Locally-defined markup may be used when local semantics have no corresponding representation in the CDA specification. CDA seeks to standardize the highest level of shared meaning while providing a clean and standard mechanism for tagging meaning that is not shared. In order to support local extensibility requirements, it is permitted to include additional XML elements and attributes that are not included in the CDA schema. These extensions should not change the meaning of any of the standard data items, and receivers must be able to safely ignore these elements. Document recipients must be able to faithfully render the CDA document while ignoring extensions.

Extensions may be included in the instance in a namespace other than the HL7v3 namespace, but must not be included within an element of type ED (e.g., <text> within <procedure>) since the contents of an ED datatype within the conformant document may be in a different namespace. Since all conformant content (outside of elements of type ED) is in the HL7 namespace, the sender can put any extension content into a foreign namespace (any namespace other than the HL7 namespace). Receiving systems must not report an error if such extensions are present. [HL7 Clinical Document Architecture \[HL7CDAR2\]](#)

A number of extensions to CDA have been defined in this implementation guide. To maintain consistency, the same development paradigm has been used as CDA.

These Australian Digital Health Agency CDA extensions have been added to the Australian Digital Health Agency CDA schema and are incorporated in the namespace <http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0> as shown in [Appendix B, Examples](#). Future versions of CDA extensions will be versioned as per the following example:

<http://ns.electronichealth.net.au/Ci/Cda/Extensions/4.0>

The Australian Digital Health Agency CDA schema therefore differs from the base HL7 CDA W3C XML schema (referred to in this implementation guide as the HL7 CDA schema). CDA documents which include extensions will fail to validate against the HL7 CDA schema – this is a known limitation.

A shared health summary document that conforms to this specification will validate against the Australian Digital Health Agency CDA schema that accompanies this specification, and will validate against the HL7 CDA schema once the extensions have been removed. Note that merely passing schema validation does not ensure conformance. For more information, refer to [Base conformance requirements](#).

2.3 Conformance conventions

This implementation guide specifies the CDA templates for implementing a shared health summary. A CDA template is a set of constraints, and where necessary, custom extensions to [HL7 Clinical Document Architecture \[HL7CDAR2\]](#), expressed using conformance conventions as defined in this implementation guide.

CDA templates are presented in a CDA mapping table (see [Mapping presentation and structure](#)) and indicated by the presence of a templateId (see [Template identifiers](#)).

2.3.1 Template identifiers

Template identifiers (`templateId`) are unique to each CDA template. When valued in an instance, the template identifier signals the assertion of conformance to a set of template-defined constraints. The root value of this element (e.g. `@root = "1.2.36.1.2001.1001.100.1002.226"`) provides a unique identifier for the template in question.

The following example demonstrates assertion of conformance to two CDA templates. This use of `templateId` indicates that the CDA instance not only conforms to the CDA specification, but in addition, conforms to two templates.

Example 2.1. Use of `templateId` to assert conformance to two CDA templates

```
<ClinicalDocument classCode="DOCCLIN" moodCode="EVN" xmlns="urn:hl7-org:v3" xmlns:ex="urn:hl7-org/v3-example"
xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
  <typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>
  <!-- ClinicalDocument templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100033"/>
  <!-- ClinicalDocument (Shared Medicines List Authored by Practitioner) templateId-->
  <templateId root="1.2.36.1.2001.1001.102.101.100065"/>
  ...
</ClinicalDocument>
```

2.3.2 Open and closed templates

A CDA template may be either an open template or a closed template:

- In an open template all of the features of the CDA R2 base specification [[HL7CDAR2](#)] are allowed except as constrained by explicitly specified constraints.
- In a closed template everything that is allowed must be explicitly specified and nothing further may be allowed.

The template context in this implementation guide is that of an open template unless otherwise stated. A closed template is indicated by the presence of the following constraint:

This template **SHALL** be a closed template

For example if a CDA template says nothing about the use of the `id` element:

- In an open template context this means that `id` is allowed as specified in the schema
- In a closed template context this means that no use of `id` is allowed

Example 2.2. CDA mapping fragment - Interpreting an open template for logical elements

Logical element	Logical element description	Logic-al card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements		Context: /			
Composition	A clinical document written by the nominated provider, which contains key pieces of information about an individual's health status and is useful to a wide range of providers in assessing individuals and delivering care.	0..*	Composition	ClinicalDocument	In CDA the maximum occurrences of ClinicalDocument is 1. Although the model indicates that Composition is 0..*, in a CDA implementation this is limited to 0..1. In addition to the template defined in this mapping table, ClinicalDocument SHALL conform to the template defined in ClinicalDocument.
				ClinicalDocument/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				ClinicalDocument/templateId/@root="1.2.36.1.2001.1001.102.101.100020"	
Composition > section (Event Overview)	Summary information concerning the event.	1..1	BackboneElement	ClinicalDocument/component/structuredBody/component[event]	section SHALL conform to the template defined in section (Event Overview).
				ClinicalDocument/component/structuredBody/component[event]/section	
Composition > section (Allergies)	Information about allergies or intolerances identified or reported during this encounter. This may include statements that a patient does not have an allergy or category of allergies.	0..1	BackboneElement	ClinicalDocument/component/structuredBody/component[allergy]	section SHALL conform to the template defined in section (Allergies).
				ClinicalDocument/component/structuredBody/component[allergy]/section	

The above template fragment states that each instance of the logical element Composition is represented as a ClinicalDocument that:

- explicitly requires an instance of templateId with a root that conforms to the fixed value constraint and an instance of extension that conforms to the fixed value constraint. Other attributes of templateId, e.g. assigningAuthorityName, are implicitly allowed.
- implicitly allows any other child attributes or elements of ClinicalDocument including other instances of templateId.
- explicitly requires exactly one component with an instance of section that conforms to section (Event Overview) [templateId: 1.2.36.1.2001.1001.102.101.100059]. Other component elements or attributes are implicitly allowed.
- explicitly allows at most one component with an instance of section that conforms to section (Allergies) [templateId: 1.2.36.1.2001.1001.102.101.100069]. Other component elements or attributes are implicitly allowed.
- implicitly allows one or more instances of a component with a section that does not conform to either section (Event Overview) [templateId: 1.2.36.1.2001.1001.102.101.100059] or section (Allergies) [templateId: 1.2.36.1.2001.1001.102.101.100069].

2.3.3 Fixed value constraint

A fixed value constraint is used to bind the value of an element or attribute to the exact string as presented between the quote marks (i.e. "FIXED_VALUE"). This type of constraint is frequently used in a template to cast an element to a particular data type, or bind an element of type Coded Simple (CS) to a single code, or fix an attribute of a primitive type to a value.

A fixed value constraint in the "CDA schema element" column of a CDA mapping table will use [XPath like notation](#), for example:

```
/ClinicalDocument/confidentialityCode/@nullFlavor="N/A"
```

The use of "=" is to be interpreted as **SHALL**. The above example specifies a conformance requirement that the nullFlavor attribute **SHALL** be instantiated as "N/A".

A fixed value constraint in the "CDA constraints and comments" column of a CDA mapping table will make use of [Conformance verbs](#), for example:

```
displayName SHOULD be "Closing the Gap Copayment Eligibility Indicator"
```

2.3.4 XPath like notation

This implementation guide uses an XML Path Language (XPath) like notation to identify the CDA schema element(s) to which conformance requirements are applied.

This notation provides a mechanism that will be familiar to developers for identifying parts of an XML document. XPath syntax selects nodes from an XML document using a path containing the context of the node(s). The path is constructed from node names and attribute names (prefixed by a "@") and catenated with a "/" symbol. In addition an [index] is used to differentiate similar mappings e.g. participant[location] and participant[author].

The syntax is: {/name{[index]}}n

Where:

- {} indicates optional
- {}n means a section that may repeat
- [index] differentiates two similar mappings and indicates that a pattern 'like this' is to be applied (see [Interpreting cardinality in a CDA mapping table for logical elements](#))

An index after the name, such as component[admin_obs] or entry[close_gap] implies that there are expected to be two or more different component elements and entry elements instantiated in the ClinicalDocument instance. The indexes differentiate which CDA schema element is referenced in the path.

The value attribute of the value element from the below example could be referred to with the path /ClinicalDocument/component/structuredBody/component[admin_obs]/section/entry[close_gap]/observation/value/@value.

Example 2.3. XPath like notation

```
<ClinicalDocument xmlns="urn:hl7-org:v3" xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
  xmlns:xs="http://www.w3.org/2001/XMLSchema" xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
  ...
  <component>
    <structuredBody>
      <component>
        <component>
          <section>
            <templateId root="1.2.36.1.2001.1001.102.101.100000"/>
            <code code="102.16080" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Administrative Observations"/>
            <title>Administrative Observations</title>
            <entry>
              <observation classCode="OBS" moodCode="EVN">
                <code codeSystem="1.2.36.1.2001.1001.101" code="103.32011" displayName="Closing the Gap Copayment Eligibility Indicator" />
                <value xsi:type="BL" value="true"/>
              </observation>
            </entry>
          ...
        </section>
      </component>
    </structuredBody>
  </component>
</ClinicalDocument>
```

The corresponding entries in the CDA schema element column of a CDA mapping table for /ClinicalDocument/component/structuredBody/component[admin_obs]/section/entry[close_gap]/observation/value could be expressed using the XPath like notation as in the template fragment below.

Example 2.4. CDA mapping fragment - XPath like notation

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements				Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section	
Patient > closing-the-gap-registration	Indication for eligibility for the Closing the Gap program.	0..1	boolean	entry[close_gap]	The containing component[admin_obs]/section SHALL conform to the template defined in component (Administrative Observations) .
				entry[close_gap]/observation	
				entry[close_gap]/observation/@classCode="OBS"	
				entry[close_gap]/observation/@moodCode="EVN"	
				entry[close_gap]/observation/code	
				entry[close_gap]/observation/code/@code="103.32011"	NCTIS Data Components
				entry[close_gap]/observation/code/@codeSystem="1.2.36.1.2001.1001.101"	
				entry[close_gap]/observation/code/@displayName	displayName SHOULD be "Closing the Gap Copayment Eligibility Indicator".
				entry[close_gap]/observation/value	closing-the-gap-registration is "true" if eligible for Closing the Gap co-payment. value/@xsi:type SHALL be "BL".

2.3.5 Terminology binding

Vocabulary is specified in this implementation guide as:

- [Fixed value constraint](#) if only one permissible value is allowed, or
- Binding to a value set if more than one permissible value is allowed, e.g. [Medication Act Status HL7 v3 \(required\)](#)

Where used in this implementation guide, binding strengths are hyperlinked to their normative definition. An excerpt is provided in the below table for ease of use, where there are conflicts the target normative definition in [FHIR Release 3 \(STU\) \[HL7FHIR3\]](#) applies.

Binding strength	Description
required	To be conformant, codes in this element SHALL be from the specified value set.
extensible	To be conformant, codes in this element SHALL be from the specified value set if any of the codes within the value set can apply to the concept being communicated.
preferred	Instances are encouraged to draw from the specified codes for interoperability purposes but are not required to do so to be considered conformant.
example	Instances are not expected or even encouraged to draw from the specified value set. The value set merely provides examples of the types of concepts intended to be included.

Terminology binding notation

A value set binding will be specified in the "CDA constraints and comments" column of a CDA mapping table as the title of the value set (hyperlinked to its definition) followed by identification of the [binding strength](#) (hyperlinked to its definition). For example:

[Encounter Act Status HL7 v3 \(required\)](#)

In simple terms the above required binding indicates that the CDA schema element **SHALL** be valued with one of the codes from that value set. However valuing of an element in CDA is always in the context of the data type and the code system specification (e.g. case sensitive or version required).

Example of interpreting a required terminology binding on an element of type Coded Simple Value (CS)

A Coded Simple Value data type, or CS is defined in the HL7 V3 Data types standards [HL7V3]. It is the simplest form of coded data and consists only of a code, other attributes are prohibited. The code system and code system version are fixed by the context in which CS value occurs. Common instances typed as CS include statusCode, @classCode, @moodCode, and @nullFlavor which have HL7-defined value sets.

For example, [Encounter Act Status HL7 v3 \(required\)](#), applied to a encounter/statusCode element is to be interpreted as:

- statusCode/@code **SHALL** be present and **SHALL** contain a code from [Encounter Act Status HL7 v3](#)
- statusCode/@nullFlavor **SHALL NOT** be present as no meaningful value can be supplied
- no other attributes can be supplied as encounter/statusCode is of type Coded Simple (CS) which prohibits additional attributes

Example 2.5. Interpreting required value set binding

```
<statusCode code="active" />
```

Example of interpreting a required terminology binding on an element of type Concept Descriptor (CD)

A Concept Descriptor data type, or CD, is defined in the HL7 V3 Data types standards [HL7V3]. It is a reference to a concept defined in a code system. Common instances typed as CD include code, and value when typed to CD.

For example, [Encounter Act Status HL7 v3 \(required\)](#) applied to an observation/code is to be interpreted as:

- code/@code **SHALL** be present and **SHALL** contain a code from [Encounter Act Status HL7 v3](#)
- code/@codeSystem="2.16.840.1.113883.5.14" **SHALL** be present
- code/@nullFlavor **SHALL NOT** be present as no meaningful value can be supplied
- code/@displayName **SHOULD** be present and **SHOULD** contain the display associated with the selected code from the value set
- code/@codeSystemName **SHOULD** be present and **SHOULD** contain the display associated with the code system as it is registered with a registration authority such as HL7
- code/@originalText **SHOULD** be present and **SHOULD** carry the full text associated with this code as selected by, typed by, or displayed to the author
- code/@qualifier **SHALL NOT** be present as the example code system does not define qualifier values

- code/@translation **MAY** be present if an alternative terminology is in use in the sending system and a translation is available

Example 2.6. Interpreting required value set binding

```
<code code="active" codeSystem="2.16.840.1.113883.5.14" />  
<!-- or -->  
<code code="active" codeSystem="2.16.840.1.113883.5.14"  
codeSystemName="v3.ActStatus" displayName="active"/>  
<!-- or -->  
<code code="active" codeSystem="2.16.840.1.113883.5.14"  
codeSystemName="v3.ActStatus" displayName="active">  
  <originalText>Active</originalText>  
</code>
```

2.3.6 Conformance verbs

Where used in this implementation guide, the keywords **SHALL**, **SHOULD**, **MAY**, **SHALL NOT** and **SHOULD NOT** from [Key Words for Use in RFCs to Indicate Requirement Levels \[RFC2119\]](#) are to be interpreted as described in the table below.

Conformance verb	Interpretation
SHALL	<p>An absolute requirement.</p> <p>Where SHALL appears in any conformance constraint it indicates a mandatory requirement.</p> <p>Where SHALL is applied to the occurrences of an element or attribute then that element or attribute must be present but can be null if the value is not known and the value has not been constrained to not allow a null value.</p>
SHOULD	<p>A requirement that is considered best practice or recommendation for inclusion. There may be valid reasons to ignore an item, but the full implications must be understood and carefully weighed before choosing a different course.</p> <p>Where SHOULD appears in a conformance constraint that constrains the allowed occurrences of an item it indicates that the item may not be present but does not override the upper bound of the cardinality range.</p> <p>For a sending application where SHOULD is applied to the occurrences of an item then that item must be present if a sending application has the data for that data element. If the value is not known the element or attribute does not need to be included.</p> <p>Implementers must support an optional requirement.</p>
MAY	<p>A requirement that can be included or omitted as the author decides with no implications.</p> <p>Where MAY appears in a conformance constraint that constrains the allowed occurrences of an item it indicates that the item may not be present but does not override the upper bound of the cardinality range.</p> <p>Implementers must support an optional requirement.</p>
SHALL NOT	<p>An absolute prohibition.</p> <p>Where SHALL NOT appears in any conformance constraint it indicates a mandatory prohibition requirement.</p>

Conformance verb	Interpretation
SHOULD NOT	<p>A requirement that is considered best practice or recommendation against inclusion. There may be valid reasons to ignore an item, but the full implications must be understood and carefully weighed before choosing a different course.</p> <p>Where SHOULD NOT appears in a conformance constraint that constrains the allowed occurrences of an item it indicates that the item may not be present but does not override the upper bound of the cardinality range.</p> <p>For a sending application where SHOULD NOT is applied to the occurrences of an item then that element or attribute must be present if a sending application has the data for that data element. If the value is not known the element or attribute does not need to be included.</p> <p>Implementers must support an optional requirement.</p>

2.3.7 Cardinality notation

The cardinality range specifies the allowable occurrences in the format "m..n" where m is the minimum allowed members of the set (lower bound) and n is the maximum allowed members of the set (upper bound). The allowed values for m and n are 0, any positive integer, and *.

The table below demonstrates a representative set of examples of cardinality range and how to interpret that cardinality range; p is positive integer greater than the minimum allowed members of the set.

Cardinality range	Interpretation
0..0	zero (explicitly prohibited)
0..1	zero or one
1..1	exactly one
0..*	zero or more
1..*	at least one
2..*	at least two
1..p	at least one and not more than p
2..p	at least two and not more than p

2.3.8 Interpreting cardinality in a CDA mapping table for logical elements

A CDA mapping table for logical elements will include a logical cardinality range for each logical element and a series of CDA schema elements that when instantiated are considered to be the CDA representation of that logical element.

In order to instantiate a logical element all CDA schema elements mapped to that logical element are to be instantiated unless a constraint is present in the mapping table to indicate otherwise. This means that while the first CDA schema element in a series has a comparative relationship to the logical cardinality, the effect on the additional CDA schema elements in a series is always that their minimum occurrence is to be interpreted as 1.

The logical cardinality is applied to the first mapped CDA schema element in a series in the following manner:

- The most strict minimum occurrence between the logical cardinality or the CDA schema cardinality is applied.
 - If a logical element has a minimum cardinality of 1 and the mapped CDA schema element has a minimum cardinality of 0 then the most strict cardinality of 1 applies to that CDA schema element.
- A CDA schema element with an [index] (see [XPath like notation](#)), e.g. `representedOrganization/name[business]`, has the maximum occurrence of the logical element applied as a pattern 'like this'.
 - For example, if the logical cardinality of Organization > name is 0..1 and that logical element is mapped to `representedOrganization/name[business] = "TestOrg"` (CDA schema cardinality of 0..*), then a maximum of one instance of `representedOrganization/name` that has a value of "TestOrg" may be present. Other instances of `representedOrganization/name` that do not meet the pattern of "TestOrg" may be present.
- A CDA schema element with no [index] (see [XPath like notation](#)), e.g. `representedOrganization/name`, has the most strict maximum occurrence between the logical cardinality or the CDA schema cardinality applied.
 - For example, if the logical cardinality of Organization > name is 0..1 and that logical element is mapped to `representedOrganization/name` (CDA schema cardinality of 0..*), then the most strict cardinality of 1 applies to that CDA schema element.

Example 2.7. CDA mapping fragment - Interpreting cardinality in a CDA mapping table for logical elements

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Body Level 3 Data Elements					
<code>section</code>	A set of allergies or intolerances that have been categorised as critical.	Cardinality comes from linking element	BackboneElement	<code>section</code>	section/@nullFlavor SHALL NOT be present.
				<code>section/templatelid</code>	
				<code>section/templatelid/@root="1.2.36.1.2001.1001.102.101.100092"</code>	

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
section > title	The label for this particular section. This will be part of the rendered content for the document, and is often used to build a table of contents.	1..1	string	section/title	
section > code	A code identifying the kind of content contained within the section. This must be consistent with the section title.	1..1	CodeableConcept	section/code	
				section/code/@code="48765-2"	
				section/code/@codeSystem="2.16.840.1.113883.6.1"	LOINC
				section/code/@displayName	displayName SHOULD be "Allergies &or adverse reactions".
section > text	A human-readable narrative that contains the attested content of the section, used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it 'clinically safe' for a human to just read the narrative.	1..1	Narrative	section/text	
section > entry	A reference to the actual resource from which the narrative in the section is derived.	1..*	Reference (Summary Statement of Allergy or Intolerance)	section/entry[adv]	observation SHALL conform to the template defined in observation (Critical Allergy or Intolerance).
				section/entry[adv]/observation	

The above template fragment states that each instance of the logical element section is represented as a section with:

- section attributes that are not nullFlavor (e.g. classCode) are allowed as defined in the CDA schema as long as conformance to [Base conformance requirements](#) is maintained.
- One templateId with a root="1.2.36.1.2001.1001.102.101.100092". Additional instances of templateId are allowed.
- Exactly one title.
- Exactly one code with a code="48765-2" and a codeSystem="2.16.840.1.113883.6.1" and a displayName.
- At least one entry[adv]/observation that conforms to the template observation (Summary Statement of Allergy or Intolerance) [templateId: 1.2.36.1.2001.1001.102.101.100093]. Additional instances of entry that do not contain an observation are allowed.
- Additional section elements (e.g. author) are allowed as defined in the CDA schema as long as conformance to [Base conformance requirements](#) is maintained.

Example 2.8. Interpreting cardinality in a CDA mapping table for logical elements

```
<clinicalDocument xmlns="urn:hl7-org:v3" xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
  xmlns:xs="http://www.w3.org/2001/XMLSchema" xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
  ...
  <component>
    <structuredBody>
      ...
      <!-- section (Allergies) -->
      <component>
        <section>
```

```
<templateId root="1.2.36.1.2001.1001.102.101.100092"/>
<code code="48765-2" codeSystem="2.16.840.1.113883.6.1" displayName="Allergies &or adverse reactions"/>
<title>Critical Allergies and Adverse Reactions</title>
<text mediaType="text/x-hl7-text+xml">Allergy to Latex (CRITICAL)</text>
...
<!--section entry -->
<entry typeCode="DRIV">
  <observation classCode="OBS" moodCode="EVN">
    <templateId root="1.2.36.1.2001.1001.102.101.100093"/>
    ...
  </observation>
</entry>
</section>
</component>
...
</ClinicalDocument>
```

2.4 Mapping presentation and structure

The CDA templates described in this implementation guide are presented in table format and will be either:

- a mapping of each logical element of the logical model (i.e. profiled FHIR resources published in [Shared Health Summary FHIR Implementation Guide \[DH2020I\]](#)) to a corresponding CDA attribute or element, or
- a set of CDA attributes or elements with specified infrastructure or control requirements that are not sourced from the logical model but are necessary for supporting the usage scenarios in a CDA implementation.

CDA templates mapping logical elements are roughly grouped by HL7 Reference Information Model (RIM) class within a templates chapter, e.g. [8 Participation CDA templates](#).

The heading for each child section identifies the CDA schema element that is templated, and may also identify the name of part of the logical model that the template corresponds to, e.g. recordTarget (My Health Record Patient) defines the CDA template of the recordTarget CDA schema element to represent the logical model My Health Record Patient.

2.4.1 Legend - CDA mapping table for logical elements

A CDA mapping table for logical elements aims to take implementers step by step through mapping each element of the logical model to a corresponding CDA attribute or element. The following section describes in more detail the fields used to present the mapping content in this implementation guide.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA conformance level , e.g. CDA Header, CDA Body Level 3 Data Elements					Context: The root context that is applied as a prefix to the CDA schema element paths in the mapping rows below
The logical hierarchical path in the logical model expressed using names of the elements in the logical model. If there is a name in round brackets after the path, this is the label for that element or resource. The text in bold (the last in the path) is the subject for this row in the convention <Parent (Label)> > <Child (Label)>, e.g. Composition > section (Allergies)	The description of the element in the logical model.	<p>The cardinality of the logical element in the logical model (see Cardinality notation).</p> <p>The root element of each template will typically express an inherited cardinality from the parent element in a parent template by stating:</p> <p style="padding-left: 20px;">Cardinality comes from linking element</p> <p>A logical cardinality is applied to the mapped CDA schema elements as described in Interpreting cardinality in a CDA mapping table for logical elements:</p> <ul style="list-style-type: none"> • The most strict minimum occurrence between the logical cardinality or the CDA schema defined cardinality is applied. • The most strict maximum occurrence applies to CDA schema elements without an [index]. • The maximum occurrence of the logical cardinality applies as a pattern 'like this' to CDA schema elements with an [index]. 	<p>The type of the logical element (hyper-linked to the definition of the [HL7FHIR3] type) in the logical model.</p> <p>This may be expressed as a type that is further constrained by a model in the convention <model name>, e.g.</p> <p style="padding-left: 20px;">Patient with Mandatory IHI.</p>	<p>The CDA schema element(s) in the CDA template that when instantiated are considered to be the CDA representation of that logical element; expressed using an XPath like notation, e.g.:</p> <p style="padding-left: 20px;">participant[location]/associatedEntity/code</p> <p>The path always starts from the context as defined in the grey header row above each group of mapping rows.</p> <p>The last CDA schema element in the path is presented in bold to aid the reader.</p> <p>Typically a logical model element will map to multiple CDA schema elements. In order to instantiate the logical element in CDA, the minimum cardinality of the mapped CDA schema elements should be understood to be 1 unless an associated constraint is present to indicate a different cardinality (see Interpreting cardinality in a CDA mapping table for logical elements).</p>	<p>Additional information or guidance on implementing the logical element in CDA to support usage scenarios, e.g.</p> <p style="padding-left: 20px;">When sending to the My Health Record, an IHI is expected.</p> <p>Constraints on the CDA schema elements, identified by use of Conformance verbs, e.g.</p> <p style="padding-left: 20px;">code/original-Text or code/@displayName SHALL be included.</p> <p>Terminology binding, e.g.</p> <p style="padding-left: 20px;">Address Type HL7 v3 (required).</p>

2.4.2 Legend - CDA mapping table for CDA schema elements

A CDA mapping table for CDA schema elements will define conformance requirements that are not sourced from a logical model and that apply cross all of the supported usage scenarios. The following section describes in more detail the fields used to present the mapping content in this implementation guide.

CDA mapping

CDA schema element	CDA element description	CDA card	CDA constraints and comments
CDA conformance level, e.g. CDA Header, CDA Body Level 3 Data Elements			
The CDA schema element(s) in the CDA template using an XPath like notation , e.g.: ClinicalDocument/versionNumber/@value The path always starts from the context as defined in the grey header row above each group of mapping rows. The last CDA schema element in the path is presented in bold to aid the reader.	The description of the CDA schema element definitions, sourced from HL7 Clinical Document Architecture, Release 2 [HL7CDAR2] .	The cardinality of the CDA schema element in the template (see Cardinality notation). The root element of a template may express an inherited cardinality from the parent element in a parent template by stating: Cardinality comes from linking element	Context: The root context that is applied as a prefix to the CDA schema element paths in the mapping rows below Additional information or guidance on the use of the CDA schema element to support usage scenarios, e.g. The use of templateId signals the imposition of a set of template-defined constraints. Constraints on the CDA schema elements, identified by use of Conformance verbs , e.g. code/originalText or code/@displayName SHALL be included. Terminology binding , e.g. Address Type HL7 v3 (required) .

3 Conformance

Conformance claims are typically made against the templates in this implementation guide and additional conformance profiles documented elsewhere such as [Shared Health Summary Summary - PCEHR Conformance Profile \[NEHT2015ah\]](#).

3.1 Base conformance requirements

Any document that claims conformance to a ClinicalDocument template defined in this implementation guide or any derived conformance profile **SHALL** meet these base requirements:

- It **SHALL** be a valid HL7 CDA instance. In particular:
 - It **SHALL** be valid against the HL7 CDA schema (once extensions have been removed).
 - It **SHALL** conform to the HL7 V3 R1 data type specification.
 - It **SHALL** conform to the semantics of the RIM and Structural Vocabulary.
- It **SHALL** be valid against the Australian Digital Health Agency CDA schema that accompanies this implementation guide after any additional extensions not in the Australian Digital Health Agency extension namespace have been removed, along with any other CDA content not described by this implementation guide.
- It **SHALL** conform to the CDA templates it claims conformance to.
- It **SHALL** be valid against the additional conformance requirements that are established in this implementation guide (i.e. any normative use of the word "shall" identified by the term presented in uppercase and bold typeface).
- The narrative **SHALL** conform to the requirements described in this implementation guide.
- The document **SHALL** conform to the requirements specified in the CDA Rendering Specification [\[NEHT2012s\]](#).
- Any additional content included in the CDA document that is not described by this implementation guide:
 - **SHALL NOT** qualify or negate content described by this implementation guide
 - **SHALL** be clinically safe for receivers of the document to ignore the non-narrative additions when interpreting the existing content.

A system that *consumes* CDA documents that claim conformance to a ClinicalDocument template defined in this implementation guide or any derived conformance profile **SHALL** be able to:

- correctly process conformant instance documents, including correctly understanding all the information in the header and it **MAY** but is not required to, reject non-conformant documents.
- correctly render the document for end-users when appropriate (see [Clinical Document Architecture Release 2](#)) but is not required to process any or all of the structured data entries in the CDA document.

3.2 Conformance profile conformance requirements

Conformance profiles of this implementation guide **MAY** make additional rules that override templates in this implementation guide in regard to:

- Allowing the use of alternative value sets in place of the value sets - this is limited to not overriding the rules of the terminology binding strength.
 - For example, a [required](#) value set may be overridden by a value set whose values are a subset of those of the [required](#) binding.
- Restricting the data type of a CDA schema element or attribute.
- Restricting the allowed values of a CDA schema element or attribute.
- Restricting the cardinality of a CDA schema element or attribute.
- Providing more specific or additional mappings to CDA schema elements or attributes.
- Providing refined usage scenarios, definitions, and implementation guidance.

A conformance profile cannot break the rules established in this implementation guide.

3.3 CDA narrative conformance requirements

CDA requires that each section in its body include a narrative block, containing a clinically complete version of the section's encoded content using custom hypertext markup defined by HL7. The narrative is the human-readable and attestable part of a CDA document, and can stand alone as an accurate representation of the content of the document without any need to consult entries in the body.

It is an [HL7 Clinical Document Architecture \[HL7CDAR2\]](#) requirement that all clinical information **SHALL** be marked up in CDA narratives.

It is an [HL7 Clinical Document Architecture \[HL7CDAR2\]](#) requirement that the rendered narrative **SHALL** be able to stand alone as a source of authenticated information for consuming parties. Clinically relevant content from the CDA body **SHALL NOT** be omitted from the narrative.

There is no canonical markup for specific CDA components, but some conformance requirements apply:

- The narrative block **SHALL** be encapsulated within the text component of the CDA section.
- The narrative contents **SHALL** conform to the requirements specified in the CDA Rendering Specification [\[NEHT2012s\]](#).
- The narrative contents **SHALL** completely and accurately represent the clinical information encoded in the section. Clinical content **SHALL NOT** be omitted from the narrative.
 - In accordance with the requirement to completely represent section contents, elements of type [CodeableConcept](#) **SHALL** include an `originalText` or a `displayName` attribute (or both). Where available, the `originalText` **SHOULD** be found in the narrative, otherwise the `displayName` **SHOULD** be found in the narrative.
 - In accordance with the requirement to represent section contents in that section, the narrative of the content for a section **SHALL** be contained in that section or, if appropriate, the narrative of an ancestor section.
- The narrative **SHALL** conform to the content requirements of the CDA specification [\[HL7CDAR2\]](#) and the XML schema.

Clinical judgement is required to determine the appropriate presentation for narrative. We may release additional guidance in this regard.

DRAFT

4 Shared Health Summary hierarchy

Shared Health Summary is defined as:

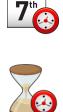
A clinical document written by the nominated provider, which contains key pieces of information about an individual's health status and is useful to a wide range of providers in assessing individuals and delivering care. [Shared Health Summary FHIR Implementation Guide \[DH2020i\]](#)

The table below provides a hierarchical view of the Shared Health Summary model as a tree structure in a hierarchical table; it is not intended to represent how the data contents are represented in a CDA document.

Composition (Shared Health Summary), published as a set of FHIR profiles, can be found in the [Shared Health Summary FHIR Implementation Guide \[DH2020i\]](#).

Logical element	Logical card	Logical type	CDA template
		Shared Health Summary	ClinicalDocument (Shared Health Summary)
	1..1	Reference(PractitionerRole with Practitioner with Mandatory Identifier)	author (PractitionerRole with Practitioner with Mandatory Identifier)
	0..1	Identifier	
	1..1	code	
	1..1	CodeableConcept	
	1..1	Reference(Patient with Mandatory IHI My Health Record Patient)	recordTarget (Patient with Mandatory IHI) recordTarget (My Health Record Patient)
	1..1	dateTime	
	1..1	Reference(Practitioner as Practitioner with Mandatory Identifier)	
	1..1	string	
	1..1	BackboneElement	legalAuthenticator
	1..1	code	
	1..1	dateTime	
	1..1	Reference(Practitioner with Mandatory Identifier)	
	1..1	Reference(Organization with Mandatory Identifier)	custodian (Organization with Mandatory Identifier)
	1..1	BackboneElement	section (Allergies)
	1..1	string	
	1..1	CodeableConcept	
	1..1	Narrative	

Logical element				Logical card	Logical type	CDA template
			entry	0..*	Reference (Summary Statement of Allergy or Intolerance)	observation (Summary Statement of Allergy or Intolerance)
			author-related-person	0..1	Reference (Base RelatedPerson)	
			clinicalStatus	0..1	code	
			verificationStatus	1..1	code	
			type	0..1	code	
			code	1..1	CodeableConcept	
			patient	1..1	Reference (Patient with Mandatory IHI)	
			onset[x]	0..1	dateTime , Age , Period , Range	
			recorder	0..1	Reference (Base Patient Base Practitioner)	author (Base Patient) author (PractitionerRole with Practitioner with Mandatory Identifier)
			note	0..*	Annotation	
			reaction	0..*	BackboneElement	
			substance	0..1	CodeableConcept	
			manifestation	1..*	CodeableConcept	
			emptyReason	0..1	CodeableConcept	
		section (Medications)		1..1	BackboneElement	section (Medications)
			title	1..1	string	
			code	1..1	CodeableConcept	
			text	1..1	Narrative	
			entry	0..*	Reference (Summary Statement of Known Medicine)	substanceAdministration (Summary Statement of Known Medicine)
			status	1..1	code	

Logical element				Logical card	Logical type	CDA template
		 001011001	category	0..1	CodeableConcept	
		 001011001	medication[x]	1..1	CodeableConcept	
			informationSource	0..1	Reference (Base Patient Base Practitioner Base RelatedPerson)	
			subject	1..1	Reference (Patient with Mandatory IHI)	
		 001011001	taken	1..1	code	
		 001011001	reasonCode	0..1	CodeableConcept	
			note	0..*	Annotation	
			dosage	1..1	Reference (AU Base Dosage)	
		entry		0..1	Reference (Assertion of No Relevant Finding)	observation (Assertion of No Relevant Finding)
		 001011001	status	1..1	code	
		 001011001	code	1..1	CodeableConcept	
			subject	1..1	Reference (Patient with Mandatory IHI)	
		 	effective[x]	0..1	dateTime Period	
			performer	0..*	Reference (Base Practitioner Base Organization Base RelatedPerson Base Patient)	author (PractitionerRole with Practitioner with Mandatory Identifier) participant (author Base Organization) author (Base RelatedPerson) author (Base Patient)
		 001011001	value[x]	1..1	CodeableConcept	
		 001011001	emptyReason	0..1	CodeableConcept	
		section (Medical History)		1..1	BackboneElement	section (Medical History)
		 001011001	title	1..1		string
		 001011001	code	1..1		CodeableConcept
			text	1..1	Narrative	

Logical element				Logical card	Logical type	CDA template
			entry		0..*	Reference (Summary Statement of Condition)
			recorder		0..1	Reference (Base Practitioner Base Patient Base RelatedPerson)
			clinicalStatus		0..1	code
			verificationStatus		0..1	code
			code		1..1	CodeableConcept
			subject		1..1	Reference (Patient with Mandatory IHI)
			onset[x]		0..1	dateTime , Age , Period , Range
			abatement[x]		0..1	dateTime , Age , boolean , Period , Range
			note		0..*	Annotation
			entry		0..*	Reference (Summary Statement of Known Procedure)
			status		1..1	code
			code		1..1	CodeableConcept
			subject		1..1	Reference (Patient with Mandatory IHI)
			performed[x]		0..1	dateTime , Period
			note		0..*	Annotation

Logical element				Logical card	Logical type	CDA template	
			entry	0..1	Reference (Assertion of No Relevant Finding)	observation (Assertion of No Relevant Finding)	
			status	1..1	code		
			code	1..1	CodeableConcept		
			subject	1..1	Reference (Patient with Mandatory IHI)		
			effective[x]	0..1	dateTime Period		
			performer	0..*	Reference (Base Practitioner Base Organization Base RelatedPerson Base Patient)	author (PractitionerRole with Practitioner with Mandatory Identifier) participant (author Base Organization) author (Base RelatedPerson) author (Base Patient)	
			value[x]	1..1	CodeableConcept		
			emptyReason	0..1	CodeableConcept		
		section (Immunisations)			1..1	BackboneElement	section (Immunisations)
			title	1..1	string		
			code	1..1	CodeableConcept		
			text	1..1	Narrative		
			entry	0..*	Reference (Summary Statement of Administered Vaccine)	substanceAdministration (Summary Statement of Administered Vaccine)	
			status	1..1	code		
			notGiven	1..1	boolean		
			vaccineCode	1..1	CodeableConcept		
			patient	1..1	Reference (Patient with Mandatory IHI)		
			date	0..1	dateTime		
			primarySource	1..1	boolean		
			vaccinationProtocol	0..*	BackboneElement		
			doseSequence	0..1	positiveInt		

Logical element					Logical card	Logical type	CDA template
			 001011001	doseStatus	1..1	CodeableConcept	
			entry		0..1	Reference (Assertion of No Relevant Finding)	observation (Assertion of No Relevant Finding)
			 001011001	status		1..1	code
			 001011001	code		1..1	CodeableConcept
				subject		1..1	Reference (Patient with Mandatory IHI)
			 MAY 7 th 	effective[x]		0..1	dateTime Period
			  	performer		0..*	Reference (Base Practitioner Base Organization Base RelatedPerson Base Patient) author (PractitionerRole with Practitioner with Mandatory Identifier) participant (author Base Organization) author (Base RelatedPerson) author (Base Patient)
			 001011001	value[x]		1..1	CodeableConcept
		 001011001	emptyReason		0..1	CodeableConcept	

Note



The column "Logical element" contains the name of that element in the logical model.

The column "Logical card" contains the logical cardinality of that element in the logical model.

The column "Logical type" contains the type of the logical element (hyper-linked to the definition of the [\[HL7FHIR3\]](#) type) in the logical model.

The column "CDA template" contains the title of the corresponding CDA template for that logical element (hyper-linked to CDA mapping table for that template). The convention for the CDA template title is <CDA schema element> (<model name> where the template is not defined in [5 CDA Header templates](#)).

5 CDA Header templates

This chapter contains the CDA Header requirements for this implementation guide; these are infrastructure or control requirements that are not sourced from the Shared Health Summary model.

All the definitions in this chapter are sourced from HL7 Clinical Document Architecture, Release 2 [\[HL7CDAR2\]](#).

5.1 ClinicalDocument

This template is referenced by [ClinicalDocument \(Shared Health Summary\)](#).

See [Legend - CDA mapping table for CDA schema elements](#) for an explanation of mapping table presentation.

CDA mapping

CDA schema element	CDA element description	CDA card	CDA constraints and comments
CDA Header Data Elements		Context: /	
ClinicalDocument	The ClinicalDocument class is the entry point into the CDA R-MIM, and corresponds to the <ClinicalDocument> XML element that is the root element of a CDA document.	1..1	<p>This template SHALL be a closed template.</p> <p>All attributes of the ClinicalDocument element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.</p> <p>All instances of a time value SHALL include hours, minutes and a time zone.</p> <p>The CDA document SHALL be valid against the Australian Digital Health Agency CDA schema after any additional extensions not in the Australian Digital Health Agency extension namespace have been removed.</p>
ClinicalDocument/realmCode	A realmCode signals the imposition of realm-specific constraints. The value identifies the realm in question.	0..*	All attributes of the realmCode element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.
ClinicalDocument/ typeId	A technology-neutral explicit reference to the CDA Release 2 specification.	1..1	
ClinicalDocument/ typeId/@extension="POCD_HD000040"		1..1	The unique identifier for the CDA Release 2 Hierarchical Description.
ClinicalDocument/ typeId/@root="2.16.840.1.113883.1.3"		1..1	The OID for HL7 Registered models.

CDA schema element	CDA element description	CDA card	CDA constraints and comments
ClinicalDocument/templateId	A templateId signals the imposition of a set of template-defined constraints. The value provides a unique identifier for the templates in question.	1..*	<p>All attributes of the templateId element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.</p> <p>Exactly one template identifier SHALL indicate the constraints defined in this mapping table and have @root="1.2.36.1.2001.1001.102.101.100033".</p> <p>Exactly one template identifier SHALL indicate the constraints defined in the CDA Rendering Specification [NEHT2012s] and have @root="1.2.36.1.2001.1001.100.149".</p> <p>In addition to the template identifiers above, a template identifier is expected for the clinical document model as per ClinicalDocument (Shared Health Summary). Additional template identifiers may be required by other specifications.</p> <p>Systems are not required to recognise any other template identifiers than the clinical document model templateId in order to understand the document as a [type] but these identifiers may influence how the document must be handled.</p>
ClinicalDocument/id	Represents the unique instance identifier of a clinical document.	1..1	<p>All attributes of the id element defined by the Australian Digital Health Agency CDA schema SHALL be allowed with the exception that @nullFlavor SHALL NOT be present.</p> <p>id/@root SHALL be present and it SHALL be a UUID or an OID.</p>
ClinicalDocument/code	The code specifying the particular kind of document (e.g. History and Physical, Discharge Summary, Progress Note).	1..1	All attributes of the code element defined by the Australian Digital Health Agency CDA schema SHALL be allowed with the exception that @nullFlavor SHALL NOT be present.
ClinicalDocument/title	Represents the title of the document.	0..1	
ClinicalDocument/effectiveTime	Signifies the document creation time, when the document first came into being. Where the CDA document is a transform from an original document in some other format, the ClinicalDocument.effectiveTime is the time the original document is created.	1..1	All attributes of the effectiveTime element defined by the Australian Digital Health Agency CDA schema SHALL be allowed with the exception that @nullFlavor SHALL NOT be present.
ClinicalDocument/confidentialityCode/@nullFlavor="NA"	Codes that identify how sensitive a piece of information is and/or that indicate how the information may be made available or disclosed.	1..1	
ClinicalDocument/languageCode	Specifies the human language of character data (whether they be in contents or attribute values).	0..1	<Language Code> – <DIALECT> The <Language Code> SHALL be "en". The <DIALECT> SHOULD be "AU".
ClinicalDocument/languageCode/@code		1..1	
ClinicalDocument/setId	Represents an identifier that is common across all document revisions.	0..1	All attributes of the setId element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.
ClinicalDocument/versionNumber	An integer value used to version successive replacement documents.	0..1	
ClinicalDocument/versionNumber/@value		1..1	
ClinicalDocument/ext:completionCode	The lifecycle status of a document.	1..1	<p>All attributes of the completionCode element defined by the Australian Digital Health Agency CDA schema SHALL be allowed with the exception that @nullFlavor SHALL NOT be present.</p> <p>Australian Healthcare Clinical Document Architecture Document Lifecycle Status (required)</p>
ClinicalDocument/recordTarget	Represents the medical record that this document belongs to.	1..1	All attributes and elements of the recordTarget element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.
ClinicalDocument/author	Represents the humans and/or machines that authored the document.	1..1	All attributes and elements of the author element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.
ClinicalDocument/dataEnterer	Represents the participant who has transformed a dictated note into text.	0..1	All attributes and elements of the dataEnterer element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.

CDA schema element	CDA element description	CDA card	CDA constraints and comments
ClinicalDocument/informant	Represents an informant (or source of information) who provides relevant information, such as the parent of a comatose patient who describes the patient's behavior prior to the onset of coma. Unless otherwise stated, the patient is implicitly the informant.	0..*	All attributes and elements of the informant element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.
ClinicalDocument/custodian	Represents the organization from which the document originates and that is in charge of maintaining the document. The custodian is the steward that is entrusted with the care of the document. Every CDA document has exactly one custodian.	1..1	All attributes and elements of the custodian element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.
ClinicalDocument/informationRecipient	Represents a recipient who should receive a copy of the document.	0..*	All attributes and elements of the informationRecipient element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.
ClinicalDocument/legalAuthenticator	Represents a participant who has legally authenticated the document.	0..1	All attributes and elements of the legalAuthenticator element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.
ClinicalDocument/authenticator	Represents a participant who has attested to the accuracy of the document, but who does not have privileges to legally authenticate the document. An example would be a resident physician who sees a patient and dictates a note, then later signs it.	0..*	All attributes and elements of the authenticator element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.
ClinicalDocument/participant	Represents a participant not explicitly mentioned by other classes that was somehow involved.	0..*	All attributes and elements of the participant element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.
ClinicalDocument/inFulfillmentOf	Relates the current document to an order this document fulfills (in whole or in part).	0..*	All attributes and elements of the inFulfillmentOf element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.
ClinicalDocument/documentationOf	Relates the current document to the related event that this document is documentation of.	0..*	All attributes and elements of the documentationOf element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.
ClinicalDocument/relatedDocument	Relates the current document to a parent document.	0..*	All attributes and elements of the relatedDocument element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.
ClinicalDocument/authorization	Relates the current document to consents associated with this document. The consent authorizes or certifies acts specified in the current document.	0..*	All attributes and elements of the authorization element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.
ClinicalDocument/componentOf	Relates the current document to the encounter. The current document is a documentation of events that occurred during the encounter.	0..1	All attributes and elements of the componentOf element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.
ClinicalDocument/component	Relates the associated document body as a component of the document.	1..1	All attributes and elements of the component element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.

5.2 legalAuthenticator

This template is referenced by [ClinicalDocument \(Shared Health Summary\)](#).

See [Legend - CDA mapping table for CDA schema elements](#) for an explanation of mapping table presentation.

CDA mapping

CDA schema element	CDA element description	CDA card	CDA constraints and comments
CDA Header Data Elements		Context: /ClinicalDocument/	
legalAuthenticator	Represents a participant who has legally authenticated the document.	Cardinality comes from linking element	
legalAuthenticator/templateId	The use of templateId signals the imposition of a set of template-defined constraints.	1..1	
legalAuthenticator/templateId/@root="1.2.36.1.2001.1001.102.101.100012"		1..1	
legalAuthenticator/time/@value	Indicates the time of authentication.	1..1	
legalAuthenticator/signatureCode/@code="S"	Indicates that the signature has been affixed and is on file.	1..1	
legalAuthenticator/assignedEntity	A legalAuthenticator is a person in the role of an assigned entity (AssignedEntity class). An assigned entity is a person assigned to the role by the scoping organization. The entity playing the role is a person (Person class). The entity scoping the role is an organization (Organization class).	1..1	
legalAuthenticator/assignedEntity/id	A unique identifier for the player entity in this role.	1..1	id/@root SHALL be present and it SHALL be a UUID or an OID.
legalAuthenticator/assignedEntity/code	The specific kind of role.	0..1	
legalAuthenticator/assignedEntity/addr	A postal address for the entity (assignedPerson) while in the role (assignedEntity).	0..*	
legalAuthenticator/assignedEntity/telecom	A telecommunication address for the entity (assignedPerson) while in the role (assignedEntity).	0..*	
legalAuthenticator/assignedEntity/assignedPerson	The entity playing the role (assignedEntity) is a person.	1..1	
legalAuthenticator/assignedEntity/assignedPerson/name	A non-unique textual identifier or moniker for the entity (assignedPerson).	0..*	
legalAuthenticator/assignedEntity/assignedPerson/ext:asEntityIdentifier	The entity identifier of the person.	0..*	The common pattern Entity Identifier SHALL be applied.
legalAuthenticator/assignedEntity/representedOrganization	The entity scoping the role (assignedEntity).	0..1	
legalAuthenticator/assignedEntity/representedOrganization/name	A non-unique textual identifier or moniker for the entity (representedOrganization).	0..*	
legalAuthenticator/assignedEntity/representedOrganization/ext:asEntityIdentifier	A unique identifier for the scoping entity (represented organization) in this role (assignedEntity).	0..*	The common pattern Entity Identifier SHALL be applied.

5.3 component (Administrative Observations)

This template is referenced by [recordTarget \(Patient with Mandatory IHI\)](#), and [recordTarget \(My Health Record Patient\)](#).

See [Legend - CDA mapping table for CDA schema elements](#) for an explanation of mapping table presentation.

CDA mapping

CDA schema element	CDA element description	CDA card	CDA constraints and comments
Conformance level comes from linking elements	Context: /ClinicalDocument/component/structuredBody/		
component[admin_obs]	The models contain a number of elements for which there are no equivalent elements at that point in the hierarchical structure of the model mapped into CDA. These elements are considered to be "Administrative Observations" about the encounter, the patient or some other participant.	Cardinality comes from linking element	ClinicalDocument SHALL contain at most one Administrative Observation section. The Administrative Observations section SHALL NOT be populated if there are no entries or text to go in it.
component[admin_obs]/section		1..1	
component[admin_obs]/section/templateId		1..1	The use of templateId signals the imposition of a set of template-defined constraints.
component[admin_obs]/section/templateId/@root="1.2.36.1.2001.1001.102.101.100000"		1..1	
component[admin_obs]/section/id	An observation included in this section is an observation relating to the patient (i.e. recordTarget) unless a reference to a different entity is instantiated as part of that observation (e.g. observation/participant/participantRole).	0..1	id/@root SHALL be present and it SHALL be a UUID or an OID.
component[admin_obs]/section/code		1..1	
component[admin_obs]/section/code/@code="102.16080"		1..1	
component[admin_obs]/section/code/@codeSystem="1.2.36.1.2001.1001.101"		1..1	NCTIS Data Components
component[admin_obs]/section/code/@displayName		0..1	displayName SHOULD be "Administrative Observations".
component[admin_obs]/section/title="Administrative Observations"		0..1	
component[admin_obs]/section/text		0..1	

6 Document CDA templates

This chapter defines each of the document-level usage scenario models, e.g. Composition (Shared Health Summary), as a `ClinicalDocument` template.

6.1 ClinicalDocument (Shared Health Summary)

The following are the usage scenarios expected:

- A clinical information system (CIS) sends or receives a Shared Health Summary with the My Health Record system
- A contracted service provider (CSP) sends or receives a Shared Health Summary with the My Health Record system
- A registered repository receives a Shared Health Summary from the My Health Record system

For the usage scenarios for this template it is required that the composition include only the specified top-level sections; additional sections to handle local content not covered by the primary design can be included as one or more child sections within one of the specified top-level sections if desired.

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logic-al card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements		Context: /			
Composition	A clinical document written by the nominated provider, which contains key pieces of information about an individual's health status and is useful to a wide range of providers in assessing individuals and delivering care.	0..*	Composition	<code>ClinicalDocument</code>	In CDA the maximum occurrences of <code>ClinicalDocument</code> is 1. Although the model indicates that <code>Composition</code> is 0..*, in a CDA implementation this is limited to 0..1. In addition to the template defined in this mapping table, <code>ClinicalDocument</code> SHALL conform to the template defined in ClinicalDocument .
				<code>ClinicalDocument/templateId</code>	The use of <code>templateId</code> signals the imposition of a set of template-defined constraints.
				<code>ClinicalDocument/templateId/@root="1.2.36.1.2001.1001.102.101.100019"</code>	

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Composition > composition-author-role	A practitioner role that authored this composition. This is not to be confused with who typed in the information.	1..1	Reference (PractitionerRole with Practitioner with Mandatory Identifier)	ClinicalDocument/author	author SHALL conform to the template defined in author (PractitionerRole with Practitioner with Mandatory Identifier) .
Composition > identifier	Logical identifier for the composition, assigned when created. This identifier stays constant as the composition is changed over time.	0..1	Identifier	ClinicalDocument/setId	
Composition > status	The workflow/clinical status of this composition. The status is a marker for the clinical standing of the document.	1..1	code	ClinicalDocument/ext:completionCode	Australian Healthcare Clinical Document Architecture Document Lifecycle Status (required) ¹
Composition > type	Specifies the particular kind of composition (e.g. History and Physical, Discharge Summary, Progress Note). This usually equates to the purpose of making the composition.	1..1	CodeableConcept	ClinicalDocument/code	
				ClinicalDocument/code/@code="60591-5"	
				ClinicalDocument/code/@codeSystem="2.16.840.1.113883.6.1"	LOINC
				ClinicalDocument/code/@displayName	displayName SHOULD be "Patient summary".
Composition > subject	Who or what the composition is about. The composition can be about a person, (patient or healthcare practitioner), a device (e.g. a machine) or even a group of subjects (such as a document about a herd of livestock, or a set of patients that share a common exposure).	1..1	Reference (Patient with Mandatory IHI My Health Record Patient)	ClinicalDocument/recordTarget	When sending to the My Health Record, recordTarget (My Health Record Patient) is expected. recordTarget SHALL conform to one of the templates defined in: recordTarget (Patient with Mandatory IHI) or recordTarget (My Health Record Patient) .
Composition > date	The composition editing time, when the composition was last logically changed by the author.	1..1	dateTime	ClinicalDocument/author/time	
Composition > author	Identifies who is responsible for the information in the composition, not necessarily who typed it in.	1..1	Reference (Practitioner with Mandatory Identifier)	ClinicalDocument/author/assignedAuthor/assignedPerson	In CDA an author (Practitioner) assignedPerson (Practitioner with Mandatory Identifier) is part of composition-author-role (PractitionerRole) author (PractitionerRole with Practitioner with Mandatory Identifier).
Composition > title	Official human-readable label for the composition.	1..1	string	ClinicalDocument/title="Shared Health Summary"	
Composition > attester (Legal Attester)	A participant who has attested to the accuracy of the composition/document.	1..1	BackboneElement	ClinicalDocument/legalAuthenticator	legalAuthenticator SHALL conform to the template defined in legalAuthenticator .
Composition > attester (Legal Attester) > mode	The type of attestation the authenticator offers.	1..1	code	n/a	Not mapped separately, the logical mode of "legal" is implicit in legalAuthenticator.
Composition > attester (Legal Attester) > time	When the composition was attested by the party.	1..1	dateTime	ClinicalDocument/legalAuthenticator/time/@value	
Composition > attester (Legal Attester) > party	Who attested the composition in the specified way.	1..1	Reference (Practitioner with Mandatory Identifier)	ClinicalDocument/legalAuthenticator/assignedEntity	The practitioner SHALL have an identifier (legalAuthenticator/assignedEntity/assignedPerson/ext:asEntityIdentifier).
Composition > custodian	Identifies the organization or group who is responsible for ongoing maintenance of and access to the composition/document information.	1..1	Reference (Organization with Mandatory Identifier)	ClinicalDocument/custodian	custodian SHALL conform to the template defined in custodian (Organization with Mandatory Identifier) .

Logical element	Logical element description	Logic-al card	Logical type	CDA schema element	CDA constraints and comments
Composition > section (Allergies)	Information about allergies and intolerances of the patient. This includes statements that a patient does not have an allergy or category of allergies.	1..1	BackboneElement	ClinicalDocument/component/structuredBody/component[allergy]	
				ClinicalDocument/component/structuredBody/component[allergy]/section	section SHALL conform to the template defined in section (Allergies) .
Composition > section (Medications)	Medicines that the patient is currently taking including self-prescribed, clinician prescribed and nonprescription medication.	1..1	BackboneElement	ClinicalDocument/component/structuredBody/component[meds]	
				ClinicalDocument/component/structuredBody/component[meds]/section	section SHALL conform to the template defined in section (Medications) .
Composition > section (Medical History)	Information about the problems, diagnoses and medical or surgical procedures of a patient. This can include statements that a patient does not have a particular condition.	1..1	BackboneElement	ClinicalDocument/component/structuredBody/component[med_hist]	
				ClinicalDocument/component/structuredBody/component[med_hist]/section	section SHALL conform to the template defined in section (Medical History) .
Composition > section (Immunisations)	Information about the immunisation history, i.e. administered vaccines, of a patient.	1..1	BackboneElement	ClinicalDocument/component/structuredBody/component[imms]	
				ClinicalDocument/component/structuredBody/component[imms]/section	section SHALL conform to the template defined in section (Immunisations) .

¹This value set differs from the value set bound to status in the Agency logical model (see [Shared Health Summary FHIR Implementation Guide \[DH2020i\]](#)) to support the existing CDA implementation environment. The concept map [CompositionStatus \(HL7 FHIR\) to Australian Healthcare Clinical Document Architecture Document Lifecycle Status](#) provides a mapping between the two value sets.

7 Section CDA templates

This chapter defines the section templates referenced by a ClinicalDocument template for a document-level model in [6 Document CDA templates](#).

7.1 section (Allergies)

This template is referenced by [ClinicalDocument \(Shared Health Summary\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Body Level 3 Data Elements		Context: Comes from linking elements			
section	Information about allergies and intolerances of the patient. This includes statements that a patient does not have an allergy or category of allergies.	Cardinality comes from linking element	BackboneElement	section	This section SHALL contain at least one entry (entry[adv]) or an emptyReason (entry[adv_empty]) but SHALL NOT contain both.
				section/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				section/templateId/@root="1.2.36.1.2001.1001.102.101.100008"	
section > title	The label for this particular section. This will be part of the rendered content for the document, and is often used to build a table of contents.	1..1	string	section/title="Allergies and Adverse Reactions"	
section > code	A code identifying the kind of content contained within the section. This must be consistent with the section title.	1..1	CodeableConcept	section/code	
				section/code/@code="48765-2"	
				section/code/@codeSystem="2.16.840.1.113883.6.1"	LOINC
				section/code/@displayName	displayName SHOULD be "Allergies &or adverse reactions".
section > text	A human-readable narrative that contains the attested content of the section, used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it 'clinically safe' for a human to just read the narrative.	1..1	Narrative	section/text	

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
section > entry	A reference to the actual resource from which the narrative in the section is derived.	0..*	Reference (Summary Statement of Allergy or Intolerance)	section/entry[adv]	A statement of allergy or intolerance can be sent to state that a patient does have an allergy or category of allergies or it can be sent to state that they do not e.g. 716186003 No known allergy 716184000 No known latex allergy .
				section/entry[adv]/observation	observation SHALL conform to the template defined in observation (Summary Statement of Allergy or Intolerance) .
section > emptyReason	If the section is empty, why the list is empty. An empty section typically has some text explaining the empty reason.	0..1	CodeableConcept	section/entry[adv_empty]	
				section/entry[adv_empty]/observation	
				section/entry[adv_empty]/observation/@classCode="OBS"	
				section/entry[adv_empty]/observation/@moodCode="EVN"	
				section/entry[adv_empty]/observation/code	
				section/entry[adv_empty]/observation/code/@code="ASSERTION"	
				section/entry[adv_empty]/observation/code/@codeSystem="2.16.840.1.113883.5.4"	v3 Code System ActCode
				section/entry[adv_empty]/observation/code/@displayName	displayName SHOULD be "Assertion".
				section/entry[adv_empty]/observation/value	value/@xsi:type SHALL be "CD". value/originalText or value/@displayName SHALL be included. Health Summary Non-Clinical Empty Reason (required)

¹This value set differs from the value set bound to status in the Agency logical model (see [Shared Health Summary FHIR Implementation Guide \[DH2020i\]](#)) due to pre-adoption of FHIR Release 4 terminology.

7.2 section (Medications)

This template is referenced by [ClinicalDocument \(Shared Health Summary\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Body Level 3 Data Elements		Context: Comes from linking elements			
section	Medicines that the patient is currently taking including self-prescribed, clinician prescribed and nonprescription medication.	Cardinality comes from linking element	BackboneElement	section	<p>This section SHALL contain:</p> <ul style="list-style-type: none">at least one entry (section/entry[meds]) or an emptyReason (section/entry[meds_empty_rsn]) <p>This section SHALL NOT contain:</p> <ul style="list-style-type: none">both an entry (section/entry[meds]) and an emptyReason (section/entry[meds_empty_rsn])both an entry (section/entry[meds]) that conforms to substanceAdministration (Summary Statement of Known Medicine) and an entry that conforms to observation (Assertion of No Relevant Finding)more than one entry (section/entry[meds]) that conforms to observation (Assertion of No Relevant Finding)
				section/ templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				section/templateId/@root="1.2.36.1.2001.1001.102.101.100011"	
section > title	The label for this particular section. This will be part of the rendered content for the document, and is often used to build a table of contents.	1..1	string	section/title="Current Medications"	
section > code	A code identifying the kind of content contained within the section. This must be consistent with the section title.	1..1	CodeableConcept	section/code	
				section/code/@code="101.32009"	
				section/code/@codeSystem="1.2.36.1.2001.1001.101"	NCTIS Data Components
				section/code/@displayName	displayName SHOULD be "Current Medicine".

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
section > text	A human-readable narrative that contains the attested content of the section, used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it 'clinically safe' for a human to just read the narrative.	1..1	Narrative	section/text	
section > entry	A reference to the actual resource from which the narrative in the section is derived.	0..*	Reference (Summary Statement of Known Medicine Assertion of No Relevant Finding)	section/entry[meds]	<p>A section entry (section/entry[meds]) SHALL be instantiated as an:</p> <ul style="list-style-type: none"> act (section/entry[meds]/act) conforming to substanceAdministration (Summary Statement of Known Medicine), or observation (section/entry[meds]/observation) conforming to observation (Assertion of No Relevant Finding) asserting that there are no known current medications (observation/value/@code="1234391000168107")
section > emptyReason	If the section is empty, why the list is empty. An empty section typically has some text explaining the empty reason.	0..1	CodeableConcept	section/entry[meds_empty] section/entry[meds_empty]/observation section/entry[meds_empty]/observation/@classCode="OBS" section/entry[meds_empty]/observation/@moodCode="EVN" section/entry[meds_empty]/observation/code section/entry[meds_empty]/observation/code/@code="ASSERTION" section/entry[meds_empty]/observation/code/@codeSystem="2.16.840.1.11383.5.4" section/entry[meds_empty]/observation/code/@displayName section/entry[meds_empty]/observation/value	displayName SHOULD be "Assertion". value/@xsi:type SHALL be "CD". value/originalText or value/@displayName SHALL be included. Health Summary Non-Clinical Empty Reason (required)

¹This value set differs from the value set bound to status in the Agency logical model (see [Shared Health Summary FHIR Implementation Guide \[DH2020ij\]](#)) due to pre-adoption of FHIR Release 4 terminology.

7.3 section (Medical History)

This template is referenced by [ClinicalDocument \(Shared Health Summary\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Body Level 3 Data Elements					Context: Comes from linking elements
section	Information about the problems, diagnoses and medical or surgical procedures of a patient. This can include statements that a patient does not have a particular condition.	Cardinality comes from linking element	BackboneElement	section	<p>This section SHALL contain:</p> <ul style="list-style-type: none">at least one entry (section/entry[med_hist]) or an emptyReason (section/entry[med_hist_empty_rsn]) <p>This section SHALL NOT contain:</p> <ul style="list-style-type: none">both an entry (section/entry[med_hist]) and an emptyReason (section/entry[med_hist_empty_rsn])both an entry (section/entry[med_hist]) that conforms to observation (Assertion of No Relevant Finding) and an entry that conforms to observation (Summary Statement of Condition) or procedure (Summary Statement of Known Procedure)more than one entry (section/entry[jimms]) that conforms to observation (Assertion of No Relevant Finding)
				section/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				section/templateId/@root="1.2.36.1.2001.1001.102.101.100041"	
section > title	The label for this particular section. This will be part of the rendered content for the document, and is often used to build a table of contents.	1..1	string	section/title="Medical History"	
section > code	A code identifying the kind of content contained within the section. This must be consistent with the section title.	1..1	CodeableConcept	section/code	
				section/code/@code="101.16117"	
				section/code/@codeSystem="1.2.36.1.2001.1001.101"	NCTIS Data Components
				section/code/@displayName	displayName SHOULD be "Medical History".

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
section > text	A human-readable narrative that contains the attested content of the section, used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it 'clinically safe' for a human to just read the narrative.	1..1	Narrative	section/text	
section > entry	A reference to the actual resource from which the narrative in the section is derived.	0..*	Reference (Summary Statement of Condition Summary Statement of Known Procedure Assertion of No Relevant Finding)	section/entry[med_hist]	<p>A section entry SHALL be instantiated as an:</p> <ul style="list-style-type: none"> observation (section/entry[med_hist]/observation) conforming to observation (Summary Statement of Condition), or procedure (section/entry[med_hist]/procedure) conforming to procedure (Summary Statement of Known Procedure), or observation (section/entry[meds]/observation) conforming to observation (Assertion of No Relevant Finding) asserting that there is no relevant medical history (entry[med_hist]/observation/value/@code="1224831000168103")
section > emptyReason	If the section is empty, why the list is empty. An empty section typically has some text explaining the empty reason.	0..1	CodeableConcept	section/entry[med_hist_empty_rsn] section/entry[med_hist_empty_rsn]/observation section/entry[med_hist_empty_rsn]/observation/@classCode="OBS" section/entry[med_hist_empty_rsn]/observation/@moodCode="EVN" section/entry[med_hist_empty_rsn]/observation/code section/entry[med_hist_empty_rsn]/observation/code/@code="ASSERTION" section/entry[med_hist_empty_rsn]/observation/code/@codeSystem="2.16.840.1.113883.5.4" section/entry[med_hist_empty_rsn]/observation/code/@displayName section/entry[med_hist_empty_rsn]/observation/value	displayName SHOULD be "Assertion". value/@xsi:type SHALL be "CD". value/originalText or value/@displayName SHALL be included. Health Summary Non-Clinical Empty Reason (required)

7.4 section (Immunisations)

This template is referenced by [ClinicalDocument \(Shared Health Summary\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Body Level 3 Data Elements		Context: Comes from linking elements			
section	Information about the immunisation history, i.e. administered vaccines, of a patient.	DYNAMIC-CARD	BackboneElement	section	<p>This section SHALL contain:</p> <ul style="list-style-type: none">an emptyReason (section/entry[imms_empty_rsn]) or at least one entry (section/entry[imms]) <p>This section SHALL NOT contain:</p> <ul style="list-style-type: none">both an entry (section/entry[imms]) and an emptyReason (section/entry[imms_empty_rsn])both an entry (section/entry[imms]) that conforms to observation (Assertion of No Relevant Finding) and an entry that conforms to substanceAdministration (Summary Statement of Administered Vaccine)more than one entry (section/entry[imms]) that conforms to observation (Assertion of No Relevant Finding)
				section/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				section/templateId/@root="1.2.36.1.2001.1001.102.101.100042"	
section > title	The label for this particular section. This will be part of the rendered content for the document, and is often used to build a table of contents.	1..1	string	section/title="Immunisations"	
section > code	A code identifying the kind of content contained within the section. This must be consistent with the section title.	1..1	CodeableConcept	section/code	
				section/code/@code="11369-6"	
				section/code/@codeSystem="2.16.840.1.113883.6.1"	LOINC
				section/code/@displayName	displayName SHOULD be "Immunization".

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
section > text	A human-readable narrative that contains the attested content of the section, used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it 'clinically safe' for a human to just read the narrative.	1..1	Narrative	section/text	
section > entry	A reference to the actual resource from which the narrative in the section is derived.	0..*	Reference (Summary Statement of Administered Vaccine Assertion of No Relevant Finding)	section/entry[imms]	<p>A section entry SHALL be instantiated as an:</p> <ul style="list-style-type: none"> act (section/entry[imms]/act) conforming to substanceAdministration (Summary Statement of Administered Vaccine), or observation (section/entry[imms]/observation) conforming to observation (Assertion of No Relevant Finding) asserting no history of vaccination (section/entry[imms]/observation/value/@code="1234401000168109")
section > emptyReason	If the section is empty, why the list is empty. An empty section typically has some text explaining the empty reason.	0..1	CodeableConcept	section/entry[imms_empty_rsn] section/entry[imms_empty_rsn]/observation section/entry[imms_empty_rsn]/observation/@classCode="OBS" section/entry[imms_empty_rsn]/observation/@moodCode="EVN" section/entry[imms_empty_rsn]/observation/code section/entry[imms_empty_rsn]/observation/code/@code="ASSERTION" section/entry[imms_empty_rsn]/observation/code/@codeSystem="2.16.840.1.113883.5.4" section/entry[imms_empty_rsn]/observation/code/@displayName section/entry[imms_empty_rsn]/observation/value	<p>v3 Code System ActCode</p> <p>displayName SHOULD be "Assertion".</p> <p>value/@xsi:type SHALL be "CD".</p> <p>value/originalText or value/@displayName SHALL be included.</p> <p>Health Summary Non-Clinical Empty Reason (required)</p>

8 Participation CDA templates

This chapter defines the participation templates referenced other templates such as those in [7 Section CDA templates](#) and [6 Document CDA templates](#).

8.1 recordTarget (My Health Record Patient)

This template is referenced by [ClinicalDocument \(Shared Health Summary\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements		Context: /ClinicalDocument/			
Patient	Demographics and other administrative information about an individual receiving care or other health-related services.	Cardinality comes from linking element	Patient	recordTarget	recordTarget/patientRole/telecom SHALL NOT be present. recordTarget/patientRole/addr SHALL NOT be present.
				recordTarget/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				recordTarget/templateId/@root="1.2.36.1.2001.1001.102.101.100091"	
				recordTarget/patientRole	
				recordTarget/patientRole/id	id/@root SHALL be present and it SHALL be a UUID or an OID.
				recordTarget/patientRole/patient	
Patient > birthPlace	The registered place of birth of the patient. A system may use the address.text if they don't store the birthPlace address in discrete elements.	0..1	Address	recordTarget/patientRole/patient/birthplace	
				recordTarget/patientRole/patient/birthplace/place	
				recordTarget/patientRole/patient/birthplace/place/addr	Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address.
Patient > indigenous-status	National Health Data Dictionary (NHDD) based indigenous status for a patient.	1..1	Coding	recordTarget/patientRole/patient/ethnicGroupCode	Australian Indigenous Status (required)

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements					Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/
Patient > closing-the-gap-registration	Indication for eligibility for the Closing the Gap program.	0..1	boolean	entry[close_gap] entry[close_gap]/observation entry[close_gap]/observation/@classCode="OBS" entry[close_gap]/observation/@moodCode="EVN" entry[close_gap]/observation/code entry[close_gap]/observation/code/@code="103.32011" entry[close_gap]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" entry[close_gap]/observation/code/@displayName entry[close_gap]/observation/value	The containing component[admin_obs]/section SHALL conform to the template defined in component (Administrative Observations) . NCTIS Data Components displayName SHOULD be "Closing the Gap Copayment Eligibility Indicator". closing-the-gap-registration is "true" if eligible for Closing the Gap co-payment. value/@xsi:type SHALL be "BL".
Patient > patient-mothersMaidenName	Mother's maiden (unmarried) name, commonly collected to help verify patient identity.	0..1	string	entry[mothers_name] entry[mothers_name]/observation entry[mothers_name]/observation/@classCode="OBS" entry[mothers_name]/observation/@moodCode="EVN" entry[mothers_name]/observation/code entry[mothers_name]/observation/code/@code="103.10245" entry[mothers_name]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" entry[mothers_name]/observation/code/@displayName entry[mothers_name]/observation/value	The containing component[admin_obs]/section SHALL conform to the template defined in component (Administrative Observations) . NCTIS Data Components displayName SHOULD be "Mother's Original Family Name". value/@xsi:type SHALL be "ST".
CDA Header Data Elements					Context: /ClinicalDocument/
Patient > identifier	An identifier for this patient.	1..*	Identifier	recordTarget/patientRole/patient/ext:asEntityIdentifier	The logical cardinality of identifier is 1..*. In this template the minimum cardinality is satisfied by supplying a National Individual Healthcare Identifier (ext:asEntityIdentifier[ihi]). The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .

Logical element	Logical element description	Logic-al card	Logical type	CDA schema element	CDA constraints and comments
Patient > identifier (National Individual Healthcare Identifier (IHI))	National Healthcare Identifier (IHI) for the patient.	1..1	Identifier	recordTarget/patientRole/patient/ext:asEntityIdentifier[ihi]	In CDA, an Individual Healthcare Identifier (IHI) is sent as the last arc of an OID.
				recordTarget/patientRole/patient/ext:asEntityIdentifier[ihi]/@classCode="IDENT"	For example an IHI of 8003608833357361 would be sent as 1.2.36.1.2001.1003.0.8003608833357361.
				recordTarget/patientRole/patient/ext:asEntityIdentifier[ihi]/ext:id	If present, ext:asEntityIdentifier[ihi]/ext:assigningGeographicArea/ext:name SHALL be "National Identifier".
				recordTarget/patientRole/patient/ext:asEntityIdentifier[ihi]/ext:id/@root	ext:id/@extension SHALL NOT be present.
				recordTarget/patientRole/patient/ext:asEntityIdentifier[ihi]/ext:id/@assigningAuthorityName="IHI"	root SHALL be an OID. root SHALL have the OID arcs "1.2.36.1.2001.1003.0" preceding the IHI value. The IHI value (last arc of the root OID) prefix SHALL be "800360". The IHI value (last arc of the root OID) SHALL pass the Luhn algorithm check.
Patient > active	Whether this patient record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Patient > name	A name associated with the individual.	1..*	Base HumanName	recordTarget/patientRole/patient/name	At least one name SHALL contain a family name (name/family). The model Base HumanName is not applied to name. Recommended mappings for this logical type to CDA (R2) are available: Base HumanName .
Patient > gender	Administrative Gender - the gender that the patient is considered to have for administration and record keeping purposes.	1..1	code	recordTarget/patientRole/patient/administrativeGenderCode	AdministrativeGender (required)¹
Patient > birthDate	The date of birth for the individual.	1..1	date	recordTarget/patientRole/patient/birthTime	

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements					Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/
Patient > birthDate > date-accuracy-indicator	General date accuracy indicator coding.	0..1	Coding	entry[dob_acc] entry[dob_acc]/observation entry[dob_acc]/observation/@classCode="OBS" entry[dob_acc]/observation/@moodCode="EVN" entry[dob_acc]/observation/code entry[dob_acc]/observation/code/@code="102.16234" entry[dob_acc]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" entry[dob_acc]/observation/code/@displayName entry[dob_acc]/observation/value	The containing component[admin_obs]/section SHALL conform to the template defined in component (Administrative Observations) . NCTIS Data Components displayName SHOULD be "Date of Birth Accuracy Indicator". value/@xsi:type SHALL be "CD". Date Accuracy Indicator (required)
CDA Header Data Elements					Context: /ClinicalDocument/
Patient > birthDate > patient-birthTime	The time of day that the Patient was born. This includes the date to ensure that the timezone information can be communicated effectively.	0..1	dateTime	n/a	Not mapped separately, encompassed in patientRole/patient/birthTime.
Patient > deceased[x]	Indicates if the individual is deceased or not. Deceased date accuracy indicator is optional.	0..1	boolean dateTime	recordTarget/patientRole/patient/ext:deceasedInd recordTarget/patientRole/patient/ext:deceasedTime	Only one of ext:deceasedInd or ext:deceasedTime SHOULD be instantiated.
CDA Header Data Elements					Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/
Patient > deceased[x] > date-accuracy-indicator	General date accuracy indicator coding.	0..1	Coding	entry[dod_acc] entry[dod_acc]/observation entry[dod_acc]/observation/@classCode="OBS" entry[dod_acc]/observation/@moodCode="EVN" entry[dod_acc]/observation/code entry[dod_acc]/observation/code/@code="102.16252" entry[dod_acc]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" entry[dod_acc]/observation/code/@displayName entry[dod_acc]/observation/value	The containing component[admin_obs]/section SHALL conform to the template defined in component (Administrative Observations) . NCTIS Data Components displayName SHOULD be "Date of Death Accuracy Indicator". value/@xsi:type SHALL be "CD". Date Accuracy Indicator (required)

Logical element	Logical element description	Logic-al card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements				Context: /ClinicalDocument/	
Patient > maritalStatus	This field contains a patient's most recent marital (civil) status.	0..1	CodeableConcept	recordTarget/patientRole/patient/maritalStatusCode	maritalStatusCode/originalText or maritalStatusCode/@displayName SHALL be included. Marital Status Codes (extensible)
Patient > multipleBirth[x]	Indicates whether the patient is part of a multiple (bool) or indicates the actual birth order (integer).	0..1	boolean integer	recordTarget/patientRole/patient/ext:multipleBirthInd	Only one of ext:multipleBirthInd or ext:multipleBirthOrderNumber SHOULD be instantiated.
				recordTarget/patientRole/patient/ext:multipleBirthOrderNumber	
Patient > contact	A contact party (e.g. guardian, partner, friend) for the patient.	0..*	BackboneElement	participant[pat_contact]	In CDA, a patient's contact is represented by a participant. participant SHALL conform to the template defined in participant (Patient contact) .
Patient > communication	Languages which may be used to communicate with the patient about his or her health.	0..*	BackboneElement	recordTarget/patientRole/patient/languageCommunication	
Patient > communication > lan- guage	The ISO-639-1 alpha 2 code in lower case for the language, optionally followed by a hyphen and the ISO-3166-1 alpha 2 code for the region in upper case; e.g. 'en' for English, or 'en-US' for American English versus 'en-EN' for England English.	1..1	CodeableConcept	recordTarget/patientRole/patient/languageCommunication/languageCode	This CDA schema element is of type CodedSimpleValue (CS). Common Languages in Australia (extensible)
Patient > communication > pre- ferred	Indicates whether or not the patient prefers this language (over other languages he masters up a certain level).	0..1	boolean	recordTarget/patientRole/patient/languageCommunication/preferenceInd	
Patient > generalPractitioner	Patient's nominated care provider.	0..*	Reference (Base Organization Base Practitioner)	participant[gen_prac]	participant SHALL conform to one of the templates defined in: participant (generalPractitioner Base Organization) or participant (generalPractitioner Base Practitioner) .
Patient > managingOrganization	Organization that is the custodian of the patient record.	0..1	Reference (Base Organization)	recordTarget/patientRole/providerOrganization	providerOrganization SHALL conform to the template defined in providerOrganization (Base Organization) .

¹This hyperlink resolves to the FHIR Release 4 description due to a technical defect in the FHIR STU3 description of this code system for OID-based systems.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements				Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/	
Patient > closing-the-gap-registration	Indication for eligibility for the Closing the Gap program.	0..1	boolean	entry[close_gap] entry[close_gap]/observation entry[close_gap]/observation/@classCode="OBS" entry[close_gap]/observation/@moodCode="EVN" entry[close_gap]/observation/code entry[close_gap]/observation/code/@code="103.32011" entry[close_gap]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" entry[close_gap]/observation/code/@displayName entry[close_gap]/observation/value	The containing component[admin_obs]/section SHALL conform to the template defined in component (Administrative Observations) . NCTIS Data Components displayName SHOULD be "Closing the Gap Copayment Eligibility Indicator". closing-the-gap-registration is "true" if eligible for Closing the Gap co-payment. value/@xsi:type SHALL be "BL".
Patient > patient-mothersMaidenName	Mother's maiden (unmarried) name, commonly collected to help verify patient identity.	0..1	string	entry[mothers_name] entry[mothers_name]/observation entry[mothers_name]/observation/@classCode="OBS" entry[mothers_name]/observation/@moodCode="EVN" entry[mothers_name]/observation/code entry[mothers_name]/observation/code/@code="103.10245" entry[mothers_name]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" entry[mothers_name]/observation/code/@displayName entry[mothers_name]/observation/value	The containing component[admin_obs]/section SHALL conform to the template defined in component (Administrative Observations) . NCTIS Data Components displayName SHOULD be "Mother's Original Family Name". value/@xsi:type SHALL be "ST".
CDA Header Data Elements				Context: /ClinicalDocument/	
Patient > identifier	An identifier for this patient.	1..*	Identifier	recordTarget/patientRole/patient/ext:asEntityIdentifier	The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Patient > identifier (IHI)	National identifier for the patient	1..*	Identifier	recordTarget/patientRole/patient/ext:asEntityIdentifier recordTarget/patientRole/patient/ext:asEntityIdentifier/@classCode="IDENT" recordTarget/patientRole/patient/ext:asEntityIdentifier/ext:id recordTarget/patientRole/patient/ext:asEntityIdentifier/ext:id/@root recordTarget/patientRole/patient/ext:asEntityIdentifier/ext:id/@assigningAuthorityName="IHI" recordTarget/patientRole/patient/ext:asEntityIdentifier/ext:assigningGeographicArea recordTarget/patientRole/patient/ext:asEntityIdentifier/ext:assigningGeographicArea/@classCode="PLC" recordTarget/patientRole/patient/ext:asEntityIdentifier/ext:assigningGeographicArea/ext:name	In CDA, an Australian National Individual Healthcare Identifier (IHI) is sent as the last arc of an OID in id/@root. For example an IHI of 8003608833357361 would be sent as 1.2.36.1.2001.1003.0.8003608833357361. ext:id/@extension SHALL NOT be present. root SHALL be an OID. root SHALL have the OID arcs "1.2.36.1.2001.1003.0" preceding the IHI value. The IHI value (last arc of the root OID) SHALL be "800360". The IHI value (last arc of the root OID) SHALL pass the Luhn algorithm check.
Patient > active	Whether this patient record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Patient > name	A name associated with the individual.	0..*	Base HumanName	recordTarget/patientRole/patient/name	The model Base HumanName is not applied to name. Recommended mappings for this logical type to CDA (R2) are available: Base HumanName .
Patient > telecom	A contact detail (e.g. a telephone number or an email address) by which the individual may be contacted.	0..*	ContactPoint	recordTarget/patientRole/telecom	Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
Patient > gender	Administrative Gender - the gender that the patient is considered to have for administration and record keeping purposes.	0..1	code	recordTarget/patientRole/patient/administrativeGenderCode	In the Australian Digital Health Agency CDA schema the minimum occurrence of administrativeGenderCode is 1. Although administrativeGenderCode is required, a sending system may send a patient without gender by instantiating administrativeGenderCode/@nullFlavor="NI". No other nullFlavor value SHALL be allowed. AdministrativeGender (required)¹
Patient > birthDate	The date of birth for the individual.	0..1	date	recordTarget/patientRole/patient/birthTime	

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements				Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/	
Patient > birthDate > date-accuracy-indicator	General date accuracy indicator coding.	0..1	Coding	entry[dob_acc]	The containing component[admin_obs]/section SHALL conform to the template defined in component (Administrative Observations) .
				entry[dob_acc]/observation	
				entry[dob_acc]/observation/@classCode="OBS"	
				entry[dob_acc]/observation/@moodCode="EVN"	
				entry[dob_acc]/observation/code	
				entry[dob_acc]/observation/code/@code="102.16234"	
				entry[dob_acc]/observation/code/@codeSystem="1.2.36.1.2001.1001.101"	NCTIS Data Components
				entry[dob_acc]/observation/code/@displayName	displayName SHOULD be "Date of Birth Accuracy Indicator".
				entry[dob_acc]/observation/value	value/@xsi:type SHALL be "CD". Date Accuracy Indicator (required)
CDA Header Data Elements				Context: /ClinicalDocument/	
Patient > birthDate > patient-birthTime	The time of day that the Patient was born. This includes the date to ensure that the timezone information can be communicated effectively.	0..1	dateTime	n/a	Not mapped separately, encompassed in patientRole/patient/birthTime.
Patient > deceased[x]	Indicates if the individual is deceased or not. Deceased date accuracy indicator is optional.	0..1	boolean dateTime	recordTarget/patientRole/patient/ext:deceasedInd	Only one of ext:deceasedInd or ext:deceasedTime SHOULD be instantiated.
				recordTarget/patientRole/patient/ext:deceasedTime	
CDA Header Data Elements				Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/	
Patient > deceased[x] > date-accuracy-indicator	General date accuracy indicator coding.	0..1	Coding	entry[dod_acc]	The containing component[admin_obs]/section SHALL conform to the template defined in component (Administrative Observations) .
				entry[dod_acc]/observation	
				entry[dod_acc]/observation/@classCode="OBS"	
				entry[dod_acc]/observation/@moodCode="EVN"	
				entry[dod_acc]/observation/code	
				entry[dod_acc]/observation/code/@code="102.16252"	
				entry[dod_acc]/observation/code/@codeSystem="1.2.36.1.2001.1001.101"	NCTIS Data Components
				entry[dod_acc]/observation/code/@displayName	displayName SHOULD be "Date of Death Accuracy Indicator".
				entry[dod_acc]/observation/value	value/@xsi:type SHALL be "CD". Date Accuracy Indicator (required)

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements		Context: /ClinicalDocument/			
Patient > address	Addresses for the individual.	0..*	Address	recordTarget/patientRole/addr	Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
Patient > maritalStatus	This field contains a patient's most recent marital (civil) status.	0..1	CodeableConcept	recordTarget/patientRole/patient/ maritalStatusCode	maritalStatusCode/originalText or maritalStatusCode/@displayName SHALL be included. Marital Status Codes (extensible)
Patient > multipleBirth[x]	Indicates whether the patient is part of a multiple (bool) or indicates the actual birth order (integer).	0..1	boolean integer	recordTarget/patientRole/patient/ext:multipleBirthInd	Only one of ext:multipleBirthInd or ext:multipleBirthOrderNumber SHOULD be instantiated.
				recordTarget/patientRole/patient/ext:multipleBirthOrderNumber	
Patient > contact	A contact party (e.g. guardian, partner, friend) for the patient.	0..*	BackboneElement	participant[pat_contact]	In CDA, a patient's contact is represented by a participant. participant SHALL conform to the template defined in participant (Patient contact) .
Patient > communication	Languages which may be used to communicate with the patient about his or her health.	0..*	BackboneElement	recordTarget/patientRole/patient/languageCommunication	
Patient > communication > language	The ISO-639-1 alpha 2 code in lower case for the language, optionally followed by a hyphen and the ISO-3166-1 alpha 2 code for the region in upper case; e.g. 'en' for English, or 'en-US' for American English versus 'en-EN' for England English.	1..1	CodeableConcept	recordTarget/patientRole/patient/languageCommunication/languageCode	This CDA schema element is of type CodedSimpleValue (CS). Common Languages in Australia (extensible)
Patient > communication > preferred	Indicates whether or not the patient prefers this language (over other languages he masters up a certain level).	0..1	boolean	recordTarget/patientRole/patient/languageCommunication/preferenceInd	
Patient > generalPractitioner	Patient's nominated care provider.	0..*	Reference (Base Organization Base Practitioner)	participant[gen_prac]	participant SHALL conform to one of the templates defined in: participant (generalPractitioner Base Organization) or participant (generalPractitioner Base Practitioner) .
Patient > managingOrganization	Organization that is the custodian of the patient record.	0..1	Reference (Base Organization)	recordTarget/patientRole/providerOrganization	providerOrganization SHALL conform to the template defined in providerOrganization (Base Organization) .

¹This hyperlink resolves to the FHIR Release 4 description due to a technical defect in the FHIR STU3 description of this code system for OID-based systems.

8.3 participant (Patient contact)

This template is referenced by [recordTarget \(Patient with Mandatory IHI\)](#), and [recordTarget \(My Health Record Patient\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements		Context: /ClinicalDocument/			
Patient > contact	A contact party (e.g. guardian, partner, friend) for the patient.	Cardinality comes from linking element	BackboneElement	participant[pat_contact]	The patient's contact SHALL have at least:
				participant[pat_contact]/@typeCode="IND"	<ul style="list-style-type: none"> name (participant[pat_contact]/associatedEntity/associatedPerson/name), or telecom (participant[pat_contact]/associatedEntity/telecom), or address (participant[pat_contact]/associatedEntity/ad-dr), or organization (participant[pat_contact]/associatedEntity/scopingOrganization)
				participant[pat_contact]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				participant[pat_contact]/templateId/@root="1.2.36.1.2001.1001.102.101.100056"	
				participant[pat_contact]/associatedEntity	
				participant[pat_contact]/associatedEntity/@classCode="CON"	
Patient > contact > relationship	The nature of the relationship between the patient and the contact person.	0..*	CodeableConcept	participant[pat_contact]/associatedEntity/associatedPerson/ext:personalRelationship	The common pattern Personal Relationship SHALL be applied.
				participant[pat_contact]/associatedEntity/associatedPerson/ext:personalRelationship/ext:code	ext:code/originalText or ext:code/@displayName SHALL be included. Contact Relationship Type (extensible)
Patient > contact > name	A name associated with the contact person.	0..1	Base HumanName	participant[pat_contact]/associatedEntity/associatedPerson/name	The model Base HumanName is not applied to name. Recommended mappings for this logical type to CDA (R2) are available: Base HumanName .

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Patient > contact > telecom	A contact detail for the person, e.g. a telephone number or an email address.	0..*	ContactPoint	participant[pat_contact]/associatedEntity/telecom	Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
Patient > contact > address	Address for the contact person.	0..1	Address	participant[pat_contact]/associatedEntity/addr	Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
Patient > contact > gender	Administrative Gender - the gender that the contact person is considered to have for administration and record keeping purposes.	0..1	code	participant[pat_contact]/associatedEntity/associatedPerson/ext:administrativeGenderCode	AdministrativeGender (required) ¹
Patient > contact > organization	Organization on behalf of which the contact is acting or for which the contact is working.	0..1	Reference(Base Organization)	participant[pat_contact]/associatedEntity/scopingOrganization	scopingOrganization SHALL conform to the template defined in scopingOrganization (Base Organization) .
Patient > contact > period	The period during which this contact person or organization is valid to be contacted relating to this patient.	0..1	Period	n/a	This logical element has no mapping to CDA.

¹This hyperlink resolves to the FHIR Release 4 description due to a technical defect in the FHIR STU3 description of this code system for OID-based systems.

8.4 participant (Organization contact)

This template is referenced by [participant \(generalPractitioner Base Organization\)](#), [custodian \(Organization with Mandatory Identifier\)](#), [providerOrganization \(Base Organization\)](#), [representativeOrganization \(Base Organization\)](#), [scopingOrganization \(Base Organization\)](#), and [wholeOrganization \(Base Organization\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements				Context: /ClinicalDocument/	
Organization > contact	Contact for the organization for a certain purpose.	Cardinality comes from linking element	Organization	participant[org_contact]	
				participant[org_contact]/@typeCode="IND"	
				participant[org_contact]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				participant[org_contact]/templateId/@root="1.2.36.1.2001.1001.102.101.100035"	
				participant[org_contact]/associatedEntity	
				participant[org_contact]/associatedEntity/@classCode="CON"	
				participant[org_contact]/associatedEntity/scopingOrganization	
				participant[org_contact]/associatedEntity/scopingOrganization/id	Organization > contact is represented in CDA by a participant that is scoped by the Organization for which they are a contact. This id SHALL hold the same value as the organization this is a contact for (the value in this id element SHALL be present in a separate participation). id/@root SHALL be present and it SHALL be a UUID or an OID.
Organization > contact > purpose	Indicates a purpose for which the contact can be reached.	0..1	CodeableConcept	participant[org_contact]/associatedEntity/code	code/originalText or code/@displayName SHALL be included. Contact entity type (extensible) ¹
Organization > contact > name	A name associated with the contact.	0..1	Base HumanName	participant[org_contact]/associatedEntity/associatedPerson	
				participant[org_contact]/associatedEntity/associatedPerson/name	The model Base HumanName is not applied to name. Recommended mappings for this logical type to CDA (R2) are available: Base HumanName .
Organization > contact > telecom	A contact detail (e.g. a telephone number or an email address) by which the party may be contacted.	0..*	ContactPoint	participant[org_contact]/associatedEntity/telecom	Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Organization > contact > address	Visiting or postal addresses for the contact.	0..1	Address	participant[org_contact]/associatedEntity/addr	Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .

¹This value set differs from the value set bound to contact purpose in the Agency logical model (see [Shared Health Summary FHIR Implementation Guide \[DH2020i\]](#)) due to pre-adoption of FHIR Release 4 terminology.

8.5 participant (generalPractitioner Base Organization)

This template is referenced by [recordTarget \(Patient with Mandatory IHI\)](#), and [recordTarget \(My Health Record Patient\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical type	Logical card	CDA schema element	CDA constraints and comments
CDA Header Data Elements					Context: /ClinicalDocument/
Organization	A formally or informally recognized grouping of people or organizations formed for the purpose of achieving some form of collective action. Includes companies, institutions, corporations, departments, community groups, healthcare practice groups, etc.	Cardinality comes from linking element	Organization	<code>participant[gen_prac]</code>	Organization SHALL have at least:
				<code>participant[gen_prac]/@typeCode="PART"</code>	<ul style="list-style-type: none"> • identifier (<code>participant[gen_prac]/associatedEntity/scopingOrganization/ext:asEntityIdentifier</code>), or • name (<code>participant[gen_prac]/associatedEntity/scopingOrganization/name</code>)
				<code>participant[gen_prac]/templateId</code>	The use of templateId signals the imposition of a set of template-defined constraints.
				<code>participant[gen_prac]/templateId/@root="1.2.36.1.2001.1001.102.101.100036"</code>	
				<code>participant[gen_prac]/functionCode/@code="PCP"</code>	
				<code>participant[gen_prac]/associatedEntity</code>	
				<code>participant[gen_prac]/associatedEntity/@classCode="PROV"</code>	
Organization > identifier	Identifier for the organization that is used to identify the organization across multiple disparate systems.	0..*	Identifier	<code>participant[gen_prac]/associatedEntity/scopingOrganization/ext:asEntityIdentifier</code>	The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .
Organization > active	Whether the organization's record is still in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Organization > type	The kind(s) of organization that this is.	0..*	CodeableConcept	<code>participant[gen_prac]/associatedEntity/code</code>	In CDA the maximum occurrences of associatedEntity/code is 1. Although the model indicates that code is 0..*, in a CDA implementation this is limited to 0..1. <code>code/originalText</code> or <code>code/@displayName</code> SHALL be included. OrganizationType (example)

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Organization > name	A name associated with the organization.	0..1	string	participant[gen_prac]/associatedEntity/scopingOrganization/ name[org_name]	In CDA name and alias are represented by scopingOrganization/name.
Organization > alias	A list of alternate names that the organization is known as, or was known as in the past.	0..*	string	participant[gen_prac]/associatedEntity/scopingOrganization/ name[alias]	In CDA name and alias are represented by scopingOrganization/name.
Organization > telecom	A contact detail for the organization.	0..*	ContactPoint	participant[gen_prac]/associatedEntity/ telecom	telecom/@use Organization Telecom Use HL7 V3 (required) ¹ . Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
Organization > address	An address for the organization.	0..*	Address	participant[gen_prac]/associatedEntity/ addr	addr/@use Organization Address Use HL7 V3 (required) ² . Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
Organization > partOf	The organization of which this organization forms a part.	0..1	Reference (Base Organization)	participant[gen_prac]/associatedEntity/scopingOrganization/ asOrganizationPartOf participant[gen_prac]/associatedEntity/scopingOrganization/ asOrganizationPartOf/wholeOrganization	wholeOrganization SHALL conform to the template defined in wholeOrganization (Base Organization) .
Organization > contact	Contact for the organization for a certain purpose.	0..*	BackboneElement	participant[org_contact]	participant[org_contact] SHALL conform to the template defined in participant (Organization contact) .

¹This value set differs from the value set bound to use in [ContactPoint](#) due to constraints on @use in the HL7 CDA Schema. The concept map [v3 map for ContactPointUse](#) provides a mapping between the two value sets.

²This value set differs from the value set bound to use in [Address](#) due to constraints on @use in the HL7 CDA schema. The concept map [v3 map for AddressUse](#) provides a mapping between the two value sets.

8.6 participant (generalPractitioner Base Practitioner)

This template is referenced by [recordTarget \(Patient with Mandatory IHI\)](#), and [recordTarget \(My Health Record Patient\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements				Context: /ClinicalDocument/	
Practitioner	A person who is directly or indirectly involved in the provisioning of healthcare.	Cardinality comes from linking element	Practitioner	<code>participant[gen_prac]</code>	Practitioner SHALL have at least: <ul style="list-style-type: none"> • identifier (<code>participant[gen_prac]/associatedEntity/associatedPerson/ext:asEntityIdentifier</code>), or • name (<code>participant[gen_prac]/associatedEntity/associatedPerson/name</code>)
				<code>participant[gen_prac]/@typeCode="PART"</code>	
				<code>participant[gen_prac]/templateId</code>	The use of templateId signals the imposition of a set of template-defined constraints.
				<code>participant[gen_prac]/templateId/@root="1.2.36.1.2001.1001.102.101.100037"</code>	
				<code>participant[gen_prac]/functionCode/@code="PCP"</code>	
				<code>participant[gen_prac]/associatedEntity</code>	
				<code>participant[gen_prac]/associatedEntity/@classCode="PROV"</code>	
				<code>participant[gen_prac]/associatedEntity/id</code>	<code>id/@root</code> SHALL be present and it SHALL be a UUID or an OID.
				<code>participant[gen_prac]/associatedEntity/code</code>	The cardinality of code SHALL be interpreted as 0..1. Australian and New Zealand Standard Classification of Occupations (preferred)
Practitioner > identifier	An identifier that applies to this person in this role.	0..*	Identifier	<code>participant[gen_prac]/associatedEntity/associatedPerson/ext:asEntityIdentifier</code>	The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .
Practitioner > active	Whether this practitioner's record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Practitioner > name	The name(s) associated with the practitioner.	0..*	Base HumanName	<code>participant[gen_prac]/associatedEntity/associatedPerson/name</code>	The model Base HumanName is not applied to name. Recommended mappings for this logical type to CDA (R2) are available: Base HumanName .

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Practitioner > telecom	A contact detail for the practitioner, e.g. a telephone number or an email address.	0..*	ContactPoint	participant[gen_prac]/associatedEntity/telecom	Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
Practitioner > address	Address(es) of the practitioner that are not role specific (typically home address). Work addresses are not typically entered in this property as they are usually role dependent.	0..*	Address	participant[gen_prac]/associatedEntity/addr	Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
Practitioner > gender	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	code	n/a	This logical element has no mapping to CDA.
Practitioner > birthDate	The date of birth for the practitioner.	0..1	date	n/a	This logical element has no mapping to CDA.
Practitioner > qualification	Qualifications obtained by training and certification.	0..*	BackboneElement	See: instantiation choices	<p>It is possible that the qualification may be able to be captured as a complex structure or as a text list.</p> <p>instantiation choices:</p> <p>If the qualification or list of qualifications is the result of capturing a text field then qualification is expected to be instantiated as ext:asQualifications/@classCode="QUAL". The common pattern Qualification SHALL be applied.</p> <p>If more information can be captured than a narrative list then qualification is expected to be instantiated as ClinicalDocument/component/structuredBody/component[admin_obs]/section/ext:coverage2[prac_qual] and SHALL conform to the template defined in ext:coverage2 (Practitioner qualification).</p>
Practitioner > communication	A language the practitioner is able to use in patient communication.	0..*	CodeableConcept	participant[gen_prac]/associatedEntity/associatedPerson/ ext:languageCommunication	The common pattern Language Communication SHALL be applied.

8.7 author (PractitionerRole with Practitioner with Mandatory Identifier)

This template is referenced by [ClinicalDocument \(Shared Health Summary\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements				Context: Comes from linking elements	
PractitionerRole	A specific set of Roles/Locations/specialties/services that a practitioner may perform at an organization for a period of time.	Cardinality comes from linking element	PractitionerRole	author	
				author/ templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				author/templateId/@root="1.2.36.1.2001.1001.102.101.100006"	
				author/ assignedAuthor	
				author/assignedAuthor/ id	id/@root SHALL be present and it SHALL be a UUID or an OID.
PractitionerRole > identifier	Business identifiers for practitioner in a role.	0..*	Identifier	author/assignedAuthor/assignedPerson/ ext:asEntityIdentifier	In CDA the identifier for both PractitionerRole and Practitioner for an author participation are included in assignedPerson/ext:asEntityIdentifier. When sending to the My Health Record, an HPI-I is expected. The cardinality of ext:asEntityIdentifier SHALL be interpreted as 1..*. The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .
PractitionerRole > active	Whether this practitioner's record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
PractitionerRole > period	The period during which the person is authorized to act as a practitioner in these role(s) for the organization.	0..1	Period	n/a	This logical element has no mapping to CDA.
PractitionerRole > practitioner	Practitioner that is able to provide the defined services for the organization.	1..1	Reference (Practitioner with Mandatory Identifier)	author/assignedAuthor/assignedPerson	assignedPerson SHALL conform to the template defined in assignedPerson (Practitioner with Mandatory Identifier) .
PractitionerRole > organization	The organization where the Practitioner performs the roles associated.	0..1	Reference (Base Organization)	author/assignedAuthor/representedOrganization	representedOrganization SHALL conform to the template defined in representedOrganization (Base Organization) .

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
PractitionerRole > code	Roles which this practitioner is authorized to perform for the organization.	0..*	CodeableConcept	author/assignedAuthor/code	In CDA the maximum occurrences of assignedAuthor/code is 1. Although the model indicates that code is 0..*, in a CDA implementation this is limited to 0..1. A code equivalent to the provider's professional role, e.g. 159011008 Community pharmacist is expected. code/originalText or code/@displayName SHALL be included. Australian and New Zealand Standard Classification of Occupations (preferred) or Practitioner Role (preferred) ¹
PractitionerRole > specialty	Specific specialty of the practitioner.	0..*	CodeableConcept	n/a	This logical element has no mapping to CDA.
PractitionerRole > location	The location(s) at which this practitioner provides care.	0..*	Reference(Location)	n/a	This logical element has no mapping to CDA.
PractitionerRole > healthcareService	The list of healthcare services that this worker provides for this role's Organization/Location(s).	0..*	Reference(Health-careService)	n/a	Not currently mapped to CDA. See Known issues .
PractitionerRole > telecom	Contact details that are specific to the role/location/service.	0..*	ContactPoint	author/assignedAuthor/telecom	In CDA the telecom for both PractitionerRole and Practitioner for an author participation are included in assignedAuthor/telecom. Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
PractitionerRole > availableTime	A collection of times that the Service Site is available.	0..*	BackboneElement	n/a	This logical element has no mapping to CDA.
PractitionerRole > notAvailable	The HealthcareService is not available during this period of time due to the provided reason.	0..*	BackboneElement	n/a	This logical element has no mapping to CDA.
PractitionerRole > availabilityExceptions	A description of site availability exceptions, e.g. public holiday availability. Succinctly describing all possible exceptions to normal site availability as details in the available Times and not available Times.	0..1	string	n/a	This logical element has no mapping to CDA.

¹Note: The source representation of this terminology binding on code in PractitionerRole with Practitioner with Mandatory Identifier [DH2020i] is as an optional slice on the [coding](#) part of the code element. In the representation of the model presented in this specification it is normalised as a set of preferred bindings.

8.8 custodian (Organization with Mandatory Identifier)

This template is referenced by [ClinicalDocument \(Shared Health Summary\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements			Context: /ClinicalDocument/		
Organization	A formally or informally recognized grouping of people or organizations formed for the purpose of achieving some form of collective action. Includes companies, institutions, corporations, departments, community groups, healthcare practice groups, etc.	Cardinality comes from linking element	Organization	custodian	
				custodian/ templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				custodian/templateId/@root="1.2.36.1.2001.1001.102.101.100002"	
				custodian/assignedCustodian	
				custodian/assignedCustodian/representedCustodianOrganization	
				custodian/assignedCustodian/representedCustodianOrganization/id	id/@root SHALL be present and it SHALL be a UUID or an OID.
Organization > identifier	Identifier for the organization that is used to identify the organization across multiple disparate systems.	1..*	Identifier	custodian/assignedCustodian/representedCustodianOrganization/ext:asEntityIdentifier	When sending to the My Health Record, an HPI-O is expected. The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .
Organization > active	Whether the organization's record is still in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Organization > type	The kind(s) of organization that this is.	0..*	CodeableConcept	n/a	This logical element has no mapping to CDA.
Organization > name	A name associated with the organization.	0..1	string	custodian/assignedCustodian/representedCustodianOrganization/name	
Organization > alias	A list of alternate names that the organization is known as, or was known as in the past.	0..*	string	n/a	This logical element has no mapping to CDA.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Organization > telecom	A contact detail for the organization.	0..*	ContactPoint	custodian/assignedCustodian/representedCustodianOrganization/ telecom	In CDA the maximum occurrences of representedCustodian-Organization/telecom is 1. Although the model indicates that telecom is 0.. *, in a CDA implementation this is limited to 0..1. telecom/@use Organization Telecom Use HL7 V3 (required) ¹ . Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
Organization > address	An address for the organization.	0..*	Address	custodian/assignedCustodian/representedCustodianOrganization/ addr	addr/@use Organization Address Use HL7 V3 (required) ² . In CDA the maximum occurrences of representedCustodian-Organization/addr is 1. Although the model indicates that address is 0.. *, in a CDA implementation this is limited to 0..1. Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
Organization > partOf	The organization of which this organization forms a part.	0..1	Reference (Base Organization)	n/a	This logical element has no mapping to CDA.
Organization > contact	Contact for the organization for a certain purpose.	0..*	BackboneElement	participant[org_contact]	participant[org_contact] SHALL conform to the template defined in participant (Organization contact) .

¹This value set differs from the value set bound to use in [ContactPoint](#) due to constraints on @use in the HL7 CDA Schema. The concept map [v3 map for ContactPointUse](#) provides a mapping between the two value sets.

²This value set differs from the value set bound to use in [Address](#) due to constraints on @use in the HL7 CDA schema. The concept map [v3 map for AddressUse](#) provides a mapping between the two value sets.

8.9 informant (Base Patient)

This template is referenced by [substanceAdministration \(Summary Statement of Known Medicine\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements				Context: Comes from linking element	
Patient	Demographics and other administrative information about an individual receiving care or other health-related services.	Cardinality comes from linking element	Patient	informant	Patient SHALL have at least: <ul style="list-style-type: none">• name (informant/assignedEntity/assignedPerson/name), or• identifier (informant/assignedEntity/assignedPerson/ext:asEntityIdentifier)
				informant/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				informant/templateId/@root="1.2.36.1.2001.1001.102.101.100051"	
				informant/assignedEntity	
				informant/assignedEntity/id	informant (patient) is represented in CDA by an informant with the same id as the patient that is the subject of this document. This id SHALL hold the same value as patientRole/id.
				informant/assignedEntity/code	
				informant/assignedEntity/code/@code="ONESELF"	
				informant/assignedEntity/code/@codeSystem="2.16.840.1.113883.5.111"	v3 Code System RoleCode
				informant/assignedEntity/assignedPerson	
Patient > birthPlace	The registered place of birth of the patient. A system may use the address.text if they don't store the birthPlace address in discrete elements.	0..1	Address	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/birthplace/place/addr.
Patient > indigenous-status	National Health Data Dictionary (NHDD) based indigenous status for a patient.	0..1	Coding	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ethnicGroupCode.
Patient > closing-the-gap-registration	Indication for eligibility for the Closing the Gap program.	0..1	boolean	n/a	Not mapped directly for this participant; this is implicit in entry[close_gap]/observation/value.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Patient > patient-mothersMaidenName	Mother's maiden (unmarried) name, commonly collected to help verify patient identity.	0..1	string	n/a	Not mapped directly for this participant; this is implicit in entry[mothers_name]/observation/value.
Patient > identifier	An identifier for this patient.	0..*	Identifier	informant/assignedEntity/assignedPerson/ext:asEntityIdentifier	The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .
Patient > active	Whether this patient record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Patient > name	A name associated with the individual.	0..*	Base HumanName	informant/assignedEntity/assignedPerson/name	The model Base HumanName is not applied to name. Recommended mappings for this logical type to CDA (R2) are available: Base HumanName .
Patient > telecom	A contact detail (e.g. a telephone number or an email address) by which the individual may be contacted.	0..*	ContactPoint	informant/assignedEntity/telecom	When sending to the My Health Record, telecom is not expected to be sent. Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
Patient > gender	Administrative Gender - the gender that the patient is considered to have for administration and record keeping purposes.	0..1	code	informant/assignedEntity/assignedPerson/ext:administrativeGenderCode	AdministrativeGender (required) ¹
Patient > birthDate	The date of birth for the individual.	0..1	date	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/birthTime.
Patient > deceased[x]	Indicates if the individual is deceased or not. Deceased date accuracy indicator is optional.	0..1	boolean dateTime	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ext:deceasedTime or patientRole/patient/ext:deceasedInd.
Patient > address	Addresses for the individual.	0..*	Address	informant/assignedEntity/addr	When sending to the My Health Record, address is not expected to be sent. Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
Patient > maritalStatus	This field contains a patient's most recent marital (civil) status.	0..1	CodeableConcept	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/maritalStatusCode.
Patient > multipleBirth[x]	Indicates whether the patient is part of a multiple (bool) or indicates the actual birth order (integer).	0..1	boolean integer	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ext:multipleBirthInd or patientRole/patient/multipleBirthOrderNumber.
Patient > contact	A contact party (e.g. guardian, partner, friend) for the patient.	0..*	BackboneElement	n/a	This logical element has no mapping to CDA.
Patient > communication	Languages which may be used to communicate with the patient about his or her health.	0..*	BackboneElement	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/languageCommunication.
Patient > generalPractitioner	Patient's nominated care provider.	0..*	Reference (Base Organization Base Practitioner)	n/a	This logical element has no mapping to CDA.

Logical element	Logical element description	Logic-al card	Logical type	CDA schema element	CDA constraints and comments
Patient > managingOrganization	Organization that is the custodian of the patient record.	0..1	Reference (Base Organization)	n/a	This logical element has no mapping to CDA.

¹This hyperlink resolves to the FHIR Release 4 description due to a technical defect in the FHIR STU3 description of this code system for OID-based systems.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
RelatedPerson > name	A name associated with the person.	0..*	Base HumanName	informant/relatedEntity/relatedPerson/name	The model Base HumanName is not applied to name. Recommended mappings for this logical type to CDA (R2) are available: Base HumanName .
RelatedPerson > telecom	A contact detail for the person, e.g. a telephone number or an email address.	0..*	ContactPoint	informant/relatedEntity/telecom	
RelatedPerson > gender	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	code	informant/relatedEntity/relatedPerson/ext:administrativeGenderCode	AdministrativeGender (required) ¹
RelatedPerson > birthDate	The date on which the related person was born.	0..1	date	informant/relatedEntity/relatedPerson/ext:birthTime	
RelatedPerson > address	Address where the related person can be contacted or visited.	0..*	Address	informant/relatedEntity/addr	Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
RelatedPerson > period	The period of time that this relationship is considered to be valid. If there are no dates defined, then the interval is unknown.	0..1	Period	n/a	Not mapped separately, implicit in ext:personalRelationship/ext:effectiveTime.

¹This hyperlink resolves to the FHIR Release 4 description due to a technical defect in the FHIR STU3 description of this code system for OID-based systems.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Practitioner > address	Address(es) of the practitioner that are not role specific (typically home address). Work addresses are not typically entered in this property as they are usually role dependent.	0..*	Address	informant/assignedEntity/addr	Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
Practitioner > gender	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	code	n/a	This logical element has no mapping to CDA.
Practitioner > birthDate	The date of birth for the practitioner.	0..1	date	n/a	This logical element has no mapping to CDA.
Practitioner > qualification	Qualifications obtained by training and certification.	0..*	BackboneElement	See: instantiation choices	<p>It is possible that the qualification may be able to be captured as a complex structure or as a text list.</p> <p>instantiation choices:</p> <p>If the qualification or list of qualifications is the result of capturing a text field then qualification is expected to be instantiated as ext:asQualifications/@classCode="QUAL". The common pattern Qualification SHALL be applied.</p> <p>If more information can be captured than a narrative list then qualification is expected to be instantiated as ext:coverage2[prac_qual] and SHALL conform to the template defined in ext:coverage2 (Practitioner qualification):</p> <ul style="list-style-type: none"> qualification for a Practitioner SHALL be instantiated in the same section e.g. qualification for an AllergyIntolerance recorder is expected to be instantiated as ClinicalDocument/component/structuredBody/component[allergy]/section/ext:coverage2[prac_qual], or qualification for a CDA Header Practitioner (e.g. ClinicalDocument author) SHALL be instantiated as ClinicalDocument/component/structuredBody/component[admin_obs]/section/ext:coverage2[prac_qual]
Practitioner > communication	A language the practitioner is able to use in patient communication.	0..*	CodeableConcept	informant/assignedEntity/assignedPerson/ext:languageCommunication	The common pattern Language Communication SHALL be applied.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Patient > patient-mothersMaiden-Name	Mother's maiden (unmarried) name, commonly collected to help verify patient identity.	0..1	string	n/a	Not mapped directly for this participant; this is implicit in entry[mothers_name]/observation/value.
Patient > identifier	An identifier for this patient.	0..*	Identifier	author/assignedAuthor/assignedPerson/ext:asEntityIdentifier	When sending to the My Health Record, an IHI is expected. The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .
Patient > active	Whether this patient record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Patient > name	A name associated with the individual.	0..*	Base HumanName	author/assignedAuthor/assignedPerson/ name	The model Base HumanName is not applied to name. Recommended mappings for this logical type to CDA (R2) are available: Base HumanName .
Patient > telecom	A contact detail (e.g. a telephone number or an email address) by which the individual may be contacted.	0..*	ContactPoint	author/assignedAuthor/ telecom	When sending to the My Health Record, telecom is not expected to be sent. Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
Patient > gender	Administrative Gender - the gender that the patient is considered to have for administration and record keeping purposes.	0..1	code	author/assignedAuthor/assignedPerson/ext:administrativeGenderCode	AdministrativeGender (required) ¹
Patient > birthDate	The date of birth for the individual.	0..1	date	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/birthTime.
Patient > deceased[x]	Indicates if the individual is deceased or not. Deceased date accuracy indicator is optional.	0..1	boolean dateTime	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ext:deceasedTime or patientRole/patient/ext:deceasedInd.
Patient > address	Addresses for the individual.	0..*	Address	author/assignedAuthor/ addr	When sending to the My Health Record, address is not expected to be sent. Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
Patient > maritalStatus	This field contains a patient's most recent marital (civil) status.	0..1	CodeableConcept	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/maritalStatusCode.
Patient > multipleBirth[x]	Indicates whether the patient is part of a multiple (bool) or indicates the actual birth order (integer).	0..1	boolean integer	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ext:multipleBirthInd or patientRole/patient/multipleBirthOrderNumber.
Patient > contact	A contact party (e.g. guardian, partner, friend) for the patient.	0..*	BackboneElement	n/a	This logical element has no mapping to CDA.
Patient > communication	Languages which may be used to communicate with the patient about his or her health.	0..*	BackboneElement	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/languageCommunication.
Patient > generalPractitioner	Patient's nominated care provider.	0..*	Reference (Base Organization Base Practitioner)	n/a	This logical element has no mapping to CDA.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Patient > managingOrganization	Organization that is the custodian of the patient record.	0..1	Reference (Base Organization)	n/a	This logical element has no mapping to CDA.

¹This hyperlink resolves to the FHIR Release 4 description due to a technical defect in the FHIR STU3 description of this code system for OID-based systems.

8.13 author (Base PractitionerRole)

This template is referenced by [observation \(Summary Statement of Allergy or Intolerance\)](#), and [observation \(Assertion of No Relevant Finding\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements				Context: Comes from linking elements	
PractitionerRole	A specific set of Roles/Locations/specialties/services that a practitioner may perform at an organization for a period of time.	Cardinality comes from linking element	PractitionerRole	author	PractitionerRole SHALL have at least: <ul style="list-style-type: none"> • practitioner role or practitioner identifier (author/assignedAuthor/assignedPerson/ext:asEntityIdentifier), or • practitioner name (author/assignedAuthor/assignedPerson/name)
				author/ templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				author/templateId/@root="1.2.36.1.2001.1001.102.101.100085"	
				author/assignedAuthor	
				author/assignedAuthor/id	id/@root SHALL be present and it SHALL be a UUID or an OID.
PractitionerRole > identifier	Business identifiers for practitioner in a role.	0..*	Identifier	author/assignedAuthor/assignedPerson/ext:asEntityIdentifier	In CDA the identifier for both PractitionerRole and Practitioner for an author participation are included in assignedPerson/ext:asEntityIdentifier. When sending to the My Health Record, an HPI-I is expected. The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .
PractitionerRole > active	Whether this practitioner's record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
PractitionerRole > period	The period during which the person is authorized to act as a practitioner in these role(s) for the organization.	0..1	Period	n/a	This logical element has no mapping to CDA.
PractitionerRole > practitioner	Practitioner that is able to provide the defined services for the organization.	0..1	Reference (Base Practitioner)	author/assignedAuthor/assignedPerson	assignedPerson SHALL conform to the template defined in assignedPerson (Base Practitioner) .
PractitionerRole > organization	The organization where the Practitioner performs the roles associated.	0..1	Reference (Base Organization)	author/assignedAuthor/representedOrganization	representedOrganization SHALL conform to the template defined in representedOrganization (Base Organization) .

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
PractitionerRole > code	Roles which this practitioner is authorized to perform for the organization.	0..*	CodeableConcept	author/assignedAuthor/code	In CDA the maximum occurrences of assignedAuthor/code is 1. Although the model indicates that code is 0..*, in a CDA implementation this is limited to 0..1. A code equivalent to the provider's professional role, e.g. 159011008 Community pharmacist is expected. Australian and New Zealand Standard Classification of Occupations (preferred) or Practitioner Role (preferred) ¹
PractitionerRole > specialty	Specific specialty of the practitioner.	0..*	CodeableConcept	n/a	This logical element has no mapping to CDA.
PractitionerRole > location	The location(s) at which this practitioner provides care.	0..*	Reference(Location)	n/a	This logical element has no mapping to CDA.
PractitionerRole > healthcareService	The list of healthcare services that this worker provides for this role's Organization/Location(s).	0..*	Reference(Health-careService)	n/a	Not currently mapped to CDA. See Known issues .
PractitionerRole > telecom	Contact details that are specific to the role/location/service.	0..*	ContactPoint	author/assignedAuthor/telecom	In CDA the telecom for both PractitionerRole and Practitioner for an author participation are included in assignedAuthor/telecom. Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
PractitionerRole > availableTime	A collection of times that the Service Site is available.	0..*	BackboneElement	n/a	This logical element has no mapping to CDA.
PractitionerRole > notAvailable	The HealthcareService is not available during this period of time due to the provided reason.	0..*	BackboneElement	n/a	This logical element has no mapping to CDA.
PractitionerRole > availabilityExceptions	A description of site availability exceptions, e.g. public holiday availability. Succinctly describing all possible exceptions to normal site availability as details in the available Times and not available Times.	0..1	string	n/a	This logical element has no mapping to CDA.

¹Note: The source representation of this terminology binding on code in PractitionerRole with Practitioner with Mandatory Identifier [DH2020i] is as an optional slice on the [coding](#) part of the code element. In the representation of the model presented in this specification it is normalised as a set of preferred bindings.

8.14 author (Base RelatedPerson)

This template is referenced by [observation \(Summary Statement of Allergy or Intolerance\)](#), and [observation \(Assertion of No Relevant Finding\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements				Context: Comes from linking elements	
RelatedPerson	Information about a person that is involved in the care for a patient, but who is not the target of healthcare, nor has a formal responsibility in the care process.	Cardinality comes from linking elements	RelatedPerson	author	RelatedPerson SHALL have at least: <ul style="list-style-type: none">name (author/assignedAuthor/assignedPerson/name), oridentifier (author/assignedAuthor/assignedPerson/ext:asEntityIdentifier), orrelationship (author/assignedAuthor/assignedPerson/ext:personalRelationship)
				author/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				author/templateId/@root="1.2.36.1.2001.1001.102.101.100083"	
				author/assignedAuthor	
				author/assignedAuthor/id	id/@root SHALL be present and it SHALL be a UUID or an OID.
				author/assignedAuthor/code	
				author/assignedAuthor/code/@code="AGNT"	
				author/assignedAuthor/code/@codeSystem="2.16.840.1.113883.5.110"	v3 Code System RoleClass
				author/assignedAuthor/assignedPerson	
RelatedPerson > identifier	Identifier for a person within a particular scope.	0..*	Identifier	author/assignedAuthor/assignedPerson/ext:asEntityIdentifier	When sending to the My Health Record, an IHI is expected. The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .
RelatedPerson > active	Whether this related person record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
RelatedPerson > patient	The patient this person is related to.	1..1	Reference (Base Patient)	n/a	Not mapped directly for this participant; this is implicit in patientRole.
RelatedPerson > relationship	The nature of the relationship between a patient and the related person.	0..1	CodeableConcept	author/assignedAuthor/assignedPerson/ext:personalRelationship	The common pattern Personal Relationship SHALL be applied.
				author/assignedAuthor/assignedPerson/ext:personalRelationship/ext:code	ext:code/originalText or ext:code/@displayName SHALL be included. Related Person Relationship Type (extensible)
RelatedPerson > name	A name associated with the person.	0..*	Base HumanName	author/assignedAuthor/assignedPerson/name	The model Base HumanName is not applied to name. Recommended mappings for this logical type to CDA (R2) are available: Base HumanName .
RelatedPerson > telecom	A contact detail for the person, e.g. a telephone number or an email address.	0..*	ContactPoint	author/assignedAuthor/telecom	Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
RelatedPerson > gender	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	code	author/assignedAuthor/assignedPerson/ext:administrativeGenderCode	AdministrativeGender (required) ¹
RelatedPerson > birthDate	The date on which the related person was born.	0..1	date	author/assignedAuthor/assignedPerson/ext:birthTime	
RelatedPerson > address	Address where the related person can be contacted or visited.	0..*	Address	author/assignedAuthor/addr	Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
RelatedPerson > period	The period of time that this relationship is considered to be valid. If there are no dates defined, then the interval is unknown.	0..1	Period	n/a	Not mapped separately, implicit in ext:personalRelationship/ext:effectiveTime.

¹This hyperlink resolves to the FHIR Release 4 description due to a technical defect in the FHIR STU3 description of this code system for OID-based systems.

8.15 participant (author Base Organization)

This template is referenced by [observation \(Assertion of No Relevant Finding\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements		Context: Comes from linking elements			
Organization	A formally or informally recognized grouping of people or organizations formed for the purpose of achieving some form of collective action. Includes companies, institutions, corporations, departments, community groups, healthcare practice groups, etc.	Cardinality comes from linking element	Organization	participant[aut]	Organization SHALL have at least:
				participant[aut]/@typeCode="AUT"	<ul style="list-style-type: none"> • identifier (participant[aut]/participantRole/scopingEntity/ext:asEntityIdentifier), or • name (participant[aut]/participantRole/scopingEntity/ext:name)
				participant[aut]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				participant[aut]/templateId/@root="1.2.36.1.2001.1001.102.101.100088"	
				participant[aut]/participantRole	If participantRole/@classCode is present, it SHALL be "ASSIGNED".
				participant[aut]/participantRole/id	id/@root SHALL be present and it SHALL be a UUID or an OID.
				participant[aut]/participantRole/scopingEntity	
				participant[aut]/participantRole/scopingEntity/@classCode="ORG"	
Organization > identifier	Identifier for the organization that is used to identify the organization across multiple disparate systems.	0..*	Identifier	participant[aut]/participantRole/scopingEntity/ext:asEntityIdentifier	When sending to the My Health Record, an HPI-O is expected. The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .
Organization > active	Whether the organization's record is still in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Organization > type	The kind(s) of organization that this is.	0..*	CodeableConcept	participant[aut]/participantRole/code	In CDA the maximum occurrences of participantRole/code is 1. Although the model indicates that code is 0..*, in a CDA implementation this is limited to 0..1. code/originalText or code/@displayName SHALL be included. OrganizationType (example)
Organization > name	A name associated with the organization.	0..1	string	participant[aut]/participantRole/scopingEntity/ext:name[org_name]	In CDA name and alias are represented by scopingEntity/name.
Organization > alias	A list of alternate names that the organization is known as, or was known as in the past.	0..*	string	participant[aut]/participantRole/scopingEntity/ext:name[alias]	In CDA name and alias are represented by scopingEntity/name.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Organization > telecom	A contact detail for the organization.	0..*	ContactPoint	participant[aut]/participantRole/ telecom	telecom/@use Organization Telecom Use HL7 V3 (required) ¹ . Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
Organization > address	An address for the organization.	0..*	Address	participant[aut]/participantRole/ addr	addr/@use Organization Address Use HL7 V3 (required) ² . Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
Organization > partOf	The organization of which this organization forms a part.	0..1	Reference (Base Organization)	participant[aut]/participantRole/scopingEntity/ ext:asOrganizationPartOf	Organization partOf SHALL have at least: <ul style="list-style-type: none">• an identifier (ext:asOrganizationPartOf/ext:whiteEntity/ext:asEntityIdentifier), or• a name (ext:asOrganizationPartOf/ext:whiteEntity/ext:name)
				participant[aut]/participantRole/scopingEntity/ ext:asOrganizationPartOf/ext:whiteEntity	
				participant[aut]/participantRole/scopingEntity/ ext:asOrganizationPartOf/ext:whiteEntity/ext:id	id @root SHALL be present and it SHALL be a UUID or an OID.
				participant[aut]/participantRole/scopingEntity/ ext:asOrganizationPartOf/ext:whiteEntity/ext:code	In this template the cardinality of ext:whiteEntity/ext:code SHALL be interpreted as 0..1. ext:code/originalText or ext:code/displayName SHALL be included. OrganizationType (example)
				participant[aut]/participantRole/scopingEntity/ ext:asOrganizationPartOf/ext:whiteEntity/ext:name	In this template the cardinality of ext:whiteEntity/ext:name SHALL be interpreted as 0..*.
				participant[aut]/participantRole/scopingEntity/ ext:asOrganizationPartOf/ext:whiteEntity/ext:telecom	In this template the cardinality of ext:whiteEntity/ext:telecom SHALL be interpreted as 0..*. ext:telecom/@use Organization Telecom Use HL7 V3 (required) ³ . Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
				participant[aut]/participantRole/scopingEntity/ ext:asOrganizationPartOf/ext:whiteEntity/ext:addr	In this template the cardinality of ext:whiteEntity/ext:addr SHALL be interpreted as 0..*. ext:addr/@use Organization Address Use HL7 V3 (required) ⁴ . Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
				participant[aut]/participantRole/scopingEntity/ ext:asOrganizationPartOf/ext:whiteEntity/ext:asEntityIdentifier	In this template the cardinality of ext:whiteEntity/ext:asEntityIdentifier SHALL be interpreted as 0..*. The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements		Context: /ClinicalDocument/			
Organization > contact	Contact for the organization for a certain purpose.	0..*	BackboneElement	participant[org_contact]	participant[org_contact] SHALL conform to the template defined in participant (Organization contact) .

¹This value set differs from the value set bound to use in [ContactPoint](#) due to constraints on @use in the HL7 CDA Schema. The concept map [v3 map for ContactPointUse](#) provides a mapping between the two value sets.

²This value set differs from the value set bound to use in [Address](#) due to constraints on @use in the HL7 CDA schema. The concept map [v3 map for AddressUse](#) provides a mapping between the two value sets.

³This value set differs from the value set bound to use in [ContactPoint](#) due to constraints on @use in the HL7 CDA Schema. The concept map [v3 map for ContactPointUse](#) provides a mapping between the two value sets.

⁴This value set differs from the value set bound to use in [Address](#) due to constraints on @use in the HL7 CDA schema. The concept map [v3 map for AddressUse](#) provides a mapping between the two value sets.

9 Entity CDA templates

This chapter contains the entity templates referenced by a participation template in [8 Participation CDA templates](#).

9.1 providerOrganization (Base Organization)

This template is referenced by [recordTarget \(Patient with Mandatory IHI\)](#), and [recordTarget \(My Health Record Patient\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements		Context: /ClinicalDocument/recordTarget/patientRole/			
Organization	A formally or informally recognized grouping of people or organizations formed for the purpose of achieving some form of collective action. Includes companies, institutions, corporations, departments, community groups, healthcare practice groups, etc.	Cardinality comes from linking element	Organization	providerOrganization	Organization SHALL have at least: <ul style="list-style-type: none">• identifier (providerOrganization/ext:asEntityIdentifier), or• name (providerOrganization/name)
				providerOrganization/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				providerOrganization/templateId/@root="1.2.36.1.2001.1001.102.101.100034"	
				providerOrganization/id	id/@root SHALL be present and it SHALL be a UUID or an OID.
Organization > identifier	Identifier for the organization that is used to identify the organization across multiple disparate systems.	0..*	Identifier	providerOrganization/ext:asEntityIdentifier	The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .
Organization > active	Whether the organization's record is still in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Organization > type	The kind(s) of organization that this is.	0..*	CodeableConcept	providerOrganization/standardIndustryClassCode	In CDA the maximum occurrences of providerOrganization/standardIndustryClassCode is 1. Although the model indicates that code is 0..*, in a CDA implementation this is limited to 0..1. standardIndustryClassCode/originalText or standardIndustryClassCode/@displayName SHALL be included. OrganizationType (example)
Organization > name	A name associated with the organization.	0..1	string	providerOrganization/name[org_name]	In CDA name and alias are represented by providerOrganization/name.
Organization > alias	A list of alternate names that the organization is known as, or was known as in the past.	0..*	string	providerOrganization/name[alias]	In CDA name and alias are represented by providerOrganization/name.
Organization > telecom	A contact detail for the organization.	0..*	ContactPoint	providerOrganization/telecom	telecom/@use Organization Telecom Use HL7 V3 (required) ¹ . Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
Organization > address	An address for the organization.	0..*	Address	providerOrganization/addr	addr/@use Organization Address Use HL7 V3 (required) ² . Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
Organization > partOf	The organization of which this organization forms a part.	0..1	Reference (Base Organization)	providerOrganization/asOrganizationPartOf providerOrganization/asOrganizationPartOf/wholeOrganization	wholeOrganization SHALL conform to the template defined in wholeOrganization (Base Organization) .
CDA Header Data Elements				Context: /ClinicalDocument/	
Organization > contact	Contact for the organization for a certain purpose.	0..*	BackboneElement	participant[org_contact]	participant[org_contact] SHALL conform to the template defined in participant (Organization contact) .

¹This value set differs from the value set bound to use in [ContactPoint](#) due to constraints on @use in the HL7 CDA Schema. The concept map [v3 map for ContactPointUse](#) provides a mapping between the two value sets.

²This value set differs from the value set bound to use in [Address](#) due to constraints on @use in the HL7 CDA schema. The concept map [v3 map for AddressUse](#) provides a mapping between the two value sets.

9.2 representedOrganization (Base Organization)

This template is referenced by [author \(PractitionerRole with Practitioner with Mandatory Identifier\)](#), and [author \(Base PractitionerRole\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements		Context: Comes from linking elements			
Organization	A formally or informally recognized grouping of people or organizations formed for the purpose of achieving some form of collective action. Includes companies, institutions, corporations, departments, community groups, healthcare practice groups, etc.	Cardinality comes from linking element	Organization	representedOrganization	Organization SHALL have at least: <ul style="list-style-type: none"> • name (<code>representedOrganization/name</code>), or • identifier (<code>representedOrganization/ext:asEntityIdentifier</code>)
				representedOrganization/templateId	The use of <code>templateId</code> signals the imposition of a set of template-defined constraints.
				representedOrganization/templateId/@root="1.2.36.1.2001.1001.102.101.100039"	
				representedOrganization/id	<code>id/@root</code> SHALL be present and it SHALL be a UUID or an OID.
Organization > identifier	Identifier for the organization that is used to identify the organization across multiple disparate systems.	0..*	Identifier	<code>representedOrganization/ext:asEntityIdentifier</code>	The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .
Organization > active	Whether the organization's record is still in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Organization > type	The kind(s) of organization that this is.	0..*	CodeableConcept	<code>representedOrganization/standardIndustryClassCode</code>	In CDA the maximum occurrences of <code>representedOrganization/standardIndustryClassCode</code> is 1. Although the model indicates that code is 0..*, in a CDA implementation this is limited to 0..1. <code>standardIndustryClassCode/originalText</code> or <code>standardIndustryClassCode/@displayName</code> SHALL be included. OrganizationType (example)
Organization > name	A name associated with the organization.	0..1	string	<code>representedOrganization/name[org_name]</code>	In CDA name and alias are represented by <code>representedOrganization/name</code> .
Organization > alias	A list of alternate names that the organization is known as, or was known as in the past.	0..*	string	<code>representedOrganization/name[alias]</code>	In CDA name and alias are represented by <code>representedOrganization/name</code> .

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Organization > telecom	A contact detail for the organization.	0..*	ContactPoint	representedOrganization/telecom	telecom/@use Organization Telecom Use HL7 V3 (required) . Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
Organization > address	An address for the organization.	0..*	Address	representedOrganization/addr	addr/@use Organization Address Use HL7 V3 (required) ¹ . Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
Organization > partOf	The organization of which this organization forms a part.	0..1	Reference (Base Organization)	representedOrganization/asOrganizationPartOf representedOrganization/asOrganizationPartOf/wholeOrganization	wholeOrganization SHALL conform to the template defined in wholeOrganization (Base Organization) .
CDA Header Data Elements					Context: /ClinicalDocument/
Organization > contact	Contact for the organization for a certain purpose.	0..*	BackboneElement	participant[org_contact]	participant[org_contact] SHALL conform to the template defined in participant (Organization contact) .

¹This value set differs from the value set bound to use in [Address](#) due to constraints on @use in the HL7 CDA schema. The concept map [v3 map for AddressUse](#) provides a mapping between the two value sets.

9.3 assignedPerson (Practitioner with Mandatory Identifier)

This template is referenced by [author \(PractitionerRole with Practitioner with Mandatory Identifier\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements				Context: Comes from linking elements	
Practitioner	A person who is directly or indirectly involved in the provisioning of healthcare.	Cardinality comes from linking element	Practitioner	assignedPerson	
				assignedPerson/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				assignedPerson/templateId/@root="1.2.36.1.2001.1001.102.101.100040"	
Practitioner > identifier	An identifier that applies to this person in this role.	1..*	Identifier	assignedPerson/ext:asEntityIdentifier	When sending to the My Health Record, an HPI-I is expected. The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .
Practitioner > active	Whether this practitioner's record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Practitioner > name	The name(s) associated with the practitioner.	0..*	Base HumanName	assignedPerson/name	The model Base HumanName is not applied to name. Recommended mappings for this logical type to CDA (R2) are available: Base HumanName .
Practitioner > telecom	A contact detail for the practitioner, e.g. a telephone number or an email address.	0..*	ContactPoint	telecom	Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
Practitioner > address	Address(es) of the practitioner that are not role specific (typically home address). Work addresses are not typically entered in this property as they are usually role dependent.	0..*	Address	addr	Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
Practitioner > gender	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	code	n/a	This logical element has no mapping to CDA.
Practitioner > birthDate	The date of birth for the practitioner.	0..1	date	n/a	This logical element has no mapping to CDA.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Practitioner > qualification	Qualifications obtained by training and certification.	0..*	BackboneElement	See: instantiation choices	<p>It is possible that the qualification may be able to be captured as a complex structure or as a text list.</p> <p>instantiation choices:</p> <p>If the qualification or list of qualifications is the result of capturing a text field then qualification is expected to be instantiated as <code>assignedPerson/ext:asQualifications/@classCode="QUAL"</code>. The common pattern Qualification SHALL be applied.</p> <p>If more information can be captured than a narrative list then qualification is expected to be instantiated as <code>ext:coverage2[prac_qual]</code> and SHALL conform to the template defined in ext:coverage2 (Practitioner qualification):</p> <ul style="list-style-type: none"> qualification for a Practitioner SHALL be instantiated in the same section e.g. qualification for an AllergyIntolerance recorder is expected to be instantiated as <code>ClinicalDocument/component/structuredBody/component[allergy]/section/ext:coverage2[prac_qual]</code>, or qualification for a CDA Header Practitioner (e.g. ClinicalDocument author) SHALL be instantiated as <code>ClinicalDocument/component/structuredBody/component[admin_obs]/section/ext:coverage2[prac_qual]</code>
Practitioner > communication	A language the practitioner is able to use in patient communication.	0..*	CodeableConcept	<code>assignedPerson/ext:languageCommunication</code>	The common pattern Language Communication SHALL be applied.

9.4 assignedPerson (Base Practitioner)

This template is referenced by [author \(Base PractitionerRole\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logic-al card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements				Context: Comes from linking elements	
Practitioner	A person who is directly or indirectly involved in the provisioning of healthcare.	Cardinality comes from linking element	Practitioner	assignedPerson	Practitioner SHALL have at least: <ul style="list-style-type: none">• identifier (assignedPerson/ext:asEntityIdentifier), or• name (assignedPerson/name)
				assignedPerson/ templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				assignedPerson/templateId/@root="1.2.36.1.2001.1001.102.101.100086"	
Practitioner > identifier	An identifier that applies to this person in this role.	0..*	Identifier	assignedPerson/ext:asEntityIdentifier	The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .
Practitioner > active	Whether this practitioner's record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Practitioner > name	The name(s) associated with the practitioner.	0..*	Base HumanName	assignedPerson/name	The model Base HumanName is not applied to name. Recommended mappings for this logical type to CDA (R2) are available: Base HumanName .
Practitioner > telecom	A contact detail for the practitioner, e.g. a telephone number or an email address.	0..*	ContactPoint	telecom	Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
Practitioner > address	Address(es) of the practitioner that are not role specific (typically home address). Work addresses are not typically entered in this property as they are usually role dependent.	0..*	Address	addr	Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
Practitioner > gender	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	code	n/a	This logical element has no mapping to CDA.
Practitioner > birthDate	The date of birth for the practitioner.	0..1	date	n/a	This logical element has no mapping to CDA.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Practitioner > qualification	Qualifications obtained by training and certification.	0..*	BackboneElement	See: instantiation choices	<p>It is possible that the qualification may be able to be captured as a complex structure or as a text list.</p> <p>instantiation choices:</p> <p>If the qualification or list of qualifications is the result of capturing a text field then qualification is expected to be instantiated as <code>assignedPerson/ext:asQualifications/@classCode="QUAL"</code>. The common pattern Qualification SHALL be applied.</p> <p>If more information can be captured than a narrative list then qualification is expected to be instantiated as <code>ext:coverage2[prac_qual]</code> and SHALL conform to the template defined in ext:coverage2 (Practitioner qualification):</p> <ul style="list-style-type: none"> qualification for a Practitioner SHALL be instantiated in the same section e.g. qualification for an AllergyIntolerance recorder is expected to be instantiated as <code>ClinicalDocument/component/structuredBody/component[allergy]/section/ext:coverage2[prac_qual]</code>, or qualification for a CDA Header Practitioner (e.g. ClinicalDocument author) SHALL be instantiated as <code>ClinicalDocument/component/structuredBody/component[admin_obs]/section/ext:coverage2[prac_qual]</code>
Practitioner > communication	A language the practitioner is able to use in patient communication.	0..*	CodeableConcept	<code>assignedPerson/ext:languageCommunication</code>	The common pattern Language Communication SHALL be applied.

9.5 wholeOrganization (Base Organization)

This template is referenced by participant (generalPractitioner Base Organization), providerOrganization (Base Organization), representedOrganization (Base Organization), scopingOrganization (Base Organization), and wholeOrganization (Base Organization).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements				Context: Comes from linking elements	
Organization	A formally or informally recognized grouping of people or organizations formed for the purpose of achieving some form of collective action. Includes companies, institutions, corporations, departments, community groups, healthcare practice groups, etc.	Cardinality comes from linking element	Organization	wholeOrganization	Organization SHALL have at least: <ul style="list-style-type: none">• name (wholeOrganization/name), or• identifier (wholeOrganization/ext:asEntityIdentifier)
				wholeOrganization/ templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				wholeOrganization/templateId/@root="1.2.36.1.2001.1001.102.101.100087"	
				wholeOrganization/ id	id/@root SHALL be present and it SHALL be a UUID or an OID.
Organization > identifier	Identifier for the organization that is used to identify the organization across multiple disparate systems.	0..*	Identifier	wholeOrganization/ext:asEntityIdentifier	The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .
Organization > active	Whether the organization's record is still in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Organization > type	The kind(s) of organization that this is.	0..*	CodeableConcept	wholeOrganization/standardIndustryClassCode	In CDA the maximum occurrences of wholeOrganization/standardIndustryClassCode is 1. Although the model indicates that code is 0..*, in a CDA implementation this is limited to 0..1. standardIndustryClassCode/originalText or standardIndustryClassCode/@displayName SHALL be included. OrganizationType (example)
Organization > name	A name associated with the organization.	0..1	string	wholeOrganization/name[org_name]	In CDA name and alias are represented by wholeOrganization/name.
Organization > alias	A list of alternate names that the organization is known as, or was known as in the past.	0..*	string	wholeOrganization/name[alias]	In CDA name and alias are represented by wholeOrganization/name.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Organization > telecom	A contact detail for the organization.	0..*	ContactPoint	wholeOrganization/telecom	telecom/@use Organization Telecom Use HL7 V3 (required) ¹ . Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
Organization > address	An address for the organization.	0..*	Address	wholeOrganization/addr	addr/@use Organization Address Use HL7 V3 (required) ² . Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
Organization > partOf	The organization of which this organization forms a part.	0..1	Reference (Base Organization)	wholeOrganization/asOrganizationPartOf wholeOrganization/asOrganizationPartOf/wholeOrganization	wholeOrganization/asOrganizationPartOf/wholeOrganization SHALL conform to the template defined in wholeOrganization (Base Organization) .
CDA Header Data Elements					Context: /ClinicalDocument/
Organization > contact	Contact for the organization for a certain purpose.	0..*	BackboneElement	participant[org_contact]	participant[org_contact] SHALL conform to the template defined in participant (Organization contact) .

¹This value set differs from the value set bound to use in [ContactPoint](#) due to constraints on @use in the HL7 CDA Schema. The concept map [v3 map for ContactPointUse](#) provides a mapping between the two value sets.

²This value set differs from the value set bound to use in [Address](#) due to constraints on @use in the HL7 CDA schema. The concept map [v3 map for AddressUse](#) provides a mapping between the two value sets.

9.6 scopingOrganization (Base Organization)

This template is referenced by [participant \(Patient contact\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements		Context: Comes from linking elements			
Organization	A formally or informally recognized grouping of people or organizations formed for the purpose of achieving some form of collective action. Includes companies, institutions, corporations, departments, community groups, healthcare practice groups, etc.	Cardinality comes from linking element	Organization	scopingOrganization	Organization SHALL have at least: <ul style="list-style-type: none"> • name (scopingOrganization/name), or • identifier (scopingOrganization/ext:asEntityIdentifier)
				scopingOrganization/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				scopingOrganization/templateId/@root="1.2.36.1.2001.1001.102.101.100089"	
				scopingOrganization/id	id/@root SHALL be present and it SHALL be a UUID or an OID.
Organization > identifier	Identifier for the organization that is used to identify the organization across multiple disparate systems.	0..*	Identifier	scopingOrganization/ext:asEntityIdentifier	The common pattern Entity Identifier SHALL be applied. Recommended mappings for this logical type to CDA (R2) are available: Identifier .
Organization > active	Whether the organization's record is still in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Organization > type	The kind(s) of organization that this is.	0..*	CodeableConcept	scopingOrganization/standardIndustryClassCode	In CDA the maximum occurrences of scopingOrganization/standardIndustryClassCode is 1. Although the model indicates that code is 0..*, in a CDA implementation this is limited to 0..1. standardIndustryClassCode/originalText or standardIndustryClassCode/@displayName SHALL be included. OrganizationType (example)
Organization > name	A name associated with the organization.	0..1	string	scopingOrganization/name[org_name]	In CDA name and alias are represented by scopingOrganization/name.
Organization > alias	A list of alternate names that the organization is known as, or was known as in the past.	0..*	string	scopingOrganization/name[alias]	In CDA name and alias are represented by scopingOrganization/name.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Organization > telecom	A contact detail for the organization.	0..*	ContactPoint	scopingOrganization/ telecom	telecom/@use Organization Telecom Use HL7 V3 (required) ¹ . Recommended mappings for this logical type to CDA (R2) are available: ContactPoint .
Organization > address	An address for the organization.	0..*	Address	scopingOrganization/ addr	addr/@use Organization Address Use HL7 V3 (required) ² . Recommended mappings for this logical type to CDA (R2) are available: Address AU Base Address .
Organization > partOf	The organization of which this organization forms a part.	0..1	Reference (Base Organization)	scopingOrganization/ asOrganizationPartOf scopingOrganization/asOrganizationPartOf/ wholeOrganization	wholeOrganization SHALL conform to the template defined in wholeOrganization (Base Organization) .
CDA Header Data Elements					Context: /ClinicalDocument/
Organization > contact	Contact for the organization for a certain purpose.	0..*	BackboneElement	participant[org_contact]	participant[org_contact] SHALL conform to the template defined in participant (Organization contact) .

¹This value set differs from the value set bound to use in [ContactPoint](#) due to constraints on @use in the HL7 CDA Schema. The concept map [v3 map for ContactPointUse](#) provides a mapping between the two value sets.

²This value set differs from the value set bound to use in [Address](#) due to constraints on @use in the HL7 CDA schema. The concept map [v3 map for AddressUse](#) provides a mapping between the two value sets.

10 Act CDA templates

This chapter contains the entry-level templates, called acts (machine readable structured content), referenced by other templates such as those in [7 Section CDA templates](#).

10.1 observation (Summary Statement of Allergy or Intolerance)

This template is referenced by [section \(Allergies\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements		Context: Comes from linking elements			
AllergyIntolerance	Risk of harmful or undesirable, physiological response which is unique to an individual and associated with exposure to a substance.	Cardinality comes from linking element	AllergyIntolerance	observation	Where only a substance is available (e.g. 111088007 Latex) and not a statement of allergy or intolerance (e.g. 300916003 Allergy to latex), the substance will be sent in code (observation/value), and optionally in substance (participant[agent]/participantRole/playingEntity/code). clinicalStatus (entryRelationship[clin_status]/observation) SHALL be instantiated if verificationStatus (entryRelationship[ver_status]/observation/value/@code) is not "entered-in-error".
				observation/@classCode="OBS"	
				observation/@moodCode="EVN"	
				observation/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				observation/templateId/@root="1.2.36.1.2001.1001.102.101.100014"	
				observation/code	code is expected to be populated with AllergyIntolerance type. Where type is unavailable, a default code is provided and SHALL be instantiated as code@code="102.15517", code@displayName="Adverse Reaction", code@codeSystem="1.2.36.1.2001.1001.101".

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
AllergyIntolerance > author-related-person	Reference to related person that recorded the record and takes responsibility for its content.	0..1	Reference (Base RelatedPerson)	observation/author	If author is not instantiated, the data is considered to be included via induction in ClinicalDocument/author. author SHALL conform to one of the templates defined in: author (Base RelatedPerson) or author (Base Patient) or author (Base PractitionerRole) .
AllergyIntolerance > clinical-Status	The clinical status of the allergy or intolerance.	0..1	code	observation/entryRelationship[clin_status]	
				observation/entryRelationship[clin_status]/@typeCode="COMP"	
				observation/entryRelationship[clin_status]/observation	
				observation/entryRelationship[clin_status]/observation/@classCode="OBS"	
				observation/entryRelationship[clin_status]/observation/@moodCode="EVN"	
				observation/entryRelationship[clin_status]/observation/code	
				observation/entryRelationship[clin_status]/observation/code/@code="103.32013"	
				observation/entryRelationship[clin_status]/observation/code/@codeSystem="1.2.36.1.2001.1001.101"	NCTIS Data Components
				observation/entryRelationship[clin_status]/observation/code/@displayName	displayName SHOULD be "Clinical Status".
				observation/entryRelationship[clin_status]/observation/value	value/@xsi:type SHALL be "CD". value/@value SHOULD be "active". AllergyIntolerance Clinical Status Codes (required) ¹
AllergyIntolerance > verification-Status	Assertion about certainty associated with the propensity, or potential risk, of a reaction to the identified substance (including pharmaceutical product).	1..1	code	observation/entryRelationship[ver_status]	
				observation/entryRelationship[ver_status]/@typeCode="COMP"	
				observation/entryRelationship[ver_status]/observation	
				observation/entryRelationship[ver_status]/observation/@classCode="OBS"	
				observation/entryRelationship[ver_status]/observation/@moodCode="EVN"	
				observation/entryRelationship[ver_status]/observation/code	
				observation/entryRelationship[ver_status]/observation/code/@code="103.32012"	
				observation/entryRelationship[ver_status]/observation/code/@codeSystem="1.2.36.1.2001.1001.101"	NCTIS Data Components
				observation/entryRelationship[ver_status]/observation/code/@displayName	displayName SHOULD be "Verification Status".
				observation/entryRelationship[ver_status]/observation/value	value/@xsi:type SHALL be "CD". value/@value SHOULD be "unconfirmed" or "confirmed". AllergyIntolerance Verification Status Codes (required) ²

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
AllergyIntolerance > type	Identification of the underlying physiological mechanism for the reaction risk.	0..1	code	observation/code	AllergyIntoleranceType (required) ³
AllergyIntolerance > code	Code for an allergy or intolerance statement (either a positive or a negated/excluded statement). This may be a code for a substance or pharmaceutical product that is considered to be responsible for the adverse reaction risk (e.g., 'Latex'), an allergy or intolerance condition (e.g., 'Latex allergy'), or a negated/excluded code for a specific substance or class (e.g., 'No latex allergy') or a general or categorical negated statement (e.g., 'No known allergy', 'No known drug allergies').	1..1	CodeableConcept	observation/value	<p>value/@xsi:type SHALL be "CD".</p> <p>value/originalText or value/@displayName SHALL be included.</p> <p>Indicator of Hypersensitivity or Intolerance to Substance (preferred)</p>
AllergyIntolerance > patient	The patient who has the allergy or intolerance.	1..1	Reference(Patient with Mandatory IHI)	n/a	Not mapped directly for this model; this is implicit in patientRole.
AllergyIntolerance > onset[x]	Estimated or actual date, date-time, or age when allergy or intolerance was identified.	0..1	dateTime Age Period Range	See: instantiation choices	<p>onset[x] as a Range is not currently mapped to CDA. See Known issues.</p> <p>instantiation choices:</p> <p>If onset[x] is a dateTime or a Period then it SHALL be instantiated as observation/effectiveTime/low/@value.</p> <p>If onset[x] is an Age then it SHALL be instantiated as observation/entryRelationship[onset]/observation/value. value/@xsi:type SHALL be "PQ". The code for observation/entryRelationship[onset]/observation/code SHALL be code/@code="445518008" and code/@codeSystem="2.16.840.1.113883.6.96".</p>
AllergyIntolerance > recorder	Individual who recorded the record and takes responsibility for its content.	0..1	Reference(Base Patient Base Practitioner)	observation/author	<p>If author is not instantiated, the data is considered to be included via induction in ClinicalDocument/author.</p> <p>In CDA an author (Practitioner) is part of an author (PractitionerRole).</p> <p>author SHALL conform to one of the templates defined in: author (Base RelatedPerson) or author (Base Patient) or author (Base PractitionerRole).</p>

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
AllergyIntolerance > note	Additional narrative about the propensity for the Adverse Reaction, not captured in other fields.	0..*	Annotation	observation/entryRelationship[note]	
				observation/entryRelationship[note]/@typeCode="COMP"	
				observation/entryRelationship[note]/act	
				observation/entryRelationship[note]/act/@classCode="ACT"	
				observation/entryRelationship[note]/act/@moodCode="EVN"	
				observation/entryRelationship[note]/act/code	
				observation/entryRelationship[note]/act/code/@code="103.16044"	
				observation/entryRelationship[note]/act/code/@codeSystem="1.2.36.1.2001.1001.101"	NCTIS Data Components
				observation/entryRelationship[note]/act/code/@displayName	displayName SHOULD be "Additional Comments".
				observation/entryRelationship[note]/act/author	If this author is not instantiated, the data is considered to be included via induction in ClinicalDocument/author. In CDA the cardinality of entryRelationship[note]/act/author is 0..*. In this template the cardinality of author SHALL be limited to 0..1.
AllergyIntolerance > reaction	Details about each adverse reaction event linked to exposure to the identified substance.	0..*	BackboneElement	observation/entryRelationship[react]	
				observation/entryRelationship[react]/@typeCode="COMP"	
				observation/entryRelationship[react]/observation	
				observation/entryRelationship[react]/observation/@classCode="OBS"	
				observation/entryRelationship[react]/observation/@moodCode="EVN"	
				observation/entryRelationship[react]/observation/code	
				observation/entryRelationship[react]/observation/code/@code="102.16474"	
				observation/entryRelationship[react]/observation/code/@codeSystem="1.2.36.1.2001.1001.101"	NCTIS Data Components
				observation/entryRelationship[react]/observation/code/@displayName	displayName SHOULD be "Reaction Event".

Logical element	Logical element description	Logic-al card	Logical type	CDA schema element	CDA constraints and comments
AllergyIntolerance > reaction > substance	Identification of the specific substance (or pharmaceutical product) considered to be responsible for the Adverse Reaction event. Note: the substance for a specific reaction may be different from the substance identified as the cause of the risk, but it must be consistent with it. For instance, it may be a more specific substance (e.g. a brand medication) or a composite product that includes the identified substance. It must be clinically safe to only process the 'code' and ignore the 'reaction.substance'.	0..1	CodeableConcept	observation/entryRelationship[react]/observation/participant[agent] observation/entryRelationship[react]/observation/participant[agent]/@typeCode= "CAGNT" observation/entryRelationship[react]/observation/participant[agent]/participantRole observation/entryRelationship[react]/observation/participant[agent]/participantRole/playingEntity observation/entryRelationship[react]/observation/participant[agent]/participantRole/playingEntity/code	code/originalText or code/@displayName SHALL be included. Adverse Reaction Agent (preferred)
AllergyIntolerance > reaction > manifestation	Clinical symptoms and/or signs that are observed or associated with the adverse reaction event.	1..*	CodeableConcept	observation/entryRelationship[react]/observation/entryRelationship[mfst] observation/entryRelationship[react]/observation/entryRelationship[mfst]/@typeCode= "MFST" observation/entryRelationship[react]/observation/entryRelationship[mfst]/@inversionInd="true" observation/entryRelationship[react]/observation/entryRelationship[mfst]/observation observation/entryRelationship[react]/observation/entryRelationship[mfst]/observation/@classCode="OBS" observation/entryRelationship[react]/observation/entryRelationship[mfst]/observation/@moodCode="EVN" observation/entryRelationship[react]/observation/entryRelationship[mfst]/observation/code	code/originalText or code/@displayName SHALL be included. Clinical Finding (preferred)

¹This value set differs from the value set bound to clinicalStatus in the Agency logical model (see [Shared Health Summary FHIR Implementation Guide \[DH2020i\]](#)) due to pre-adoption of FHIR Release 4 terminology.

²This value set differs from the value set bound to verificationStatus in the Agency logical model (see [Shared Health Summary FHIR Implementation Guide \[DH2020i\]](#)) due to pre-adoption of FHIR Release 4 terminology.

³This value set differs from the value set bound to type in the Agency logical model (see [Shared Health Summary FHIR Implementation Guide \[DH2020i\]](#)) due to pre-adoption of FHIR Release 4 terminology.

10.2 substanceAdministration (Summary Statement of Known Medicine)

This template is referenced by [section \(Medications\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements		Context: Comes from linking elements			
MedicationStatement	A record of a medication that is being consumed by a patient. A MedicationStatement may indicate that the patient may be taking the medication now, or has taken the medication in the past or will be taking the medication in the future. The source of this information can be the patient, significant other (such as a family member or spouse), or a clinician. A common scenario where this information is captured is during the history taking process during a patient visit or stay. The medication information may come from sources such as the patient's memory, from a prescription bottle, or from a list of medications the patient, clinician or other party maintains. The primary difference between a medication statement and a medication administration is that the medication administration has complete administration information and is based on actual administration information from the person who administered the medication. A medication statement is often, if not always, less specific. There is no required date/time when the medication was administered, in fact we only know that a source has reported the patient is taking this medication, where details such as time, quantity, or rate or even medication product may be incomplete or missing or less precise. As stated earlier, the medication statement information may come from the patient's memory, from a prescription bottle or from a list of medications the patient, clinician or other party maintains. Medication administration is more formal and is not missing detailed information.	Cardinality comes from linking element	MedicationStatement	substanceAdministration	
				substanceAdministration/@classCode="SBADM"	
				substanceAdministration/@moodCode	When sending a Shared Health Summary, this is expected to be "EVN". This CDA schema element is of type CodedSimpleValue (CS). moodCode SHALL NOT be "RQO". HL7 v3 Value Set ActMood (required)
				substanceAdministration/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				substanceAdministration/templateId/@root="1.2.36.1.2001.1001.102.101.100015"	
MedicationStatement > status	A code representing the patient or other source's judgment about the state of the medication used that this statement is about. Generally this will be active or completed.	1..1	code	substanceAdministration/statusCode	This CDA schema element is of type CodedSimpleValue (CS). Medication Act Status HL7 V3 value set (required) ¹

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
MedicationStatement > category	Indicates where type of medication statement and where the medication is expected to be consumed or administered.	0..1	CodeableConcept	substanceAdministration/entryRelationship[category] substanceAdministration/entryRelationship[category]/@typeCode="COMP" substanceAdministration/entryRelationship[category]/observation substanceAdministration/entryRelationship[category]/observation/@classCode="OBS" substanceAdministration/entryRelationship[category]/observation/@moodCode="EVN" substanceAdministration/entryRelationship[category]/observation/code substanceAdministration/entryRelationship[category]/observation/code/@code="276339004" substanceAdministration/entryRelationship[category]/observation/code/@codeSystem="2.16.840.1.113883.6.96" substanceAdministration/entryRelationship[category]/observation/code/@displayName substanceAdministration/entryRelationship[category]/observation/value	SNOMED CT displayName SHOULD be "Environment". value/@xsi:type SHALL be "CD". value/originalText or value/@displayName SHALL be included. Medication usage category codes (preferred) ²
MedicationStatement > medication[x]	Identifies the medication being administered. This is either a link to a resource representing the details of the medication or a simple attribute carrying a code that identifies the medication from a known list of medications.	1..1	CodeableConcept	substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/code	code/originalText or code/@displayName SHALL be included. Australian Medication (preferred) Australian Pharmaceutical Benefits Scheme Schedule Item (example) ³ MIMS Terminology (example) GTIN for Medicines (example) Recommended mappings for this logical type to CDA (R2) are available: CodeableConcept as a Medicine Item Code .
MedicationStatement > informationSource	The person or organization that provided the information about the taking of this medication. Note: Use derivedFrom when a MedicationStatement is derived from other resources, e.g Claim or MedicationRequest.	0..1	Reference (Base RelatedPerson Base Patient Base Practitioner)	substanceAdministration/informant	If this informant is not instantiated, the data is considered to be included via induction in patientRole. informant SHALL conform to one of the templates defined in: informant (Base RelatedPerson) or informant (Base Patient) or informant (Base Practitioner) .
MedicationStatement > subject	The person, animal or group who is/was taking the medication.	1..1	Reference (Patient with Mandatory IHI)	n/a	Not mapped directly for this model; this is implicit in patientRole.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
MedicationStatement > taken	Indicator of the certainty of whether the medication was taken by the patient.	1..1	code	See: instantiation choices	<p>This logical element may have a value of y n unk na as per MedicationStatementTaken (required)</p> <p>instantiation choices:</p> <p>When the logical assertion is "y", there is no direct mapping into CDA as this is implicit in the instantiation of the substanceAdministration class.</p> <p>When the logical assertion is "n", taken SHALL be instantiated as substanceAdministration/@negationInd="true" unless status is "new" or "suspended" in which case this is implicit in the statusCode; a negationInd SHALL NOT be present where substanceAdministration/statusCode/@code is "new" or "suspended".</p> <p>When the logical assertion is "unk" or "na", taken SHALL be instantiated as substanceAdministration/@nullFlavor="UNK" or substanceAdministration/@nullFlavor="NA" respectively.</p>
MedicationStatement > reason-Code	A reason for why the medication is being/was taken.	0..1	CodeableConcept	substanceAdministration/entryRelationship[reason]	
				substanceAdministration/entryRelationship[reason]/@typeCode="RSON"	
				substanceAdministration/entryRelationship[reason]/observation	
				substanceAdministration/entryRelationship[reason]/observation/@classCode="OBS"	
				substanceAdministration/entryRelationship[reason]/observation/@moodCode="EVN"	
				substanceAdministration/entryRelationship[reason]/observation/code	
				substanceAdministration/entryRelationship[reason]/observation/code/@code="103.10141"	NCTIS Data Components
				substanceAdministration/entryRelationship[reason]/observation/code/@codeSystem="1.2.36.1.2001.1001.101"	
				substanceAdministration/entryRelationship[reason]/observation/code/@displayName	displayName SHOULD be "Clinical Indication".
				substanceAdministration/entryRelationship[reason]/observation/value	<p>value/@ xsi:type SHALL be "CD".</p> <p>value/originalText or value/@displayName SHALL be included.</p> <p>Medication Reason Taken (preferred)</p>

Logical element	Logical element description	Logic-al card	Logical type	CDA schema element	CDA constraints and comments
MedicationStatement > note	Provides extra information about the medication statement that is not conveyed by the other attributes.	0..*	Annotation	substanceAdministration/entryRelationship[note]	
				substanceAdministration/entryRelationship[note]/@typeCode="COMP"	
				substanceAdministration/entryRelationship[note]/act	
				substanceAdministration/entryRelationship[note]/act/@classCode="ACT"	
				substanceAdministration/entryRelationship[note]/act/@moodCode="EVN"	
				substanceAdministration/entryRelationship[note]/act/code	
				substanceAdministration/entryRelationship[note]/act/code/@code="103.16044"	
				substanceAdministration/entryRelationship[note]/act/code/@codeSystem="1.2.36.1.2001.1001.101"	NCTIS Data Components
				substanceAdministration/entryRelationship[note]/act/code/@displayName	displayName SHOULD be "Additional Comments".
				substanceAdministration/entryRelationship[note]/act/author	If this author is not instantiated, the data is considered to be included via induction in ClinicalDocument/author. In CDA the cardinality of entryRelationship[note]/act/author is 0..*. In this template the cardinality of author SHALL be limited to 0..1.
MedicationStatement > dosage	Indicates how the medication is/was or should be taken by the patient.	1..1	AU Base Dosage	substanceAdministration/text	If this effectiveTime is not instantiated, the data is considered to be included via induction in ClinicalDocument/author/time. In CDA the cardinality of entryRelationship[note]/act/effectiveTime is 0..*. In this template the cardinality of effectiveTime SHALL be limited to 0..1.
				substanceAdministration/entryRelationship[note]/act/text	text/@xsi:type SHALL be "ST".
				substanceAdministration/text	The model AU Base Dosage is not applied to text. In CDA the maximum occurrences of substanceAdministration/text is 1. The logical cardinality of 0..* may be supported by multiple statements within substanceAdministration/text or the use of additional elements as shown in the recommended mappings for the logical type. dosage SHALL at least include text or patient instructions instantiated as substanceAdministration/text. Recommended mappings for this logical type to CDA (R2) are available: AU Base Dosage .

¹This value set differs from the value set bound to status in the Agency logical model (see [Shared Health Summary FHIR Implementation Guide \[DH2020i\]](#)) due to constraints on statusCode in the HL7 CDA Schema. The concept map [MedicationStatementStatus \(HL7 FHIR\) to Medication Act Status HL7 v3](#) provides a mapping between the two value sets.

²This value set differs from the value set bound to category in the Agency logical model (see [Shared Health Summary FHIR Implementation Guide \[DH2020i\]](#)) due to pre-adoption of FHIR Release 4 terminology.

³The binding strength for the value sets additional to [Australian Medication](#) differs from the binding strength in the Agency logical model (see [Shared Health Summary FHIR Implementation Guide \[DH2020i\]](#)); this is due to normalising the representation of multiple optional terminology slices in a FHIR profile to this CDA mapping table.

10.3 observation (Assertion of No Relevant Finding)

This template is referenced by [section \(Medications\)](#), [section \(Medical History\)](#), and [section \(Immunisations\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logic-al card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements			Context: Comes from linking elements		
Observation	Statement of clinical judgement that there are no items of specific interest after a reasonable investigation.	Cardinality comes from linking element	Observation	observation	
				observation/@classCode="OBS"	
				observation/@moodCode="EVN"	
				observation/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				observation/templateId/@root="1.2.36.1.2001.1001.102.101.100032"	
Observation > status	The status of the result value.	1..1	code	observation/entryRelationship[status]	
				observation/entryRelationship[status]/@typeCode="COMP"	
				observation/entryRelationship[status]/observation	
				observation/entryRelationship[status]/observation/@classCode="OBS"	
				observation/entryRelationship[status]/observation/@moodCode="EVN"	
				observation/entryRelationship[status]/observation/code	
				observation/entryRelationship[status]/observation/code/@code="103.32010"	
				observation/entryRelationship[status]/observation/code/@codeSystem="1.2.36.1.2001.1001.101"	NCTIS Data Components
				observation/entryRelationship[status]/observation/code/@displayName	displayName SHOULD be "Observation Result Status".
				observation/entryRelationship[status]/observation/value	value/@xsi:type SHALL be "CD". ObservationStatus (required)
Observation > code	Describes what was observed. Sometimes this is called the observation 'name'.	1..1	CodeableConcept	observation/code	
				observation/code/@code="ASSERTION"	
				observation/code/@codeSystem="2.16.840.1.113883.5.4"	v3 Code System ActCode
				observation/code/@displayName	displayName SHOULD be "Assertion".

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Observation > subject	The patient, or group of patients, location, or device whose characteristics (direct or indirect) are described by the observation and into whose record the observation is placed.	1..1	Reference (Patient with Mandatory IHI)	n/a	Not mapped directly for this model; this is implicit in patientRole.
Observation > effective[x]	The time or time-period the observed value is asserted as being true. For biological subjects - e.g. human patients - this is usually called the 'physiologically relevant time'. This is usually either the time of the procedure or of specimen collection, but very often the source of the date/time is not known, only the date/time itself.	0..1	dateTime Period	observation/effectiveTime	
Observation > performer	Who was responsible for asserting the observed value as 'true'.	0..*	Reference (Base Practitioner Base Organization Base RelatedPerson Base Patient)	See: instantiation choices	<p>If performer is not instantiated the data is considered to be included via induction in ClinicalDocument/author.</p> <p>In CDA, performer is mapped to observation/author or observation/participant/@typeCode="AUT".</p> <p>instantiation choices:</p> <p>If performer is an Organization then it SHALL be instantiated as observation/participant/@typeCode="AUT", participant SHALL conform to the template defined in participant (author Base Organization).</p> <p>In CDA an author (Practitioner) is part of an author (PractitionerRole).</p> <p>If performer is a Practitioner or RelatedPerson or Patient then it SHALL be instantiated as observation/author, author SHALL conform to one of the templates defined in: author (Base PractitionerRole) or author (Base RelatedPerson) or author (Base Patient).</p>
Observation > value[x]	The information determined as a result of making the observation, if the information has a simple value.	1..1	CodeableConcept	observation/value	<p>value/@xsi:type SHALL be "CD".</p> <p>value/originalText or value/@displayName SHALL be included.</p> <p>value/@nullFlavor SHALL NOT be instantiated.</p> <p>Assertion Of Absence value set (required)</p>

¹This value set differs from the value set bound to status in the Agency logical model (see [Shared Health Summary FHIR Implementation Guide \[DH2020i\]](#)) due to pre-adoption of FHIR Release 4 terminology.

10.4 substanceAdministration (Summary Statement of Administered Vaccine)

This template is referenced by [section \(Immunisations\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements			Context: Comes from linking elements		
Immunization	Describes the event of a patient being administered a vaccination or a record of a vaccination as reported by a patient, a clinician or another party and may include vaccine reaction information and what vaccination protocol was followed.	Cardinality comes from linking element	Immunization	substanceAdministration	substanceAdministration@negationInd SHALL NOT be present.
				substanceAdministration/@classCode="SBADM"	
				substanceAdministration/@moodCode="EVN"	
				substanceAdministration/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				substanceAdministration/templateId/@root="1.2.36.1.2001.1001.102.101.100043"	
Immunization > status	Indicates the current status of the vaccination event.	1..1	code	substanceAdministration/statusCode	This CDA schema element is of type CodedSimpleValue (CS). Immunization Act Status HL7 V3 (required)¹
Immunization > notGiven	Indicates if the vaccination was or was not given.	1..1	boolean	n/a	Not mapped directly for this model; this is implicit in the instantiation of substanceAdministration.
Immunization > vaccineCode	Vaccine that was administered or was to be administered.	1..1	CodeableConcept	substanceAdministration/consumable	code/originalText or code/@displayName SHALL be included. Australian Medicines Terminology Vaccine (preferred)
				substanceAdministration/consumable/manufacturedProduct	Australian Immunisation Register Vaccine (example)²
				substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial	
				substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/code	
Immunization > patient	The patient who either received or did not receive the immunization.	1..1	Reference (Patient with Mandatory IHI)	n/a	Not mapped directly for this model; this is implicit in patientRole.
Immunization > date	Date vaccine administered or was to be administered.	0..1	dateTime	substanceAdministration/effectiveTime[imm_date]	

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Immunization > primarySource	An indication that the content of the record is based on information from the person who administered the vaccine. This reflects the context under which the data was originally recorded.	1..1	boolean	substanceAdministration/entryRelationship[prim_sour] substanceAdministration/entryRelationship[prim_sour]/typeCode="COMP" substanceAdministration/entryRelationship[prim_sour]/observation substanceAdministration/entryRelationship[prim_sour]/observation/@classCode="OBS" substanceAdministration/entryRelationship[prim_sour]/observation/@moodCode="EVN" substanceAdministration/entryRelationship[prim_sour]/observation/code substanceAdministration/entryRelationship[prim_sour]/observation/code/@code="103.17061" substanceAdministration/entryRelationship[prim_sour]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" substanceAdministration/entryRelationship[prim_sour]/observation/code/@displayName substanceAdministration/entryRelationship[prim_sour]/observation/value	displayName SHOULD be "Information from a Primary Source". value/@xsi:type SHALL be "BL".
Immunization > vaccinationProtocol	Contains information about the protocol(s) under which the vaccine was administered.	0..*	BackboneElement	n/a	This logical element has no mapping to CDA.
Immunization > vaccinationProtocol > doseSequence	Nominal position in a series.	0..1	positiveInt	substanceAdministration/entryRelationship[sply]/@typeCode="COMP" substanceAdministration/entryRelationship[sply]/sequenceNumber/@value substanceAdministration/entryRelationship[sply]/supply substanceAdministration/entryRelationship[sply]/supply/@classCode="SPLY" substanceAdministration/entryRelationship[sply]/supply/@moodCode="EVN" substanceAdministration/entryRelationship[sply]/supply/independentInd/@value="false"	
Immunization > vaccinationProtocol > doseStatus	Indicates if the immunization event should 'count' against the protocol.	1..1	CodeableConcept	substanceAdministration/text	In the logical model the cardinality of this indicates if the immunization event should 'count' against the protocol. is 1..1. In this template the cardinality of this logical element SHALL be interpreted as 0..1; if available in the source system indicates if the immunization event should 'count' against the protocol. is expected to form part of substanceAdministration/text

¹This value set differs from the value set bound to status in the Agency logical model (see [Shared Health Summary FHIR Implementation Guide \[DH2020ij\]](#)) due to constraints on statusCode in the HL7 CDA Schema. The concept map [TBD](#) provides a mapping between the two value sets.

²The binding strength for this value set differs from the binding strength in the Agency logical model (see [Shared Health Summary FHIR Implementation Guide \[DH2020ij\]](#)); this is due to normalising the representation of multiple optional terminology slices in a FHIR profile to this CDA mapping table.

10.5 observation (Summary Statement of Condition)

This template is referenced by [section \(Medical History\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements				Context: Comes from linking elements	
Condition	A clinical condition, problem, diagnosis, or other event, situation, issue, or clinical concept that has risen to a level of concern.	Cardinality comes from linking element	Condition	observation	clinicalStatus (entryRelationship[clin_status]/observation) SHALL be instantiated if verificationStatus (entryRelationship[ver_status]/observation) is present and the value (value/@code) is not "entered-in-error".
				observation/@classCode="OBS"	clinicalStatus SHALL be instantiated if abatement is present with the value of clinicalStatus (entryRelationship[clin_status]/observation/value/@code) as "inactive", "resolved", or "remission".
				observation/@moodCode="EVN"	
				observation/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				observation/templateId/@root="1.2.36.1.2001.1001.102.101.100054"	
				observation/code	
				observation/code/@code="282291009"	SNOMED CT
				observation/code/@codeSystem="2.16.840.1.113883.6.96"	
Condition > recorder	Reference to an individual who recorded the condition and takes responsibility for its content.	0..1	Reference (Base RelatedPerson Base Patient Base Practitioner)	n/a	displayName SHOULD be "Diagnosis interpretation".
					Not mapped directly for this model; this is implicit in ClinicalDocument/author.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Condition > clinicalStatus	The clinical status of the condition.	0..1	code	observation/entryRelationship[clin_status] observation/entryRelationship[clin_status]/@typeCode="COMP" observation/entryRelationship[clin_status]/observation observation/entryRelationship[clin_status]/observation/@classCode="OBS" observation/entryRelationship[clin_status]/observation/@moodCode="EVN" observation/entryRelationship[clin_status]/observation/code observation/entryRelationship[clin_status]/observation/code/@code="103.32013" observation/entryRelationship[clin_status]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" observation/entryRelationship[clin_status]/observation/code/@displayName observation/entryRelationship[clin_status]/observation/value	NCTIS Data Components displayName SHOULD be "Clinical Status". Condition Clinical Status Codes (required)
Condition > verificationStatus	The verification status to support the clinical status of the condition.	0..1	code	observation/entryRelationship[ver_status] observation/entryRelationship[ver_status]/@typeCode="COMP" observation/entryRelationship[ver_status]/observation observation/entryRelationship[ver_status]/observation/@classCode="OBS" observation/entryRelationship[ver_status]/observation/@moodCode="EVN" observation/entryRelationship[ver_status]/observation/code observation/entryRelationship[ver_status]/observation/code/@code="103.32012" observation/entryRelationship[ver_status]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" observation/entryRelationship[ver_status]/observation/code/@displayName observation/entryRelationship[ver_status]/observation/value	NCTIS Data Components displayName SHOULD be "Verification Status". Condition Verification Status (required)
Condition > code	Identification of the condition, problem or diagnosis.	1..1	CodeableConcept	observation/value	value/@xsi:type SHALL be "CD". value/originalText or value/@displayName SHALL be included. Clinical Condition (preferred)¹
Condition > subject	Indicates the patient or group who the condition record is associated with.	1..1	Reference (Patient with Mandatory IHI)	n/a	Not mapped directly for this model; this is implicit in patientRole.

Logical element	Logical element description	Logic-al card	Logical type	CDA schema element	CDA constraints and comments
Condition > onset[x]	Estimated or actual date or date-time the condition began, in the opinion of the clinician.	0..1	dateTime Age Period Range	See: instantiation choices	instantiation choices: If onset[x] is a dateTime or a Period then it SHALL be instantiated as observation/effectiveTime/low/@value. If onset[x] is an Age then it SHALL be instantiated as observation/entryRelationship[onset]/observation/value/@xsi:type SHALL be "PQ". The code for observation/entryRelationship[onset]/observation/code SHALL be code/@code="445518008" and code/@codeSystem="2.16.840.1.113883.6.96". If onset[x] is a Range then it SHALL be instantiated as TBD.
Condition > abatement[x]	The date or estimated date that the condition resolved or went into remission. This is called 'abatement' because of the many overloaded connotations associated with 'remission' or 'resolution' - Conditions are never really resolved, but they can abate.	0..1	dateTime Age boolean Period Range	See: instantiation choices	instantiation choices: If abatement[x] is a dateTime or a Period then it SHALL be instantiated as observation/effectiveTime/high/@value. If abatement[x] is an Age then it SHALL be instantiated as observation/entryRelationship[abat]/observation/value/@xsi:type SHALL be "PQ". The code for observation/entryRelationship[abat]/observation/code SHALL be code/@code="1292971000168105" and code/@codeSystem="2.16.840.1.113883.6.96". If abatement[x] is a Range then it SHALL be instantiated as TBD.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Condition > note	Additional information about the Condition. This is a general notes/comments entry for description of the Condition, its diagnosis and prognosis.	0..*	Annotation	observation/entryRelationship[note] observation/entryRelationship[note]/@typeCode="COMP" observation/entryRelationship[note]/act observation/entryRelationship[note]/act/@classCode="ACT" observation/entryRelationship[note]/act/@moodCode="EVN" observation/entryRelationship[note]/act/code observation/entryRelationship[note]/act/code/@code="103.16044" observation/entryRelationship[note]/act/code/@codeSystem="1.2.36.1.2001.1001.101" observation/entryRelationship[note]/act/code/@displayName observation/entryRelationship[note]/act/author observation/entryRelationship[note]/act/effectiveTime observation/entryRelationship[note]/act/text	NCTIS Data Components displayName SHOULD be "Additional Comments" If this author is not instantiated, the data is considered to be included via induction in ClinicalDocument/author. In CDA the cardinality of entryRelationship[note]/act/author is 0..*. In this template the cardinality of author SHALL be limited to 0..1. If this effectiveTime is not instantiated, the data is considered to be included via induction in ClinicalDocument/author/time. In CDA the cardinality of entryRelationship[note]/act/effectiveTime is 0..*. In this template the cardinality of effectiveTime SHALL be limited to 0..1. text/@xsi:type SHALL be "ST".

¹Note: The source representation of the terminology binding on code in Summary Statement of Condition [DH2020i] is as an optional slice on the [coding](#) part of the code element. In the representation of the model presented in this specification it is normalised as a preferred binding.

10.6 procedure (Summary Statement of Known Procedure)

This template is referenced by [section \(Medical History\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements				Context: Comes from linking elements	
Procedure	An action that is or was performed on a patient. This can be a physical intervention like an operation, or less invasive like counseling or hypnotherapy.	Cardinality comes from linking element	Procedure	procedure	
				procedure/@classCode="PROC"	
				procedure/@moodCode="EVN"	
				procedure/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				procedure/templateId/@root="1.2.36.1.2001.1001.102.101.100055"	
Procedure > status	A code specifying the state of the procedure. Generally this will be in-progress or completed state.	1..1	code	procedure/statusCode	This CDA schema element is of type CodedSimpleValue (CS). Procedure Act Status HL7 V3 (required)¹
Procedure > code	The specific procedure that is performed. Use text if the exact nature of the procedure cannot be coded (e.g. 'Laparoscopic Appendectomy').	1..1	CodeableConcept	procedure/code	code/originalText or code/@displayName SHALL be included. Procedure (preferred)²
Procedure > subject	The person, animal or group on which the procedure was performed.	1..1	Reference(Patient with Mandatory IHI)	n/a	Not mapped directly for this model; this is implicit in patientRole.
Procedure > performed[x]	The date(time)/period over which the procedure was performed. Allows a period to support complex procedures that span more than one date, and also allows for the length of the procedure to be captured.	0..1	dateTime Period	procedure/effectiveTime	

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Procedure > note	Any other notes about the procedure. E.g. the operative notes.	0..*	Annotation	procedure/entryRelationship[note] procedure/entryRelationship[note]/@typeCode="COMP" procedure/entryRelationship[note]/act procedure/entryRelationship[note]/act/@classCode="ACT" procedure/entryRelationship[note]/act/@moodCode="EVN" procedure/entryRelationship[note]/act/code procedure/entryRelationship[note]/act/code/@code="103.16044" procedure/entryRelationship[note]/act/code/@codeSystem="1.2.36.1.2001.1001.101" procedure/entryRelationship[note]/act/code/@displayName procedure/entryRelationship[note]/act/author procedure/entryRelationship[note]/act/effectiveTime procedure/entryRelationship[note]/act/text	NCTIS Data Components displayName SHOULD be "Additional Comments". If this author is not instantiated, the data is considered to be included via induction in ClinicalDocument/author. In CDA the cardinality of entryRelationship[note]/act/author is 0..*. In this template the cardinality of author SHALL be limited to 0..1. If this effectiveTime is not instantiated, the data is considered to be included via induction in ClinicalDocument/author/time. In CDA the cardinality of entryRelationship[note]/act/effectiveTime is 0..*. In this template the cardinality of effectiveTime SHALL be limited to 0..1. text /@xsi:type SHALL be "ST".

¹This value set differs from the value set bound to status in the Agency logical model (see [Shared Health Summary FHIR Implementation Guide \[DH2020i\]](#)) due to constraints on statusCode in the HL7 CDA Schema. The concept map [TBD](#) provides a mapping between the two value sets.

²Note: The source representation of the terminology binding on code in Summary Statement of Known Procedure [\[DH2020i\]](#) is as an optional slice on the [coding](#) part of the code element. In the representation of the model presented in this specification it is normalised as a preferred binding.

10.7 ext:coverage2 (Practitioner qualification)

This template is referenced by [participant \(generalPractitioner Base Practitioner\)](#), [informant \(Base Practitioner\)](#), and [assignedPerson \(Practitioner with Mandatory Identifier\)](#), [assignedPerson \(Base Practitioner\)](#).

See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements		Context: Comes from linking elements			
Practitioner > qualification	Qualifications obtained by training and certification.	Cardinality comes from linking element	BackboneElement	ext:coverage2[prac_qual]	
				ext:coverage2[prac_qual]/@typeCode="COVBY"	
				ext:coverage2[prac_qual]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				ext:coverage2[prac_qual]/templateId/@root="1.2.36.1.2001.1001.102.101.100038"	
				ext:coverage2[prac_qual]/ext:entitlement	
				ext:coverage2[prac_qual]/ext:entitlement/@classCode="COV"	
				ext:coverage2[prac_qual]/ext:entitlement/@moodCode="EVN"	
				ext:coverage2[prac_qual]/ext:entitlement/ext:participant[prac]	
				ext:coverage2[prac_qual]/ext:entitlement/ext:participant[prac]/@typeCode="HLD"	
				ext:coverage2[prac_qual]/ext:entitlement/ext:participant[prac]/ext:participantRole	
Practitioner > qualification > identifier	An identifier that applies to this person's qualification in this role.	0..*	Identifier	ext:coverage2[prac_qual]/ext:entitlement/ext:id	Recommended mappings for this logical type to CDA (R2) are available: Identifier .
Practitioner > qualification > code	Coded representation of the qualification.	1..1	CodeableConcept	ext:coverage2[prac_qual]/ext:entitlement/ext:code	ext:code/originalText or ext:code/@displayName SHALL be included. v2 table 0360, Version 2.7 (example)
Practitioner > qualification > period	Period during which the qualification is valid.	0..1	Period	ext:coverage2[prac_qual]/ext:entitlement/ext:effectiveTime	

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Practitioner > qualification > issuer	Organization that regulates and issues the qualification.	0..1	Reference(Organization)	ext:coverage2[prac_qual]/ext:entitlement/ext:participant[issuer] ext:coverage2[prac_qual]/ext:entitlement/ext:participant[issuer]/@typeCode="AUT" ext:coverage2[prac_qual]/ext:entitlement/ext:participant[issuer]/ext:participantRole ext:coverage2[prac_qual]/ext:entitlement/ext:participant[issuer]/ext:participantRole/@classCode="COMPAR"	

11 Common patterns

This chapter contains conformance requirements on CDA schema elements. These conformance rules apply across multiple templates, forming 'common patterns'.

11.1 Entity Identifier

See [Legend - CDA mapping table for CDA schema elements](#) for an explanation of mapping table presentation.

CDA mapping

Common pattern	CDA schema element	CDA element description	CDA card	CDA constraints and comments
Entity Identifier	ext:asEntityIdentifier	A number or code issued for the purpose of identifying a participant within a healthcare context.	Cardinality comes from linking element	
	ext:asEntityIdentifier/@classCode="IDENT"		1..1	
	ext:asEntityIdentifier/ext:id		1..1	
	ext:asEntityIdentifier/ext:id/@root		1..1	root SHALL be an OID and SHALL NOT be a UUID.
	ext:asEntityIdentifier/ext:id/@extension		0..1	
	ext:asEntityIdentifier/ext:id/@assigningAuthorityName		0..1	A name for the namespace represented in the root that is populated with the issuer, or identifier type, or a concatenation of both as appropriate. This is used for human-readable, not machine processing, purposes. assigningAuthorityName SHOULD be instantiated.
	ext:asEntityIdentifier/ext:code		0..1	
	ext:asEntityIdentifier/ext:assigningGeographicArea		0..1	
	ext:asEntityIdentifier/ext:assigningGeographicArea/@classCode="PLC"		1..1	
	ext:asEntityIdentifier/ext:assigningGeographicArea/ext:name		0..1	The range and extent that the identifier applies to the object with which it is associated that is populated directly from the geographic area. This is used for human-readable, not machine processing, purposes. ext:name SHOULD be instantiated. Healthcare Identifier Geographic Area (preferred) This CDA schema element is expected to be populated with the display, e.g. "National Identifier".

Examples

Example 11.1. Entity Identifier - Australian IHI

```
<!-- Australian IHI -->
<xs:asEntityIdentifier classCode="IDENT">
<xs:id root="1.2.36.1.2001.1003.0.800360883357361" assigningAuthorityName="IHI" />
<xs:assigningGeographicArea classCode="PLC">
  <xs:name>National Identifier</xs:name>
</xs:assigningGeographicArea>
</xs:asEntityIdentifier>
```

Example 11.2. Entity Identifier - Local Medical Record Number

```
<!-- Local Medical Record Number -->
<xs:asEntityIdentifier classCode="IDENT">
<xs:id root="1.2.36.1.2001.1005.29.8003621566684455" extension="542181" assigningAuthorityName="Croydon GP Centre" />
  <xs:code code="MR" codeSystem="2.16.840.1.113883.12.203" codeSystemName="Identifier Type (HL7)" />
</xs:asEntityIdentifier>
```

Example 11.3. Entity Identifier - Australian HPI-I

```
<!-- Australian HPI-I -->
<xs:asEntityIdentifier classCode="IDENT">
<xs:id assigningAuthorityName="HPI-I" root="1.2.36.1.2001.1003.0.8003610537409456" />
<xs:assigningGeographicArea classCode="PLC">
  <xs:name>National Identifier</xs:name>
</xs:assigningGeographicArea>
</xs:asEntityIdentifier>
```

Example 11.4. Entity Identifier - Australian HPI-O

```
<!-- Australian HPI-O -->
<xs:asEntityIdentifier classCode="IDENT">
  <xs:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />
  <xs:assigningGeographicArea classCode="PLC">
    <xs:name>National Identifier</xs:name>
  </xs:assigningGeographicArea>
</xs:asEntityIdentifier>
```

11.2 Personal Relationship

See [Legend - CDA mapping table for CDA schema elements](#) for an explanation of mapping table presentation.

CDA mapping

Common pattern	CDA schema element	CDA element description	CDA card	CDA constraints and comments
Personal Relationship	ext:personalRelationship	The personal relationship of a participant to a patient. A personal relationship is not to be instantiated if the participant is a practitioner.	Cardinality comes from linking element	
	ext:personalRelationship/@classCode="PRS"		0..1	
	ext:personalRelationship/ext:id		0..1	
	ext:personalRelationship/ext:code		1..1	
	ext:personalRelationship/ext:statusCode		0..1	v3 Code System RoleStatus (required)
	ext:personalRelationship/ext:effectiveTime		0..1	
	ext:personalRelationship/ext:asPersonalRelationship		1..1	
	ext:personalRelationship/ext:asPersonalRelationship/@classCode="PSN"		0..1	
	ext:personalRelationship/ext:asPersonalRelationship/@determinerCode="INSTANCE"		0..1	
	ext:personalRelationship/ext:asPersonalRelationship/id		1..1	This id SHALL hold the same value as patientRole/id.
	ext:personalRelationship/ext:asPersonalRelationship/administrativeGenderCode/@nullFlavor="NA"		1..1	Included for CDA conformance only.

Examples

Example 11.5. Personal Relationship - author related person

```
<!-- recordTarget (Patient) -->
<recordTarget>
  <patientRole>
    <!-- patient identifier-->
    <id extension="100543" root="2.16.840.1.113883.19.1.2.3.4"/>
  </patientRole>
</recordTarget>

<!-- author (RelatedPerson) -->
<author>
  <time value="200911031647+1000"/>
  <assignedAuthor>
    <!-- author identifier-->
    <id root="86d729b8-72d2-460a-a64c-489a51607450"/>
    <assignedPerson>
      <!-- personal relationship -->
      <ext:personalRelationship>
        <!--relationship-->
        <ext:code code="SIGOTHR" codeSystem="2.16.840.1.113883.5.111" codeSystemName="v3 Code System RoleCode" displayName="significant other" />
        <!--patient-->
        <ext:asPersonalRelationship>
          <!-- patient identifier-->
          <id extension="100543" root="2.16.840.1.113883.19.1.2.3.4"/>
          <administrativeGenderCode nullFlavor="NA" />
        </ext:asPersonalRelationship>
      </ext:personalRelationship>
    </assignedPerson>
    </assignedAuthor>
  </author>
</author>
```

Example 11.6. Personal Relationship - performer related person

```
<!-- recordTarget (Patient) -->
<recordTarget>
  <patientRole>
    <!-- patient identifier-->
    <id extension="100543" root="2.16.840.1.113883.19.1.2.3.4"/>
  </patientRole>
</recordTarget>

<!-- participant performer (RelatedPerson) -->
<participant typeCode="PRF">
  <associatedEntity classCode="ASSIGNED">
    <!--participant performer identifier-->
    <id root="f3351b5c-8a6c-437c-a55c-a6c121873456"/>
    <!-- personal relationship -->
    <associatedPerson>
      <ext:personalRelationship>
        <!--relationship-->
        <ext:code code="FAMMEMB" codeSystem="2.16.840.1.113883.5.111" codeSystemName="v3 Code System RoleCode" displayName="Family Member" />
    </associatedPerson>
  </associatedEntity>
</participant>
```

```
<!--patient-->
<ext:asPersonalRelationship>
  <!-- patient identifier-->
  <id extension="100543" root="2.16.840.1.113883.19.1.2.3.4" />
  <administrativeGenderCode nullFlavor="NA" />
</ext:asPersonalRelationship>
</ext:personalRelationship>
</associatedPerson>
</associatedEntity>
</participant>
```


Examples

Example 11.7. Qualification - Bachelor of Pharmacy

```
<!-- Qualification - Bachelor of Pharmacy -->
<ext:asQualifications classCode="QUAL">
<ext:code>
  <originalText>Bachelor of Pharmacy</originalText>
</ext:code>
</ext:asQualifications>
```

Example 11.8. Qualification - List of qualifications

```
<!-- Qualification -->
<ext:asQualifications classCode="QUAL">
<ext:code>
  <originalText>Doctor of Medicine, Fellowship of the Australian College of Rural and Remote Medicine (FACRRM)</originalText>
</ext:code>
</ext:asQualifications>
```

11.4 Language Communication

See [Legend - CDA mapping table for CDA schema elements](#) for an explanation of mapping table presentation.

CDA mapping

Common pattern	CDA schema element	CDA element description	CDA card	CDA constraints and comments
Language Communication	ext:languageCommunication	A language communication capability of an individual.	Cardinality comes from linking element	
	ext:languageCommunication/languageCode		1..1	This CDA schema element is of type CodedSimpleValue (CS). All Languages (required) Common Languages in Australia (extensible)
	ext:languageCommunication modeCode		0..1	v3 Code System LanguageAbilityMode (preferred)
	ext:languageCommunication/proficiencyLevelCode		0..1	v3 Code System LanguageAbilityProficiency (preferred)
	ext:languageCommunication/preferenceInd		0..1	This CDA schema element is of type Boolean (BL).

Examples

Example 11.9. Language Communication - English is preferred

```
<!-- Language Communication -->
<ext:languageCommunication>
  <languageCode code="en"/>
  <preferenceInd value="true"/>
</ext:languageCommunication>
```

Example 11.10. Language Communication - Pitjantjatjara is preferred

```
<!-- Language Communication -->
<ext:languageCommunication>
  <languageCode code="pjt"/>
</ext:languageCommunication>
```

Example 11.11. Language Communication - German is spoken

```
<!-- Language Communication -->
<ext:languageCommunication>
  <languageCode code="de"/>
</ext:languageCommunication>
```


Appendix A. Complex data type mappings to CDA (R2)

This informative appendix provides some guidance on how [FHIR Release 3 \(STU\) \[HL7FHIR3\]](#) complex data types referred to in the body of this specification can map to CDA (R2). The material provided are recommendations and do not represent conformance requirements.

A.1 Identifier

This informative appendix provides some guidance on how the complex data type [Identifier](#) can map to CDA (R2). In addition to material provided in this implementation guide some guidance on representation of common identifiers in CDA is provided by [Representation of Common Australian Identifiers in v2 and CDA \[HI2011\]](#) and [Common - Clinical Document \[DH2019a\]](#).

The mapping table below provides a set of preferred mappings to the InstanceIdentifier (II) data type [\[HL7V3\]](#) and the Entity Identifier (EntityIdentifier) type defined in the Australian Digital Health Agency CDA schema, and do not represent conformance requirements. See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Identifier	A technical identifier - identifies some entity uniquely and unambiguously.	Cardinality comes from linking element	Element	See: instantiation choices	<p>In CDA it is possible that an identifier is formed such that the system and value are both part of the value of the root attribute. In this circumstance the extension attribute SHOULD NOT be instantiated.</p> <p>instantiation choices:</p> <p>If the identifier is for a Patient, Practitioner, PractitionerRole, Organization, RelatedPerson, or Device, then the identifier is expected to be instantiated as ext:asEntityIdentifier/@classCode="IDENT". See <Entity Identifier> for available attributes.</p> <p>The identifier element may be instantiated as id.</p>
Identifier > use	The purpose of this identifier.	0..1	code	n/a	This logical element has no mapping to CDA.
Identifier > type	A coded type for the identifier that can be used to determine which identifier to use for a specific purpose.	0..1	CodeableConcept	//ext:asEntityIdentifier/ext:code	<p>ext:code is only available if the identifier is instantiated as ext:asEntityIdentifier/@classCode="IDENT". ext:code/originalText or ext:code/@displayName SHALL be included.</p> <p>Identifier Type Codes (extensible)</p>
Identifier > system	Establishes the namespace for the value - that is, a URL that describes a set values that are unique.	0..1	uri	See: instantiation choices	<p>instantiation choices:</p> <p>If the identifier is for a if the identifier is for a Patient, Practitioner, PractitionerRole, Organization, RelatedPerson, or Device, then the identifier system is expected to be instantiated as ext:asEntityIdentifier/ext:id/@root.</p> <p>The identifier system may be instantiated as id/@root.</p>
Identifier > value	The portion of the identifier typically relevant to the user and which is unique within the context of the system.	0..1	string	See: instantiation choices	<p>instantiation choices:</p> <p>If the identifier is for a if the identifier is for a Patient, Practitioner, PractitionerRole, Organization, RelatedPerson, or Device, then identifier value is expected to be instantiated as ext:asEntityIdentifier/ext:id/@extension.</p> <p>The identifier value may be instantiated as id/@extension.</p>

Logical element	Logical element description	Logic-al card	Logical type	CDA schema element	CDA constraints and comments
Identifier > period	Time period during which identifier is/was valid for use.	0..1	Period	n/a	This logical element has no mapping to CDA.
Identifier > assigner	Organization that issued/manages the identifier.	0..1	Reference (Organ-ization)	See: instantiation choices	<p>instantiation choices:</p> <p>If the identifier is for a Patient, Practitioner, PractitionerRole, Organization, RelatedPerson, or Device, then identifier assigner is expected to be instantiated as ext:asEntityIdentifier/ext:id/@assigningAuthorityName.</p> <p>The identifier assigner may be instantiated as id/@assigningAuthorityName.</p>

Examples

Example A.1. Identifier - Patient identifiers

```

<!-- subject -->
<recordTarget>
  <!-- subject (Patient) -->
  <patientRole>
    <patient>
      ...
      <!-- Patient.identifier as an Australian IHI -->
      <ext:asEntityIdentifier classCode="IDENT">
        <!-- identifier.type.text=IHI,
        identifier.value=800360020002222,
        identifier.system=http://ns.electronichealth.net.au/id/hi/ihi/1.0 -->
        <ext:id assigningAuthorityName="IHI" root="1.2.36.1.2001.1003.0.800360020002222" />
        <ext:assigningGeographicArea classCode="PLC">
          <ext:name>National Identifier</ext:name>
        </ext:assigningGeographicArea>
      </ext:asEntityIdentifier>

      <!-- Patient.identifier as an Institution Medical Record-->
      <ext:asEntityIdentifier classCode="IDENT">
        <!-- identifier.assigner=Croydon GP Centre,
        identifier.value=542181,
        identifier.system=urn:oid:1.2.36.1.2001.1005.29.8003621566684455 -->
        <ext:id root="1.2.36.1.2001.1005.29.8003621566684455" extension="542181" assigningAuthorityName="Croydon GP Centre" />
        <!-- Patient.identifier.type -->
        <ext:code code="MR" codeSystem="2.16.840.1.113883.12.203" codeSystemName="Identifier Type (HL7)" />
      </ext:asEntityIdentifier>

      <!-- Patient.identifier as a Medicare Number -->
      <ext:asEntityIdentifier classCode="IDENT">
        <!-- identifier.system=urn:oid:1.2.36.1.5001.1.0.7,
        identifier.value=123456789,
        identifier.assigner=Medicare Card Number -->
        <ext:id assigningAuthorityName="Medicare Card Number"
        root="1.2.36.1.5001.1.0.7" extension="1234567892"/>
        <ext:code code="MC" codeSystem="2.16.840.1.113883.12.203"
        codeSystemName="Identifier Type (HL7)" displayName="Patient's Medicare number" />
    </ext:asEntityIdentifier>
  </patient>
</patientRole>
</recordTarget>

```

```
<!-- Identifier.period is not available in an asEntityIdentifier class -->
</ext:asEntityIdentifier>

<!-- Patient.identifier as a DVA Number -->
<ext:asEntityIdentifier classCode="IDENT">
<!-- identifier.system=urn:oid:2.16.840.1.113883.3.879.270091,
    identifier.value=NBUR9080,
    identifier.assigner=Department of Veterans' Affairs -->
<ext:id assigningAuthorityName="Department of Veterans' Affairs"
  root="2.16.840.1.113883.3.879.270091" extension="NBUR9080"/>
<ext:code code="DVG" codeSystem="2.16.840.1.113883.2.3.4.1.1.203"
  codeSystemName="HL7V2Table0203IdentifierTypeAUExtended" displayName="DVA Gold Card Number"/>
<!-- Identifier.period is not available in an asEntityIdentifier class -->
</ext:asEntityIdentifier>

<!-- Patient.identifier as a Healthcare card number -->
<ext:asEntityIdentifier classCode="IDENT">
<!-- identifier.system=urn:oid:2.16.840.1.113883.3.879.270098,
    identifier.value=307111942H,
    identifier.assigner=Centrelink customer reference number -->
<ext:id assigningAuthorityName="Centrelink customer reference number"
  root="2.16.840.1.113883.3.879.270098" extension="307111942H"/>
<ext:code code="HC" codeSystem="2.16.840.1.113883.12.203"
  codeSystemName="Identifier Type (HL7)" displayName="Health Card Number"/>
</ext:asEntityIdentifier>

</patient>
</patientRole>
</recordTarget>
```

Example A.2. PractitionerRole identifiers

```
<author>
  <time value="200911031647+1000"/>
<!-- author (PractitionerRole) -->
<assignedAuthor>
  <!-- PractitionerRole.id -->
  <id root="86d729b8-72d2-460a-a64c-489a51607450"/>
<!-- PractitionerRole.practitioner(Practitioner) -->
<assignedPerson>
  <!-- Practitioner.identifier as an Australian HPI-I -->
  <ext:asEntityIdentifier classCode="IDENT">
    <!-- identifier.value=8003610537409456,
        identifier.system=urn:oid:1.2.36.1.2001.1003.0,
        identifier.assigner=HPI-I -->
    <ext:id assigningAuthorityName="HPI-I"
      root="1.2.36.1.2001.1003.0.8003610537409456"/>
    <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
    </ext:assigningGeographicArea>
  </ext:asEntityIdentifier>
<!-- PractitionerRole.identifier as an ABN scoped provider identifier -->
<ext:asEntityIdentifier classCode="IDENT">
  <!-- identifier.value=8003610537409456,
      identifier.system=urn:oid:1.2.36.1.2001.1003.0,
      identifier.assigner=HPI-I -->
  <ext:id assigningAuthorityName="Albion Hospital",
```

```
root="1.2.36.1.2001.1005.70.51824753556"
extension="peterwinslow44"/>
<!-- identifier.type -->
<ext:code code="EI"
  codeSystem="2.16.840.1.113883.18.108"
  codeSystemName="v2 Identifier Type"
  displayName="Employee number"/>
</ext:asEntityIdentifier>
</assignedPerson>
</assignedAuthor>
<!--PractitionerRole.organization (Organization)-->
<representedOrganization>
  <!-- Organization.name -->
  <name>Albion Hospital</name>
  <!--Organization.identifier as an ABN-->
  <ext:asEntityIdentifier classCode="IDENT">
    <!-- identifier.value=51824754455,
    identifier.system=urn:oid:1.2.36,
    identifier.assigner=ABN -->
    <ext:id root="1.2.36.51824754455" assigningAuthorityName="ABN" />
    <!-- identifier.type -->
    <ext:code code="XX"
      codeSystem="2.16.840.1.113883.12.203" />
  </ext:asEntityIdentifier>
</representedOrganization>
</author>
```

Example A.3. Identifier - Organization identifier

```
<custodian>
  <!-- custodian (Organization)-->
  <assignedCustodian>
    <representedCustodianOrganization>
      <!-- Organization.id-->
      <id root="d0455def-ff37-4ebe-97fb-52db7224b148" />
      <!-- Organization.identifier as a Laboratory NATA Identifier -->
      <ext:asEntityIdentifier classCode="IDENT">
        <!-- identifier.system.value=urn:oid:1.2.36.1.2001.1005.12,
        identifier.value=2184,
        identifier.assigner=NATA -->
        <ext:id assigningAuthorityName="NATA"
          root="1.2.36.1.2001.1005.12" extension="2184" />
        <!-- identifier.type -->
        <ext:code code="XX" codeSystem="2.16.840.1.113883.12.203" />
      </ext:asEntityIdentifier>
    </representedCustodianOrganization>
  </assignedCustodian>
</custodian>
```

Example A.4. Identifier - ProcedureRequest identifier

```
<!--DiagnosticReport.basedOn-->
<inFulfillmentOf typeCode="FLFS">
```

```
<!--ProcedureRequest-->
<order classCode="ACT" moodCode="RQO">
  <!-- ProcedureRequest.identifier
  identifier.system=urn:oid:1.2.36.1.2001.1005.52.8003621566684455, identifier.value=123451 -->
  <id extension="123451" root="1.2.36.1.2001.1005.52.8003621566684455" />
</order>
</in FulfillmentOf>
```

A.2 Base HumanName

This informative appendix provides some guidance on how the constrained form of complex data type [HumanName](#) as Base HumanName published by the Australian Digital Health Agency can map to CDA (R2).

The mapping table below provides a set of preferred mappings to the PersonName (PN) data type [\[HL7V3\]](#) for representing an Australian address and do not represent conformance requirements. See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
HumanName	A human's name with the ability to identify parts and usage.	Cardinality comes from linking element	Element	//name	<p>name SHALL have at least text (name with full text representation) or family (name/family) or given (name/given) instantiated.</p> <p>In CDA, a full text representation of a name is not to be included in the same instance as a structured representation with the same name parts. Either the free text representation or a name with structure (e.g. name/family or name/given) should be provided but not both.</p>
HumanName > use	Identifies the purpose for this name.	0..1	code	//name/@use	Common Person Name Use (required)¹
HumanName > text	A full text representation of the name.	0..1	string	//name	
HumanName > family	The part of a name that links to the genealogy. In some cultures (e.g. Eritrea) the family name of a son is the first name of his father.	0..1	string	//name/family	
HumanName > given	Given name.	0..*	string	//name/given	
HumanName > prefix	Part of the name that is acquired as a title due to academic, legal, employment or nobility status, etc. and that appears at the start of the name.	0..*	string	//name/prefix	A prefix value can be populated as described in AS 4846 (2014) – Person and provider identification in healthcare [SA2014a] , 4.4.2 Name Title.
HumanName > suffix	Part of the name that is acquired as a title due to academic, legal, employment or nobility status, etc. and that appears at the end of the name.	0..*	string	//name/suffix	A suffix value can be populated as described in AS 4846 (2014) – Person and provider identification in healthcare [SA2014a] , 4.5.3.2 Name Suffix.
HumanName > period	Indicates the period of time when this name was valid for the named person.	0..1	Period	//name/validTime	

¹This value set differs from the value set bound to use in [HumanName](#) due to constraints on @use in the HL7 CDA Schema. The concept map [NameUse \(HL7 FHIR\) to Common Person Name Use](#) provides a mapping between the two value sets.

Examples

Example A.5. Base HumanName - name use, given names, family name

```
<!-- HumanName where use=official -->
<name use="N">
  <!-- HumanName.given -->
  <given>Adam</given>
  <!-- HumanName.given -->
  <given>A.</given>
  <!-- HumanName.family -->
  <family>Everyman</family>
</name>
```

Example A.6. Base HumanName - unstructured name

```
<!-- HumanName where use=official -->
<name use="C">
  <!-- HumanName.text -->
  Adam A. Everyman
</name>
```

Example A.7. Base HumanName - given name only

```
<!-- HumanName where use=usual -->
<name>
  <!-- HumanName.given -->
  <given>Damo</given>
</name>
```

Example A.8. Base HumanName - structured name with period

```
<!-- HumanName where use=old -->
<name use="DN">
  <!-- HumanName.given -->
  <given>Adam</given>
  <!-- HumanName.given -->
  <given>A.</given>
  <!-- HumanName.family -->
  <family>Adamson</family>
  <!-- HumanName.period -->
  <validTime xsi:type="IVL_TS">
    <low value="01012001" />
    <high value="01012012" />
  </validTime>
</name>
```

```
</validTime>  
</name>
```

A.3 Address

This informative appendix provides some guidance on how the complex data type [Address](#) can map to CDA (R2).

The mapping table below provides a set of preferred mappings to the PostalAddress (AD) data type [\[HL7V3\]](#) and do not represent conformance requirements. See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Address	An address expressed using postal conventions (as opposed to GPS or other location definition formats). This data type may be used to convey addresses for use in delivering mail as well as for visiting locations which might not be valid for mail delivery. There are a variety of postal address formats defined around the world.	Cardinality comes from linking element	Element	//addr	
Address > use	The purpose of this address.	0..1	code	//addr/@use	addr/@use can carry more than one value by a space separated list of codes. Address Use HL7 v3 (required) ¹
Address > type	Distinguishes between physical addresses (those you can visit) and mailing addresses (e.g. PO Boxes and care-of addresses). Most addresses are both.	0..1	code	//addr/@use	addr/@use can carry more than one value by a space separated list of codes. Address Type HL7 v3 (required) ²
Address > text	A full text representation of the address.	0..1	string	//addr	The expectation is that this is free text.
Address > line	This component contains the house number, apartment number, street name, street direction, P.O. Box number, delivery hints, and similar address information.	0..*	string	//addr/streetAddressLine	
Address > city	The name of the city, town, village or other community or delivery center.	0..1	string	//addr/city	
Address > district	The name of the administrative area (county).	0..1	string	//addr/county	
Address > state	Sub-unit of a country with limited sovereignty in a federally organized country. A code may be used if codes are in common use (i.e. US 2 letter state codes).	0..1	string	//addr/state	
Address > postalCode	A postal code designating a region defined by the postal service.	0..1	string	//addr/postalCode	
Address > country	Country - a nation as commonly understood or generally accepted.	0..1	string	//addr/country	Iso 3166 Part 1: 2 Letter Codes (preferred)
Address > period	Time period when address was/is in use.	0..1	Period	//addr/useablePeriod	

¹This value set differs from the value set bound to use in [Address](#) due to constraints on @use in the HL7 CDA schema. The concept map [y3 map for AddressUse](#) provides a mapping between the two value sets.

²This value set differs from the value set bound to type in [Address](#) due to constraints on @use in the HL7 CDA schema. The concept map [v3 map for AddressType](#) provides a mapping between the two value sets.

Examples

Example A.9. Address - structured work and postal address

```
<!-- Address where use=work and type=postal -->
<addr use="PST WP">
  <!--Address.text-->
  1050 W Wishard Blvd
  RG
  5th floor
  Indianapolis, IN 46240
  <!--Address.line-->
  <streetAddressLine>1050 W Wishard Blvd</streetAddressLine>
  <!--Address.line-->
  <streetAddressLine>RG 5th floor</streetAddressLine>
  <!--Address.city-->
  <city>Indianapolis</city>
  <!--Address.state-->
  <state>IN</state>
  <!--Address.postalCode-->
  <postalCode>46240</postalCode>
</addr>
```

Example A.10. Address - structured home and physical address

```
<!-- Address where use=home and type=physical -->
<addr use="PHYS H">
  <!--Address.text-->
  1 Back Lane&#13;&#10;Holmfirth&#13;&#10;HUDDERSFIELD&#13;&#10;HD7 1HQ
  <!--Address.line-->
  <streetAddressLine>1 Back Lane</streetAddressLine>
  <!--Address.city-->
  <city>Holmfirth</city>
  <!--Address.district-->
  <county>HUDDERSFIELD</county>
  <!--Address.postalCode-->
  <postalCode>HD7 1HQ</postalCode>
</addr>
```

Example A.11. Address - temporary international address

```
<!-- Address where use=old -->
<addr use="TMP">
  <!--Address.line-->
  <streetAddressLine>Rue Lougoraia 12, app. 10</streetAddressLine>
```

```
<!--Address.city-->
<city>Korolevo</city>
<!--Address.state-->
<state>Minsk</state>
<!--Address.country-->
<country>BELARUS</country>
<!--Address.period-->
<useablePeriod xsi:type="IVL_TS">
    <low value="01012001" />
    <high value="01012012" />
</useablePeriod>
</addr>
```

A.4 AU Base Address

This informative appendix provides some guidance on how the constrained form of complex data type [Address](#) as [AU Base Address](#) published by HL7 Australia can map to CDA (R2).

The mapping table below provides a set of preferred mappings to the PostalAddress (AD) data type [\[HL7V3\]](#) for representing an Australian address and do not represent conformance requirements. See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Address	An Australian address expressed using postal conventions (as opposed to GPS or other location definition formats).	Cardinality comes from linking element	Element	//addr	addr SHALL have text or one or more line (addr/streetAddressLine).
Address > no-fixed-address	No fixed address indicator.	0..1	boolean	n/a	Not mapped directly; if 0..1 is "true", addr SHOULD be "NO FIXED ADDRESS" and addr/@use SHOULD be "PHYS".
Address > use	The purpose of this address.	0..1	code	//addr/@use	addr/@use can carry more than one value by a space separated list of codes. Address Use HL7 v3 (required) ¹
Address > type	Distinguishes between physical addresses (those you can visit) and mailing addresses (e.g. PO Boxes and care-of addresses). Most addresses are both.	0..1	code	//addr/@use	addr/@use can carry more than one value by a space separated list of codes. Address Type HL7 v3 (required) ²
Address > text	A full text representation of the address.	0..1	string	//addr	The expectation is that this is free text.
Address > line	This component contains the house number, apartment number, street name, street direction, P.O. Box number, delivery hints, and similar address information.	0..*	string	//addr/streetAddressLine	
Address > city	The name of the city, town, village or other community or delivery center.	0..1	string	//addr/city	
Address > district	The name of the administrative area (county).	0..1	string	//addr/county	
Address > state	Sub-unit of a country with limited sovereignty in a federally organized country. A code may be used if codes are in common use (i.e. US 2 letter state codes).	0..1	string	//addr/state	state SHALL be populated with the code e.g. "NT". Australian States and Territories (required)
Address > postalCode	A postal code designating a region defined by the postal service.	0..1	string	//addr/postalCode	The maximum length of postalCode SHALL be 4.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Address > country	Fixed value if present otherwise assumed to be Australia in this context.	0..1	string	//addr/country	country SHALL be "AU".
Address > period	Time period when address was/is in use.	0..1	Period	//addr/useablePeriod	

¹This value set differs from the value set bound to use in [AU Base Address](#) due to constraints on @use in the HL7 CDA schema. The concept map [v3 map for AddressUse](#) provides a mapping between the two value sets.

²This value set differs from the value set bound to type in [AU Base Address](#) due to constraints on @use in the HL7 CDA schema. The concept map [v3 map for AddressType](#) provides a mapping between the two value sets.

Examples

Example A.12. AU Base Address - no fixed address in Melbourne, VIC

```
<!-- Australian Address with no fixed address in Melbourne, VIC-->
<addr use="PHYS">
  <!--Address.text-->
  NO FIXED ADDRESS
  <!--Address.city-->
  <city>Melbourne</city>
  <!--Address.state-->
  <state>VIC</state>
</addr>
```

Example A.13. AU Base Address - unstructured address

```
<!-- Australian Address with only text-->
<addr use="PHYS">
  <!--Address.text-->
  Level 1, 300 George St, Brisbane, QLD 4000
</addr>
```

Example A.14. AU Base Address - structured postal address with period

```
<!-- Australian Address where use=work and type=postal -->
<addr use="PST_WP">
  <!--Address.line-->
  <streetAddressLine>Northern Territory Office, Department of Addresses, GPO Box 19132110</streetAddressLine>
  <!--Address.city-->
  <city>Darwin</city>
  <!--Address.state-->
  <state>NT</state>
  <!--Address.postalCode-->
  <postalCode>0801</postalCode>
<!--Address.country-->
```

```
<country>AU</country>
<!--Address.period-->
<useablePeriod xsi:type="IVL_TS">
  <low value="200311031647+1000" />
</useablePeriod>
</addr>
```

Example A.15. AU Base Address - structured physical address

```
<!-- Australian Address where use=work and type=physical -->
<addr use="PHYS WP">
<!--Address.line-->
<streetAddressLine>5th Floor, Northern Territory House, 223 Mitchell Street</streetAddressLine>
<!--Address.city-->
<city>Darwin</city>
<!--Address.state-->
<state>NT</state>
<!--Address.postalCode-->
<postalCode>0800</postalCode>
<!--Address.country-->
<country>AU</country>
</addr>
```

A.5 ContactPoint

This informative appendix provides some guidance on how the complex data type [ContactPoint](#) can map to CDA (R2).

The mapping table below provides a set of preferred mappings to the TelecommunicationAddress (TEL) data type [\[HL7V3\]](#) and do not represent conformance requirements. See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
ContactPoint	Details for all kinds of technology mediated contact points for a person or organization, including telephone, email, etc.	Cardinality comes from linking element	Element	//telecom	In CDA, ContactPoint value and system are represented as parts of telecom/@value. If ContactPoint value is present, ContactPoint system SHALL be present.
ContactPoint > system	Telecommunications form for contact point - what communications system is required to make use of the contact.	0..1	code	//telecom/@value	Makes up part of the attribute: "system:value", e.g. "tel:phone number", "mailto:email address", "http:URL", etc. HL7 URLScheme (required)
ContactPoint > value	The actual contact point details, in a form that is meaningful to the designated communication system (i.e. phone number or email address).	0..1	string	//telecom/@value	Makes up the part of the attribute: "system:value", e.g. "tel:phone number", "mailto:email address", "http:URL", etc.
ContactPoint > use	Identifies the purpose for the contact point.	0..1	code	//telecom/@use	HL7 TelecommunicationAddressUse (required)¹
ContactPoint > rank	Specifies a preferred order in which to use a set of contacts. Contacts are ranked with lower values coming before higher values.	0..1	positiveInt	n/a	This logical element has no mapping to CDA.
ContactPoint > period	Time period when the contact point was/is in use.	0..1	Period	//telecom/usablePeriod	

¹This value set differs from the value set bound to use in [ContactPoint](#) due to constraints on @use in the HL7 CDA Schema. The concept map [v3 map for ContactPointUse](#) provides a mapping between the two value sets.

Examples

Example A.16. ContactPoint - home telephone with period

```
<!-- ContactPoint where system=phone, value=+1-(03)5550-1212, use=home -->
<telecom value="tel:+1-(03)5550-1212" use="H">
  <!-- ContactPoint.period -->
```

```
<useablePeriod xsi:type="IVL_TS">
  <low value="01012001" />
  <high value="01012012" />
</useablePeriod>
</telecom>
```

Example A.17. ContactPoint - home telephone

```
<!-- ContactPoint where system=phone, value=0755501234, use=home -->
<telecom use="H" value="tel:0755501234" />
```

Example A.18. ContactPoint - work email

```
<!-- ContactPoint where system=email, value=sfranklin@amail.example.com, use=work -->
<telecom use="WB" value="mailto:sfranklin@amail.com.au" />
```

A.6 AU Base Dosage

This informative appendix provides some guidance on how the constrained form of complex data type [Dosage](#) as [AU Base Dosage](#) published by HL7 Australia can map to CDA (R2).

The mapping table below provides a set of preferred mappings to CDA Schema elements and do not represent conformance requirements. See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Dosage	Indicates how the medication is/was taken or should be taken by the patient.	Cardinality comes from linking element	Element	See: instantiation choices	instantiation choices: When a single instance of dosage is recorded the logical element has no direct mapping; it is implicit in the mapping of the child elements. When more than one instance of dosage is recorded, each instance of dosage is recorded as a child substanceAdministration, e.g. substanceAdministration/entryRelationship[dosage]/substanceAdministration[@typeCode="SBADM", @moodCode="INT"].
Dosage > sequence	Indicates the order in which the dosage instructions should be applied or interpreted.	0..1	integer	//entryRelationship[dosage] //entryRelationship[dosage]@typeCode="COMP" //entryRelationship[dosage]/sequenceNumber	sequenceNumber SHALL NOT be instantiated for a single instance of dosage. The value of sequenceNumber SHALL be an ordinal number starting at "1" and increasing by "1" for each subsequent instance of dosage.
Dosage > text	Free text dosage instructions e.g. SIG.	0..1	string	//text	
Dosage > additionalInstruction	Supplemental instruction - e.g. 'with meals'.	0..*	CodeableConcept	n/a	Not mapped directly for this model; included implicitly in text, or patientInstruction, or timing, or asNeeded.
Dosage > patientInstruction	Instructions in terms that are understood by the patient or consumer.	0..1	string	//text	
Dosage > timing	When medication should be administered.	0..1	Timing	//effectiveTime	Recommended mappings for this logical type to CDA (R2) are available: Timing .

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Dosage > asNeeded[x]	Indicates whether the Medication is only taken when needed within a specific dosing schedule (Boolean option), or it indicates the precondition for taking the Medication (CodeableConcept).	0..1	boolean CodeableConcept	//precondition //precondition/@typeCode="PRCN" //precondition/criterion //precondition/criterion/code //precondition/criterion/code/@code="ASSERTION" //precondition/criterion/code/@codeSystem="2.16.840.1.113883.5.4" //precondition/criterion/value	
					value/@xsi:type SHALL be "CD" or "BL". If value/@xsi:type is "CD" then value/originalText or value/@displayName SHALL be included. Clinical Finding (preferred)
Dosage > site	Body site to administer to.	0..1	CodeableConcept	//approachSiteCode	approachSiteCode/originalText or approachSiteCode/@displayName SHALL be included. Body Site (preferred)
Dosage > route	How drug should enter body.	0..1	CodeableConcept	//routeCode	routeCode/originalText or routeCode/@displayName SHALL be included. Route of Administration (preferred)
Dosage > method	Technique for administering medication.	0..1	CodeableConcept	//ext:methodCode	ext:methodCode/originalText or ext:methodCode/@displayName SHALL be included. SNOMED CT Administration Method Codes (preferred)
Dosage > dose[x]	Amount of medication per dose.	0..1	Range SimpleQuantity	//doseQuantity	
Dosage > maxDosePerPeriod	Upper limit on medication per unit of time.	0..1	Ratio	//maxDoseQuantity	
Dosage > maxDosePerAdministration	Upper limit on medication per administration.	0..1	SimpleQuantity	n/a	Not directly supported in CDA however this may be represented by an administration schedule with a maxDosePerAdministration in that administration schedule represented as maxDoseQuantity with a period of a single administration.
Dosage > maxDosePerLifetime	Upper limit on medication per lifetime of the patient.	0..1	SimpleQuantity	n/a	Not directly supported in CDA. One possible way to represent this concept is to represent an observation with a code equivalent to max dose per lifetime. One possibly way to represent this concept is to represent an instance of dosage with maxDoseQuantity and effectiveTime/high/@value="PINF" thus indicating that the end of the period of administration is positive infinity.
Dosage > rate[x]	Amount of medication per unit of time.	0..1	Ratio Range SimpleQuantity	//rateQuantity	

Examples

Example A.19. AU Base Dosage - MedicationStatement with two instances of structured dosage

```
<entry>
    <!-- MedicationStatement - more than one instance of Dosage -->
    <substanceAdministration classCode="SBADM" moodCode="EVN">
        <!-- identifier -->
        <id root="4255b903-6f90-41b8-a71c-8ac0ee1ebdc3"/>
        <!-- medication.as(medicationCodeableConcept) -->
        <consumable>
            <manufacturedProduct>
                <manufacturedMaterial>
                    <code code="6006011000036102"
                        codeSystem="2.16.840.1.113883.6.96"
                        displayName="Lasix 40 mg tablet">
                        <originalText>Lasix (frusemide 40 mg
                            tablet</originalText>
                    </code>
                </manufacturedMaterial>
            </manufacturedProduct>
        </consumable>
        <!-- Dosage to indicate asNeeded with a condition-->
        <entryRelationship typeCode="COMP" >
            <!-- sequence -->
            <sequenceNumber value="1"/>
            <substanceAdministration classCode="SBADM" moodCode="INT" >
                <consumable>
                    <manufacturedProduct>
                        <manufacturedMaterial nullFlavor="NA" />
                    </manufacturedProduct>
                </consumable>
                <!-- asNeededCodeableConcept - instantiated as prn with specified condition -->
                <precondition typeCode="PRCN" >
                    <criterion>
                        <code code="ASSERTION"
                            codeSystem="2.16.840.1.113883.5.4"/>
                        <!-- joint pain -->
                        <value xsi:type="CD" code="57676002"
                            codeSystem="2.16.840.1.113883.6.96"
                            displayName="Joint pain"/>
                    </criterion>
                </precondition>
            </substanceAdministration>
        </entryRelationship>
        <!-- Dosage to indicate timing -->
        <entryRelationship typeCode="COMP" >
            <!-- sequence -->
            <sequenceNumber value="2"/>
            <substanceAdministration classCode="SBADM" moodCode="INT" >
                <!-- additionalInstruction / patientInstruction -->
                <text>Every day at 8 in the morning for 10 minutes</text>
                <!-- timing -->
                <effectiveTime xsi:type="PIVL_TS" operator="A" >
                    <phase>
                        <low value="198701010800" inclusive="true"/>
                        <width value="10" unit="min"/>
                    </phase>
                <period value="1" unit="d"/>
            </substanceAdministration>
        </entryRelationship>
    </substanceAdministration>
</entry>
```

```
</effectiveTime>
<!-- route -->
<routeCode code="C38288" codeSystem="2.16.840.1.113883.3.26.1.1" codeSystemName="NCI Thesaurus" displayName="Oral"/>
<!-- dose -->
<doseQuantity value ="1" />
<consumable>
  <manufacturedProduct>
    <manufacturedMaterial nullFlavor="NA" />
  </manufacturedProduct>
</consumable>
</substanceAdministration>
</entryRelationship>
</substanceAdministration>
</entry>
```

Example A.20. AU Base Dosage - MedicationStatement with one instance of structured dosage

```
<entry>
  <!-- MedicationStatement - single instance of Dosage -->
  <substanceAdministration classCode="SBADM" moodCode="EVN" >
    <!-- identifier-->
    <id root="ab6d45ff-fd58-4f38-8009-aelaa84a4f43"/>
    <!-- method -->
    <ext:methodCode code="421134003" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Inhale" />
    <!-- route -->
    <routeCode code="ORNEB" codeSystem="2.16.840.1.113883.5.112" codeSystemName="Route Code" displayName="Inhalation, nebulization, oral"/>
    <!-- dose -->
    <doseQuantity value ="1" />
    <!-- maxDosePerPeriod -->
    <maxDoseQuantity>
      <numerator value="1" />
      <denominator value="1" unit="h" />
    </maxDoseQuantity>
    <administrationUnitCode code="415215001" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Puff" />
    <!-- medication.as(medicationCodeableConcept) -->
    <consumable>
      <manufacturedProduct>
        <manufacturedMaterial>
          <code code="7113011000036100"
            codeSystem="2.16.840.1.113883.6.96"
            displayName="Spiriva 18 microgram powder for inhalation, 1 capsule">
            <originalText>Spiriva (tiotropium bromide 18mg per
              inhalation) inhalant</originalText>
          </code>
        </manufacturedMaterial>
      </manufacturedProduct>
    </consumable>
    <!-- asNeededBoolean=true - instantiated as prn with no specified condition -->
    <precondition typeCode="PRCN">
      <criterion>
        <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>
        <value xsi:type="CD" nullFlavor="NI"/>
      </criterion>
    </precondition>
  </substanceAdministration>
</entry>
```

A.7 Timing

This informative appendix provides some guidance on how the complex data type [Timing](#) can map to CDA (R2).

The mapping table below provides a set of preferred mappings to CDA Schema elements and do not represent conformance requirements. See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Timing	Specifies an event that may occur multiple times. Timing schedules are used to record when things are planned, expected or requested to occur. The most common usage is in dosage instructions for medications. They are also used when planning care of various kinds, and may be used for reporting the schedule to which past regular activities were carried out.	Cardinality comes from linking element	Element	//effectiveTime	
Timing > event	Identifies specific times when the event occurs.	0..*	dateTime	//effectiveTime/@value	
Timing > repeat	A set of rules that describe when the event is scheduled.	0..1	Element	n/a	<p>Not mapped directly; implicit in the instantiation of the effectiveTime xsi:type, e.g. PIVL_TS or EIVL_TS, and the mapping of the child elements.</p> <p>If duration is present, durationUnit SHALL be present.</p> <p>If timeOfDay is present, when SHALL NOT be present.</p> <p>If period is present, periodUnit SHALL be present.</p> <p>duration SHALL be a non-negative value.</p> <p>period SHALL be a non-negative value.</p> <p>If periodMax is present, period SHALL be present.</p> <p>If offset is present, when SHALL be present.</p>

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Timing > repeat > bounds[x]	Either a duration for the length of the timing schedule, a range of possible length, or outer bounds for start and/or end limits of the timing schedule.	0..1	Duration Range Period	See: instantiation choices	<p>effectiveTime/@xsi:type SHALL be "IVL_TS".</p> <p>instantiation choices:</p> <p>If bounds is a Duration then it SHALL be instantiated as effective-Time/width.</p> <p>If bounds is a Range then it is expected to be included in Dosage as text, or additionalInstruction, or patientInstruction as appropriate.</p> <p>If bounds is a Period then it SHALL be instantiated as effective-Time/low/@value and effectiveTime/high/@value.</p>
Timing > repeat > count	A total count of the desired number of repetitions.	0..1	integer	//repeatNumber/@value	count SHALL only be instantiated in the repeatNumber element of the Dosage substanceAdministration act where the moodCode is "INT" or "PLAN".
Timing > repeat > countMax	A maximum value for the count of the desired repetitions (e.g. do something 6-8 times).	0..1	integer	//repeatNumber/high/@value	
Timing > repeat > duration	How long this thing happens for when it happens.	0..1	decimal	//effectiveTime/phase/width/@value	effectiveTime/@xsi:type SHOULD be "PIVL_TS".
Timing > repeat > durationMax	The upper limit of how long this thing happens for when it happens.	0..1	decimal	n/a	This logical element has no mapping to CDA.
Timing > repeat > durationUnit	The units of time for the duration, in UCUM units.	0..1	code	//effectiveTime/phase/width/@unit	effectiveTime/@xsi:type SHOULD be "PIVL_TS".
Timing > repeat > frequency	The number of times to repeat the action within the specified period / period range (i.e. both period and periodMax provided).	0..1	integer	//effectiveTime/frequency	frequency is expressed as the numerator (with an xsi:type of "INT") and period is expressed in CDA as the denominator.
				//effectiveTime/frequency/numerator	frequency is often not included in CDA as a separate element but addressed by adjusting the values of period and periodUnit to take into account frequency.
Timing > repeat > frequencyMax	If present, indicates that the frequency is a range - so to repeat between [frequency] and [frequencyMax] times within the period or period range.	0..1	integer	//effectiveTime/phase	effectiveTime/@xsi:type SHOULD be "PIVL_TS".
Timing > repeat > period	Indicates the duration of time over which repetitions are to occur; e.g. to express '3 times per day', 3 would be the frequency and '1 day' would be the period.	0..1	decimal	See: instantiation choices	<p>effectiveTime/@xsi:type SHOULD be "PIVL_TS".</p> <p>instantiation choices:</p> <p>May be represented by effectiveTime/phase or effectiveTime/period.</p>
Timing > repeat > periodMax	If present, indicates that the period is a range from [period] to [periodMax], allowing expressing concepts such as 'do this once every 3-5 days.'	0..1	decimal	See: instantiation choices	<p>effectiveTime/@xsi:type SHOULD be "PIVL_TS".</p> <p>instantiation choices:</p> <p>May be represented by effectiveTime/phase or effectiveTime/period/high.</p>

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Timing > repeat > periodUnit	The units of time for the period in UCUM units.	0..1	code	See: instantiation choices	effectiveTime/@xsi:type SHOULD be "PIVL_TS". instantiation choices: May be represented by effectiveTime/phase/@unit or effectiveTime/period/low/@unit or effectiveTime/period/high/@unit.
Timing > repeat > dayOfWeek	If one or more days of week is provided, then the action happens only on the specified day(s).	0..*	code	//effectiveTime/@xsi:type="PIVL_TS" //effectiveTime/@alignment="DW" //effectiveTime/phase //effectiveTime/phase/low/@value //effectiveTime/phase/low/@inclusive="true" //effectiveTime/phase/high/@value //effectiveTime/phase/high/@inclusive="false"	The value between low and high represents the day of the week by selecting a known day. For example a low/@value of 20001202 and a high/@value of 20001203 represents Saturday by setting the period to the whole of the Saturday of the 2nd of December 2000.
Timing > repeat > timeOfDay	Specified time of day for action to take place.	0..*	time	//effectiveTime/phase //effectiveTime/phase/low //effectiveTime/phase/low/@value	effectiveTime/@xsi:type SHOULD be "PIVL_TS".
Timing > repeat > when	Real world events that the occurrence of the event should be tied to.	0..*	code	//effectiveTime/event	This CDA schema element is of type CodedSimpleValue (CS). effectiveTime/@xsi:type SHALL be "EIVL_TS". EventTiming (required)
Timing > repeat > offset	The number of minutes from the event. If the event code does not indicate whether the minutes is before or after the event, then the offset is assumed to be after the event.	0..1	unsignedInt	//effectiveTime/offset	effectiveTime/@xsi:type SHALL be "EIVL_TS".
Timing > code	A code for the timing schedule. Some codes such as BID are ubiquitous, but many institutions define their own additional codes. If a code is provided, the code is understood to be a complete statement of whatever is specified in the structured timing data, and either the code or the data may be used to interpret the Timing, with the exception that .repeat.bounds still applies over the code (and is not contained in the code).	0..1	CodeableConcept	n/a	Not directly supported in CDA; implied by frequency.

Examples

Example A.21. Timing - Dosage with timing

```
<!-- Dosage to indicate timing -->
<entryRelationship typeCode="COMP">
```

```
<!-- sequence -->
<sequenceNumber value="2" />
<substanceAdministration classCode="SBADM" moodCode="INT">
  <!-- additionalInstruction / patientInstruction -->
  <text>Every day at 8 in the morning for 10 minutes</text>
  <!-- timing, 1st administered 2009-09-01 at 1:18am and to be taken every day at 8 in the morning for 10 minutes -->
  <!-- event -->
  <effectiveTime value="200509010118" />
  <!-- repeat -->
  <effectiveTime xsi:type="PIVL_TS" operator="A">
    <phase>
      <!-- boundsPeriod / timeOfDay -->
      <low value="200509020800" inclusive="true" />
      <!-- duration and durationUnit -->
      <width value="10" unit="min" />
    </phase>
    <!-- frequency=1, period=1 -->
    <period value="1" unit="d" />
  </effectiveTime>
  <consumable>
    <manufacturedProduct>
      <manufacturedMaterial nullFlavor="NA" />
    </manufacturedProduct>
  </consumable>
</substanceAdministration>
</entryRelationship>
```

Example A.22. Timing - b.i.d twice a day

```
<entry>
  <!-- MedicationStatement - common timing representations -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!--identifier-->
    <id root="7e5cc411-c248-4d5d-b333-257f16f9136c" />
    <!-- common timing representations taken from https://docs.google.com/document/d/1Y0Z458o_MrR2aPnpx6EygO6hpI88B195esjRWZ0agtY/edit -->
    <!-- b.i.d twice a day -->
    <effectiveTime xsi:type="PIVL_TS" institutionSpecified="true" operator="A">
      <!-- frequency=2, period=1, periodUnit=d -->
      <period value="0.5" unit="d" />
    </effectiveTime>
  </substanceAdministration>
</entry>
```

Example A.23. Timing - q12h Every 12 hours

```
<entry>
  <!-- MedicationStatement - common timing representations -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!--identifier-->
    <id root="7e5cc411-c248-4d5d-b333-257f16f9136c" />
    <!-- common timing representations taken from https://docs.google.com/document/d/1Y0Z458o_MrR2aPnpx6EygO6hpI88B195esjRWZ0agtY/edit -->
    <!-- q12h Every 12 hours -->
    <effectiveTime xsi:type="PIVL_TS" institutionSpecified="false" operator="A">
```

```
<!-- frequency=1, period=12, periodUnit=h -->
<period value="12" unit="h"/>
</effectiveTime>
</substanceAdministration>
</entry>
```

Example A.24. Timing - t.i.d Three times a day, at times determined by the person administering the medication

```
<entry>
  <!-- MedicationStatement - common timing representations -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!--identifier-->
    <id root="7e5cc411-c248-4d5d-b333-257f16f9136c"/>
    <!-- common timing representations taken from https://docs.google.com/document/d/1Y0Z458o_MrR2aPnpx6EygO6hpI88B195esjRWZ0agtY/edit -->
    <!--t.i.d Three times a day, at times determined by the person administering the medication-->
    <effectiveTime xsi:type="PIVL_TS" institutionSpecified="true"
      operator="A">
      <!-- frequency=3, period=1, periodUnit=d -->
      <period value="0.3333" unit="d"/>
    </effectiveTime>
  </substanceAdministration>
</entry>
```

Example A.25. Timing - q8h Every 8 hours

```
<entry>
  <!-- MedicationStatement - common timing representations -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!--identifier-->
    <id root="7e5cc411-c248-4d5d-b333-257f16f9136c"/>
    <!-- common timing representations taken from https://docs.google.com/document/d/1Y0Z458o_MrR2aPnpx6EygO6hpI88B195esjRWZ0agtY/edit -->
    <!-- q8h Every 8 hours -->
    <effectiveTime xsi:type="PIVL_TS" institutionSpecified="false"
      operator="A">
      <!-- frequency=1, period=8, periodUnit=h -->
      <period value="8" unit="h"/>
    </effectiveTime>
  </substanceAdministration>
</entry>
```

Example A.26. Timing - qid four times daily

```
<entry>
  <!-- MedicationStatement - common timing representations -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!--identifier-->
    <id root="7e5cc411-c248-4d5d-b333-257f16f9136c"/>
    <!-- common timing representations taken from https://docs.google.com/document/d/1Y0Z458o_MrR2aPnpx6EygO6hpI88B195esjRWZ0agtY/edit -->
    <!--qid four times daily-->
```

```
<effectiveTime xsi:type="PIVL_TS" institutionSpecified="true"
  operator="A">
  <!-- frequency=4, period=1, periodUnit=d -->
  <period value="0.25" unit="d"/>
</effectiveTime>
</substanceAdministration>
</entry>
```

Example A.27. Timing - q6h Every 6 hours

```
<entry>
  <!-- MedicationStatement - common timing representations -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!--identifier-->
    <id root="7e5cc411-c248-4d5d-b333-257f16f9136c"/>
    <!-- common timing representations taken from https://docs.google.com/document/d/1Y0Z458o_MrR2aPnpx6Eygo6hpI88B195esjRWZ0agtY/edit -->
    <!-- q6h Every 6 hours -->
    <effectiveTime xsi:type="PIVL_TS" institutionSpecified="false"
      operator="A">
      <!-- frequency=1, period=6, periodUnit=h -->
      <period value="6" unit="h"/>
    </effectiveTime>
  </substanceAdministration>
</entry>
```

Example A.28. Timing - qd daily

```
<entry>
  <!-- MedicationStatement - common timing representations -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!--identifier-->
    <id root="7e5cc411-c248-4d5d-b333-257f16f9136c"/>
    <!-- common timing representations taken from https://docs.google.com/document/d/1Y0Z458o_MrR2aPnpx6Eygo6hpI88B195esjRWZ0agtY/edit -->
    <!-- qd daily -->
    <effectiveTime xsi:type="PIVL_TS" institutionSpecified="true"
      operator="A">
      <!-- frequency=1, period=1, periodUnit=d -->
      <period value="1" unit="d"/>
    </effectiveTime>
  </substanceAdministration>
</entry>
```

Example A.29. Timing - q24h Every 24 hours

```
<entry>
  <!-- MedicationStatement - common timing representations -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!--identifier-->
```

```
<id root="7e5cc411-c248-4d5d-b333-257f16f9136c"/>
<!-- common timing representations taken from https://docs.google.com/document/d/1Y0Z458o_MrR2aPnpx6Eyg06hpI88B195esjRWZ0agtY/edit -->
<!-- q24h Every 24 hours -->
<effectiveTime xsi:type="PIVL_TS" institutionSpecified="false"
    operator="A">
    <!-- frequency=1, period=24, periodUnit=h -->
    <period value="24" unit="h"/>
</effectiveTime>
</substanceAdministration>
</entry>
```

Example A.30. Timing - qod Every other day

```
<entry>
<!-- MedicationStatement - common timing representations -->
<substanceAdministration classCode="SBADM" moodCode="EVN">
<!--identifier-->
<id root="7e5cc411-c248-4d5d-b333-257f16f9136c"/>
<!-- common timing representations taken from https://docs.google.com/document/d/1Y0Z458o_MrR2aPnpx6Eyg06hpI88B195esjRWZ0agtY/edit -->
<!-- qod Every other day -->
<effectiveTime xsi:type="PIVL_TS" institutionSpecified="false"
    operator="A">
    <!-- frequency=1, period=2, periodUnit=d -->
    <period value="2" unit="d"/>
</effectiveTime>
</substanceAdministration>
</entry>
```

Example A.31. Timing - qm Once a month

```
<entry>
<!-- MedicationStatement - common timing representations -->
<substanceAdministration classCode="SBADM" moodCode="EVN">
<!--identifier-->
<id root="7e5cc411-c248-4d5d-b333-257f16f9136c"/>
<!-- common timing representations taken from https://docs.google.com/document/d/1Y0Z458o_MrR2aPnpx6Eyg06hpI88B195esjRWZ0agtY/edit -->
<!-- qm Once a month -->
<effectiveTime xsi:type="PIVL_TS" institutionSpecified="false"
    operator="A">
    <!-- frequency=1, period=1, periodUnit=mo -->
    <period value="1" unit="m"/>
</effectiveTime>
</substanceAdministration>
</entry>
```

Example A.32. Timing - q4-6h Every 4 to 6 hours

```
<entry>
<!-- MedicationStatement - common timing representations -->
```

```
<substanceAdministration classCode="SBADM" moodCode="EVN">
  <!--identifier-->
  <id root="7e5cc411-c248-4d5d-b333-257f16f9136c"/>
  <!-- common timing representations taken from https://docs.google.com/document/d/1Y0Z458o_MrR2aPnpx6EygO6hpI88B195esjRWZ0agtY/edit -->
  <!-- q4-6h Every 4 to 6 hours -->
  <effectiveTime xsi:type="PIVL_TS" institutionSpecified="false"
    operator="A">
    <!-- frequency (where frequency=1)-->
    <period xsi:type="IVL_PQ">
      <!-- period and periodUnit -->
      <low value="4" unit="h" />
      <!-- periodMax and periodUnit -->
      <high value="6" unit="h" />
    </period>
  </effectiveTime>
</substanceAdministration>
</entry>
```

Example A.33. Timing - qam In the morning

```
<entry>
  <!-- MedicationStatement - common timing representations -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!--identifier-->
    <id root="7e5cc411-c248-4d5d-b333-257f16f9136c"/>
    <!-- common timing representations taken from https://docs.google.com/document/d/1Y0Z458o_MrR2aPnpx6EygO6hpI88B195esjRWZ0agtY/edit -->
    <!-- qam In the morning -->
    <effectiveTime xsi:type="EIVL_TS" operator="A">
      <!-- when using code from TimingEvent value set (2.16.840.1.113883.5.139) -->
      <event code="ACM"/>
    </effectiveTime>
  </substanceAdministration>
</entry>
```

Example A.34. Timing - qam Every day at 8 in the morning for 10 minutes

```
<entry>
  <!-- MedicationStatement - common timing representations -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!--identifier-->
    <id root="7e5cc411-c248-4d5d-b333-257f16f9136c"/>
    <!-- common timing representations taken from https://docs.google.com/document/d/1Y0Z458o_MrR2aPnpx6EygO6hpI88B195esjRWZ0agtY/edit -->
    <!-- qam Every day at 8 in the morning for 10 minutes -->
    <effectiveTime xsi:type="PIVL_TS" operator="A">
      <phase>
        <!-- boundsPeriod / timeOfDay -->
        <low value="198701010800" inclusive="true"/>
        <!-- duration and durationUnit -->
        <width value="10" unit="min"/>
      </phase>
    <period value="1" unit="d"/>
  </effectiveTime>
</substanceAdministration>
</entry>
```

Example A.35. Timing - 1 hour after meal

```
<entry>
  <!-- MedicationStatement - common timing representations -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!--identifier-->
    <id root="7e5cc411-c248-4d5d-b333-257f16f9136c"/>
    <!-- common timing representations taken from https://docs.google.com/document/d/1Y0Z458o_MrR2aPnpx6Eyg06hpI88B195esjRWZ0agtY/edit -->
    <!-- 1 hour after meal -->
    <effectiveTime xsi:type="EIVL_TS" operator="A">
      <!-- when using code from TimingEvent value set (2.16.840.1.113883.5.139) -->
      <event code="PC"/>
      <!-- offset -->
      <offset>
        <low value="1" unit="h" />
      </offset>
    </effectiveTime>
  </substanceAdministration>
</entry>
```

Example A.36. Timing - before dinner

```
<entry>
  <!-- MedicationStatement - common timing representations -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!--identifier-->
    <id root="7e5cc411-c248-4d5d-b333-257f16f9136c"/>
    <!-- common timing representations taken from https://docs.google.com/document/d/1Y0Z458o_MrR2aPnpx6Eyg06hpI88B195esjRWZ0agtY/edit -->
    <!-- before dinner -->
    <effectiveTime xsi:type="EIVL_TS" operator="A">
      <!-- when using code from TimingEvent value set (2.16.840.1.113883.5.139) -->
      <event code="ACV"/>
    </effectiveTime>
  </substanceAdministration>
</entry>
```

Example A.37. Timing - every evening

```
<entry>
  <!-- MedicationStatement - common timing representations -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!--identifier-->
    <id root="7e5cc411-c248-4d5d-b333-257f16f9136c"/>
    <!-- common timing representations taken from https://docs.google.com/document/d/1Y0Z458o_MrR2aPnpx6Eyg06hpI88B195esjRWZ0agtY/edit -->
    <!-- every evening -->
    <effectiveTime xsi:type="EIVL_TS" operator="A">
      <!-- when using code from TimingEvent value set (2.16.840.1.113883.5.139) -->
      <event code="ICV"/>
    </effectiveTime>
  </substanceAdministration>
</entry>
```

```
</effectiveTime>
</substanceAdministration>
</entry>
```

Example A.38. Timing - every Saturday

```
<entry>
  <!-- MedicationStatement - common timing representations -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!--identifier-->
    <id root="7e5cc411-c248-4d5d-b333-257f16f9136c"/>
    <!-- common timing representations taken from https://docs.google.com/document/d/1Y0z458o_MrR2aPnpx6EygO6hpI88B195esjRWZ0agtY/edit -->
    <effectiveTime xsi:type="PIVLT_TS" alignment="DW" operator="A">
      <!-- every Saturday -->
      <phase>
        <low value="20001202" inclusive="true"/>
        <high value="20001203" inclusive="false"/>
      </phase>
      <period value="1" unit="wk"/>
    </effectiveTime>
  </substanceAdministration>
</entry>
```

A.8 CodeableConcept as a Medicine Item Code

This informative appendix provides some guidance on how the complex data type [CodeableConcept](#) when used for a medicine item code (and related elements medication-brand-name and medication-generic-name) can map to CDA (R2).

In addition to material provided in this implementation guide, guidance on representing coding in CDA is provided by [Representing Coding in CDA Documents Implementation Guidance \[NE-HT2011bv\]](#).

Guidance

Where brand name is known, it will form part of the originalText of the medicine item code (e.g. manufacturedProduct/manufacturedMaterial/code/originalText), and optionally be in medication-brand-name (//entryRelationship[brand]/act/text).

It may be appropriate to send multiple codings for a medicine item code, in this circumstance the primary code may be carried in the medicine item code (code/@code) and additional coding sent as one or more translations (code/translation/@code).

When sending a medication without a coded value:

- the medicine item code should only be supplied as code/originalText (e.g. as manufacturedProduct/manufacturedMaterial/code/originalText)
- if both brand name and generic name can be sent, brand name will be sent as stated above; generic name will be sent only in medication-generic-name (//entryRelationship[generic]/act)
- if only generic name can be sent, it will form part of the originalText of the medicine item code (e.g. manufacturedProduct/manufacturedMaterial/code/originalText), and optionally be in medication-generic-name (//entryRelationship[generic]/act)
- if a name can be sent, but it cannot be determined if it is a brand or generic name, the name will form part of the originalText of the medicine item code (e.g. manufacturedProduct/manufacturedMaterial/code/originalText)
- if a name is not known but a meaningful description or formula can be sent, the description form part of the originalText of the medicine item code (e.g. manufacturedProduct/manufacturedMaterial/code/originalText)

The mappings in the table provided below are a set of preferred mappings from the complex data type [CodeableConcept](#) to the ConceptDescriptor (CD) data type [\[HL7V3\]](#) and do not represent conformance requirements. See [Legend - CDA mapping table for logical elements](#) for an explanation of mapping table presentation.

CDA mapping

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
CodeableConcept	A concept that may be defined by a formal reference to a terminology or ontology or may be provided by text.	Cardinality comes from linking element	Element	//code	This mapping table is applicable to any CDA schema element that can be of type CD by replacing out "//code" for that element, e.g. "//value" to become //value/@codeSystem.
CodeableConcept > coding	A reference to a code defined by a terminology system.	0..*	Coding	See: instantiation choices	instantiation choices: When a single instance of coding is recorded the logical element has no direct mapping; it is implicit in the mapping of the child elements. When more than one instance of coding is recorded, then the additional instances of coding are represented using //code/translation, e.g. //code/translation/@code and //code/translation/@codeSystem.
CodeableConcept > coding > system	The identification of the code system that defines the meaning of the symbol in the code.	0..1	uri	//code/@codeSystem	codeSystem SHALL be a UUID or an OID.
CodeableConcept > coding > version	The version of the code system which was used when choosing this code. Note that a well-maintained code system does not need the version reported, because the meaning of codes is consistent across versions. However this cannot consistently be assured, and when the meaning is not guaranteed to be consistent, the version SHOULD be exchanged.	0..1	string	//code/@codeSystemVersion	
CodeableConcept > coding > code	A symbol in syntax defined by the system. The symbol may be a predefined code or an expression in a syntax defined by the coding system (e.g. post-coordination).	0..1	code	//code/@code	
CodeableConcept > coding > display	A representation of the meaning of the code in the system, following the rules of the system.	0..1	string	//code/@displayName	
CodeableConcept > coding > userSelected	Indicates that this coding was chosen by a user directly - i.e. off a pick list of available items (codes or displays).	0..1	boolean	n/a	This logical element has no mapping to CDA.
CodeableConcept > text	A human language representation of the concept as seen/selected/uttered by the user who entered the data and/or which represents the intended meaning of the user.	0..1	string	//code/originalText	

Examples

Example A.39. CodeableConcept - Medication with coded brand

```
<!-- Medication with coded brand -->
<supply classCode="SPLY" moodCode="EVN">
  <id root="9ff3422e-4e8c-4133-8cc9-6de74ecfac48"/>
  <product>
    <manufacturedProduct>
      <manufacturedMaterial>
        <code code="17311000168105" codeSystem="2.16.840.1.113883.6.96"
          codeSystemName="SNOMED CT" displayName="Panadol">
          <originalText>Panadol</originalText>
        </code>
      </manufacturedMaterial>
    </manufacturedProduct>
  </product>
  <!-- medication-brand-name-->
  <entryRelationship typeCode="COMP">
    <act classCode="ACT" moodCode="EVN">
      <code code="1402141000168102" codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMED CT" displayName="Branded product name"/>
      <text xsi:type="ST">Panadol</text>
    </act>
  </entryRelationship>
</supply>
```

Example A.40. CodeableConcept - Medication with multiple codings

```
<!-- Medication with mutliple codings -->
<substanceAdministration classCode="SBADM" moodCode="EVN">
  <consumable>
    <manufacturedProduct>
      <manufacturedMaterial>
        <code code="28236011000036109" codeSystem="2.16.840.1.113883.6.96"
          codeSystemName="SNOMED CT" displayName="amoxicillin 250 mg capsule, 20">
          <translation code="1884E" codeSystem="1.2.36.1.2001.1004.200.10009"
            codeSystemName="Australian Pharmaceutical Benefits Scheme Schedule Item"
            displayName="amoxicillin 250 mg capsule, 20"/>
        </code>
      </manufacturedMaterial>
    </manufacturedProduct>
  </consumable>
</substanceAdministration>
```

Example A.41. CodeableConcept - Medication without a coded value

```
<!-- Medication without a coded value -->
<supply classCode="SPLY" moodCode="RQO">
  <product>
    <manufacturedProduct>
      <manufacturedMaterial>
        <code>
          <originalText>RIVAROXABAN</originalText>
        </code>
      </manufacturedMaterial>
    </manufacturedProduct>
  </product>
```

</supply>

Example A.42. CodeableConcept - Medication with both brand name and generic name and no coded value

```
<!-- Medication with both brand name and generic name and no coded value -->
<substanceAdministration classCode="SBADM" moodCode="EVN">
  <id root="67425d8f-7929-4a10-9acc-c06981e38d6a"/>
  <consumable>
    <manufacturedProduct>
      <manufacturedMaterial>
        <code>
          <originalText>Valpam</originalText>
        </code>
      </manufacturedMaterial>
    </manufacturedProduct>
  </consumable>
  <!-- medication-brand-name-->
  <entryRelationship typeCode="COMP">
    <act classCode="ACT" moodCode="EVN">
      <code code="1402141000168102" codeSystem="2.16.840.1.113883.6.96"
           codeSystemName="SNOMED CT" displayName="Branded product name"/>
      <text xsi:type="ST">Valpam</text>
    </act>
  </entryRelationship>
  <!-- medication-generic-name-->
  <entryRelationship typeCode="COMP">
    <act classCode="ACT" moodCode="EVN">
      <code code="1402131000168106" codeSystem="2.16.840.1.113883.6.96"
           codeSystemName="SNOMED CT" displayName="Generic product name"/>
      <text xsi:type="ST">Diazepam</text>
    </act>
  </entryRelationship>
</substanceAdministration>
```

Example A.43. CodeableConcept - Medication with generic name and no coded value

```
<!-- Medication with generic name and no coded value -->
<substanceAdministration classCode="SBADM" moodCode="EVN">
  <consumable>
    <manufacturedProduct>
      <manufacturedMaterial>
        <code>
          <originalText>Diazepam</originalText>
        </code>
      </manufacturedMaterial>
    </manufacturedProduct>
  </consumable>
  <!-- medication-generic-name-->
  <entryRelationship typeCode="COMP">
    <act classCode="ACT" moodCode="EVN">
      <code code="1402131000168106" codeSystem="2.16.840.1.113883.6.96"
           codeSystemName="SNOMED CT" displayName="Generic product name"/>
      <text xsi:type="ST">Diazepam</text>
    </act>
  </entryRelationship>
</substanceAdministration>
```

```
</entryRelationship>  
</substanceAdministration>
```

Appendix B. Examples

This implementation guide is intended to support multiple usage scenarios; some templates described within this implementation guide are reused across usage scenarios and other implementation guides.

This informative appendix provides examples that conform to the CDA templates defined in this implementation guide to support implementation by demonstrating one or more supported usage scenarios.

Example	Context	Usage Scenario(s)
Shared Health Summary example 1	My Health Record system	Shared Health Summary
Shared Health Summary example 2	My Health Record system	Shared Health Summary
Shared Health Summary example 3	My Health Record system	Shared Health Summary

A corresponding set of FHIR Release 3 (STU) examples, conforming to the FHIR profiles used as logical models for this CDA implementation guide, are available in the [Shared Health Summary FHIR Implementation Guide \[DH2020i\]](#).

B.1 Shared Health Summary example 1

This informative appendix provides an example instance that conforms to the requirements of this implementation guide.

Example B.1. Shared Health Summary example 1

```
<!-- This example is illustrative only. This fragment cannot be treated as clinically valid.
While every effort has been taken to ensure that the examples are consistent with the message specification, where
there are conflicts with the written message specification or schema, the specification or schema will take precedence. -->

<ClinicalDocument classCode="DOCCLIN" moodCode="EVN" xmlns="urn:hl7-org:v3"
  xmlns:ex="urn:hl7-org:v3-example"
  xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
  xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
  xsi:schemaLocation="urn:hl7-org:v3 ../../library/schema_au_published/CDA-AU-V1_0.xsd">
  <typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>
  <!-- ClinicalDocument templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100033" extension="1.0"/>
  <!-- Shared Health Summary document model templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100019" extension="1.0"/>
  <!-- CDA Rendering Specification templateId-->
  <templateId root="1.2.36.1.2001.1001.100.226" extension="1.0"/>
  <id root="2.25.134045617645909421812767683577428735500"/>
  <!-- Composition type -->
  <code code="60591-5" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
    displayName="Patient summary"/>
  <!-- Composition title -->
  <title>Shared Health Summary</title>
  <effectiveTime value="20170621090015+1000"/>
  <confidentialityCode nullFlavor="NA"/>
  <languageCode code="en-AU"/>
  <!-- Composition status -->
  <ext:completionCode code="F" codeSystem="1.2.36.1.2001.1001.101.104.20104"
    codeSystemName="NCTIS Document Status Values" displayName="Final"/>
  <!-- Composition subject -->
  <recordTarget typeCode="RCT">
    <!-- recordTarget (My Health Record Patient) templateId -->
    <templateId root="1.2.36.1.2001.1001.102.101.100091" extension="1.0"/>
    <patientRole classCode="PAT">
      <id root="7147985c-f96f-4c95-978d-93197a9c1825"/>
      <patient>
        <!-- Patient name -->
        <name>
          <given>Sammy</given>
          <family>GoodPatient</family>
        </name>
        <!-- Patient gender -->
        <administrativeGenderCode code="other" codeSystem="2.16.840.1.113883.4.642.1.2"
          codeSystemName="AdministrativeGender" displayName="Other"/>
        <!-- Patient birthDate-->
        <birthTime value="19890309"/>
        <!-- Patient indigenous-status -->
        <ethnicGroupCode code="4" codeSystem="1.2.36.1.2001.1004.200.10012"
          codeSystemName="Australian Indigenous Status" displayName="Neither Aboriginal nor Torres Strait Islander origin"/>
        <!-- Patient identifier -->
        <ext:asEntityIdentifier classCode="IDENT">
          <ext:id root="1.2.36.1.2001.1003.0.8003608833357361"
            assigningAuthorityName="IHI"/>
          <ext:assigningGeographicArea classCode="PLC">
            <ext:name>National Identifier</ext:name>
          </ext:assigningGeographicArea>
        </ext:asEntityIdentifier>
      </patient>
      <!-- Patient managingOrganization -->
      <providerOrganization classCode="ORG">
        <asOrganizationPartOf>
          <wholeOrganization>
            <id root="9bb58ba2-477c-4778-87bb-a64e1781d8e"/>
            <name>GoodDoctor Clinic</name>
          </wholeOrganization>
        </asOrganizationPartOf>
      </providerOrganization>
    </patientRole>
  </recordTarget>
  <!-- Compstion composition-author-role :: author -->
  <author typeCode="AUT">
    <!-- (PractitionerRole with Practitioner with Mandatory Identifier) templateId -->
    <templateId root="1.2.36.1.2001.1001.102.101.100006" extension="1.0"/>
    <templateId root="1.2.36.1.2001.1001.102.101.100006" extension="1.0"/>
    <!-- Composition date -->
    <time value="20170621090015+1000"/>
    <assignedAuthor>
      <id root="72fb1fca-80fb-463c-bc92-34f2b2cf0ecd"/>
      <!-- PractitionerRole code -->
      <code code="253111" codeSystem="2.16.840.1.113883.13.62"
        displayName="General Practitioner">
        <originalText>GP</originalText>
      </code>
      <!-- Practitioner telecom -->
      <telecom use="WP" value="mailto:bhelpman@example.devonportgp.com.au"/>
    <!-- PractitionerRole practitioner -->
    <assignedPerson>
```

```
<!-- assignedPerson (Practitioner with Mandatory Identifier) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100040" extension="1.0"/>
<!-- Practitioner name -->
<name>
  <given>Barry</given>
  <family>Helpman</family>
  <suffix qualifier="AC">M.D.</suffix>
</name>
<!-- PractitionerRole identifier or Practitioner identifier -->
<ext:asEntityIdentifier classCode="IDENT">
  <ext:id root="1.2.36.1.2001.1003.0.8003619900015717">
    <assigningAuthorityName>HPI-I</assigningAuthorityName>
  </ext:asEntityIdentifier>
  <ext:assigningGeographicArea classCode="PLC">
    <ext:name>National Identifier</ext:name>
  </ext:assigningGeographicArea>
</ext:asEntityIdentifier>
<ext:asEntityIdentifier classCode="IDENT">
  <ext:id root="1.2.36.174030967.0.2" extension="5544887B">
    <assigningAuthorityName>Medicare Provider number</assigningAuthorityName>
  </ext:asEntityIdentifier>
  <ext:code code="PRN" codeSystem="2.16.840.1.113883.12.203">
    <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
    </ext:assigningGeographicArea>
  </ext:asEntityIdentifier>
</assignedPerson>
<!-- PractitionerRole organization -->
<representedOrganization>
  <!-- representedOrganization (Base Organization) templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100039" extension="1.0"/>
  <id root="a4lab6d0-e084-a9a6-f5aea38b293"/>
  <!-- Organization name -->
  <name>Devonport Family Medicine Clinic</name>
  <!-- Organization telecom -->
  <telecom use="WP" value="mailto:reception@example.dfm.com.au"/>
  <telecom use="WD" value="fax:0385435557"/>
  <telecom use="WD" value="tel:0385435556"/>
  <!-- Organization address -->
  <addr use="PST">
    <streetAddressLine>LPO Box 235</streetAddressLine>
    <city>Strahan</city>
    <state>TAS</state>
    <postalCode>7468</postalCode>
  </addr>
  <!-- Organization identifier -->
  <ext:asEntityIdentifier classCode="IDENT">
    <ext:id root="1.2.36.51824754455">
      <assigningAuthorityName>Devonport Family Medicine Clinic</assigningAuthorityName>
    </ext:asEntityIdentifier>
  </representedOrganization>
</assignedAuthor>
</author>
<!-- Composition custodian -->
<custodian>
  <!-- custodian (Organization with Mandatory Identifier) templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100002" extension="1.0"/>
  <assignedCustodian>
    <representedCustodianOrganization>
      <templateId root="1.2.36.1.2001.1001.102.101.100039" extension="1.0"/>
      <id root="a4lab6d0-e084-48ea-a9a6-f5aea38b293"/>
      <!-- Organization name -->
      <name>Devonport Family Medicine Clinic</name>
      <!-- Organization telecom -->
      <telecom use="WD" value="tel:0385435556"/>
      <!-- Organization address -->
      <addr use="PST">
        <streetAddressLine>LPO Box 235</streetAddressLine>
        <city>Strahan</city>
        <state>TAS</state>
        <postalCode>7468</postalCode>
      </addr>
      <!-- Organization identifier -->
      <ext:asEntityIdentifier classCode="IDENT">
        <ext:id root="1.2.36.51824754455">
          <assigningAuthorityName>Devonport Family Medicine Clinic</assigningAuthorityName>
        </ext:asEntityIdentifier>
      </representedCustodianOrganization>
    </assignedCustodian>
  </custodian>
  <!-- attester (Legal Attester) -->
  <legalAuthenticator>
    <templateId root="1.2.36.1.2001.1001.102.101.100012" extension="1.0"/>
    <time value="20170621090015+1000"/>
    <signatureCode code="S"/>
    <assignedEntity>
      <!-- attester (Legal Attester) indicating same entity as the author via the same id -->
      <id root="72fb1fca-80fb-463c-bc92-34f2b2cf0ecd"/>
    </assignedEntity>
  </legalAuthenticator>
  <!-- Patient generalPractitioner (Base Practitioner) -->
  <participant typeCode="PART">
    <functionCode code="FCP"/>
    <associatedEntity classCode="PROV">
      <id root="fdb10052-30e9-4425-b771-8b8a81ae7107"/>
      <associatedPerson classCode="PSN">
        <!-- Practitioner name -->
```

```
<name>
  <prefix>Dr.</prefix>
  <given>Good</given>
  <family>Doctor</family>
</name>
</associatedPerson>
</associatedEntity>
</participant>
<component>
<structuredBody>
  <!-- Composition section (Medications) -->
  <component>
    <section>
      <templateId root="1.2.36.1.2001.1001.102.101.100011" extension="1.0"/>
      <id root="fca6edfa-fd96-48d3-ba6e-986ad37d7759"/>
      <!-- section code -->
      <code code="101.32009" codeSystem="1.2.36.1.2001.1001.101"
        displayName="Current Medicine"/>
      <!-- section title -->
      <title>Current Medications</title>
      <!-- section text -->
      <text mediaType="text/x-hl7-text+xml">
        <table>
          <thead>
            <tr>
              <th>Medication</th>
              <th>Dose</th>
            </tr>
          </thead>
          <tbody>
            <tr ID="medicationstatement-candesartan32mg">
              <td>Candesartan 32mg</td>
              <td>1 d</td>
            </tr>
            <tr ID="medicationstatement-metformin">
              <td>Metformin 500mg</td>
              <td>1 bd</td>
            </tr>
            <tr ID="medicationstatement-candesartan8mg">
              <td>Candesartan 8mg</td>
              <td>0.5 d</td>
            </tr>
          </tbody>
        </table>
      </text>
      <!-- section entry -->
      <entry>
        <!-- MedicationStatement; taken=y-->
        <substanceAdministration classCode="SBADM" moodCode="EVN">
          <!-- substanceAdministration (Summary Statement of Known Medicine) templateId-->
          <templateId root="1.2.36.1.2001.1001.102.101.100015" extension="1.0"/>
          <id root="ae25b0fc-408b-447b-9c13-d44a6707e3d2"/>
          <!-- MedicationStatement.dosage -->
          <text>
            <reference value="#medicationstatement-candesartan32mg"/>
          </text>
          <!-- MedicationStatement.status -->
          <statusCode code="active"/>
          <!-- MedicationStatement.dosage.timing -->
          <effectiveTime xsi:type="PIVL_TS" institutionSpecified="true"
            operator="A">
            <period value="1" unit="d"/>
          </effectiveTime>
          <!-- MedicationStatement.dosage.doseQuantity -->
          <doseQuantity value="1"/>
          <!-- MedicationStatement.medication -->
          <consumable>
            <manufacturedProduct>
              <manufacturedMaterial>
                <code code="22087011000036100"
                  codeSystem="2.16.840.1.113883.6.96"
                  codeSystemName="SNOMED CT"
                  displayName="candesartan cilexetil 32 mg tablet">
                  <originalText>Candesartan 32mg</originalText>
                </code>
              </manufacturedMaterial>
            </manufacturedProduct>
          </consumable>
        </substanceAdministration>
      </entry>
      <!-- section entry -->
      <entry>
        <!-- MedicationStatement; taken=y-->
        <substanceAdministration classCode="SBADM" moodCode="EVN">
          <!-- substanceAdministration (Summary Statement of Known Medicine) templateId-->
          <templateId root="1.2.36.1.2001.1001.102.101.100015" extension="1.0"/>
          <id root="ed67bda8-91ff-41d9-bf8c-44db8987f05e"/>
          <!-- MedicationStatement.dosage -->
          <text>
            <reference value="#medicationstatement-metformin"/>
          </text>
          <!-- MedicationStatement.status -->
          <statusCode code="active"/>
          <!-- MedicationStatement.dosage.timing -->
          <effectiveTime xsi:type="PIVL_TS" institutionSpecified="true"
            operator="A">
            <period value="0.5" unit="d"/>
          </effectiveTime>
          <!-- MedicationStatement.dosage.doseQuantity -->

```

```
<doseQuantity value="1"/>
<!-- MedicationStatement.medication -->
<consumable>
<manufacturedProduct>
<manufacturedMaterial>
<code code="23358011000036102"
      codeSystem="2.16.840.1.113883.6.96"
      codeSystemName="SNOMED CT"
      displayName="metformin hydrochloride 500 mg tablet">
  <originalText>Metformin 500mg</originalText>
</code>
</manufacturedMaterial>
</manufacturedProduct>
</consumable>
</substanceAdministration>
</entry>
<!-- section entry -->
<entry>
<!-- MedicationStatement; taken=y-->
<substanceAdministration classCode="SBADM" moodCode="EVN">
<!-- substanceAdministration (Summary Statement of Known Medicine) templateId-->
<templateId root="1.2.36.1.2001.1001.102.101.100015" extension="1.0"/>
<id root="54db2400-2419-4448-9cb8-87c5f18d566e"/>
<!-- MedicationStatement.dosage -->
<text>
<reference value="#medicationstatement-candesartan8mg"/>
</text>
<!-- MedicationStatement.status -->
<statusCode code="active"/>
<!-- MedicationStatement.dosage.timing -->
<effectiveTime xsi:type="PIVL_TS" institutionSpecified="true"
  operator="A">
<period value="1" unit="d"/>
</effectiveTime>
<!-- MedicationStatement.dosage.doseQuantity -->
<doseQuantity value="0.5"/>
<!-- MedicationStatement.medication -->
<consumable>
<manufacturedProduct>
<manufacturedMaterial>
<code code="22879011000036102"
      codeSystem="2.16.840.1.113883.6.96"
      codeSystemName="SNOMED CT"
      displayName="candesartan cilexetil 8 mg tablet">
  <originalText>Candesartan 8mg</originalText>
</code>
</manufacturedMaterial>
</manufacturedProduct>
</consumable>
</substanceAdministration>
</entry>
</section>
</component>
<!-- Composition section (Allergies) -->
<component>
<section>
<!-- section (Allergies) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100008" extension="1.0"/>
<id root="c3ee47a0-086b-47d9-8a11-51aa526d4b1d"/>
<!-- section code -->
<code code="48765-2" codeSystem="2.16.840.1.113883.6.1"
      displayName="Allergies andor adverse reactions"/>
<!-- section title -->
<title>Allergies and Adverse Reactions</title>
<!-- section text -->
<text mediaType="text/x-hl7-text+xml">
<content ID="ALLERGY">No known medication allergies.</content>
</text>
<!-- section entry -->
<entry>
<observation classCode="OBS" moodCode="EVN">
<!--observation (Summary Statement of Allergy or Intolerance) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100014" extension="1.0"/>
<id root="134649c9-53c9-41fe-984c-2b3123646800"/>
<code code="102.15517" codeSystem="1.2.36.1.2001.1001.101"
      displayName="Adverse Reaction"/>
<!--AllergyIntolerance code-->
<value xsi:type="CD" code="409137002"
      codeSystem="2.16.840.1.113883.6.96"
      displayName="No known drug allergy">
  <originalText><reference value="#ALLERGY"/></originalText>
</value>
<!-- AllergyIntolerance verificationStatus -->
<entryRelationship typeCode="COMP">
<observation classCode="OBS" moodCode="EVN">
<code code="103.32012" codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components Code System"
      displayName="Verification Status"/>
<value xsi:type="CD" code="unconfirmed"
      codeSystem="2.16.840.1.113883.4.642.1.116"
      codeSystemName="AllergyIntoleranceVerificationStatus"
      displayName="Unconfirmed"/>
</observation>
</entryRelationship>
<!-- AllergyIntolerance clinicalStatus -->
<entryRelationship typeCode="COMP">
<observation classCode="OBS" moodCode="EVN">
<code code="103.32013" codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components Code System"
```

```
displayName="Clinical Status"/>
<value xsi:type="CD" code="active"
  codeSystem="2.16.840.1.113883.4.642.1.118"
  codeSystemName="AllergyIntoleranceClinicalStatus"
  displayName="Active"/>
</observation>
</entryRelationship>
</observation>
</entry>
</section>
</component>
<!-- Composition section (Medical History) -->
<component>
<section>
  <!-- section (Medical History) templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100041" extension="1.0"/>
  <id root="0a808797-4584-4d77-a697-92378af762b4"/>
  <!-- section code -->
  <code code="101.32009" codeSystem="1.2.36.1.2001.1001.101"
    displayName="Medical History"/>
  <!-- section title -->
  <title>Medical History</title>
  <!-- section text -->
  <text mediaType="text/x-hl7-text+xml">
    <table>
      <caption>Problems and Diagnoses</caption>
      <thead>
        <tr>
          <th>Condition</th>
          <th>Onset</th>
          <th>Abatement / Resolution</th>
        </tr>
      </thead>
      <tbody>
        <tr ID="condition-pneumonia">
          <td>Atrial fibrillation</td>
          <td>2017</td>
          <td>--</td>
        </tr>
        <tr ID="condition-af">
          <td>Right lower zone pneumonia</td>
          <td>August 2018</td>
          <td>September 2018</td>
        </tr>
      </tbody>
    </table>
    <table>
      <caption>Procedures</caption>
      <thead>
        <tr>
          <th>Procedure</th>
          <th>Date</th>
        </tr>
      </thead>
      <tbody>
        <tr ID="procedure-tkr">
          <td>Total replacement of left knee joint</td>
          <td>27 February 2015</td>
        </tr>
      </tbody>
    </table>
  </text>
  <!-- section entry -->
  <entry typeCode="DRIV">
    <!-- Condition -->
    <observation classCode="OBS" moodCode="EVN">
      <!-- observation (Summary Statement of Condition) templateId-->
      <templateId root="1.2.36.1.2001.1001.102.101.100054" extension="1.0"/>
      <id root="3be1d15c-1005-4343-8137-c315dbbec4e3"/>
      <code code="282291009" codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMED CT" displayName="Diagnosis interpretation"/>
      <text>
        <reference value="#condition-af"/>
      </text>
      <!-- Condition onset[x] -->
      <effectiveTime>
        <low value="2017"/>
      </effectiveTime>
      <!-- Condition code -->
      <value xsi:type="CD" code="49436004" codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMED CT" displayName="Atrial fibrillation"/>
    </observation>
  </entry>
  <!-- section entry -->
  <entry typeCode="DRIV">
    <observation classCode="OBS" moodCode="EVN">
      <!-- observation (Summary Statement of Condition) templateId-->
      <templateId root="1.2.36.1.2001.1001.102.101.100054" extension="1.0"/>
      <id root="60a007c8-6b3a-4255-ab7c-f952eca4cccd3"/>
      <code code="282291009" codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMED CT" displayName="Diagnosis interpretation"/>
      <text>
        <reference value="#condition-pneumonia"/>
      </text>
      <effectiveTime>
        <!-- Condition onset[x] -->
        <low value="201808"/>
        <!-- Condition abatement[x] -->
        <high value="201809"/>
      </effectiveTime>
    </observation>
  </entry>
</component>
```

```
</effectiveTime>
<!-- Condition code -->
<value xsi:type="CD" code="301001009" codeSystem="2.16.840.1.113883.6.96"
codeSystemName="SNOMED CT" displayName="Right lower zone pneumonia"/>
<!-- Condition clinicalStatus -->
<entryRelationship typeCode="COMP">
<observation classCode="OBS" moodCode="EVN">
<code code="103.32013" codeSystem="1.2.36.1.2001.1001.101"
codeSystemName="NCTIS Data Components Code System"
displayName="Clinical Status"/>
<value xsi:type="CD" code="resolved"
codeSystem="2.16.840.1.113883.4.642.1.156"
codeSystemName="Condition Clinical Status Codes"
displayName="Resolved"/>
</observation>
</entryRelationship>
<!-- Condition verificationStatus -->
<entryRelationship typeCode="COMP">
<observation classCode="OBS" moodCode="EVN">
<code code="103.32012" codeSystem="1.2.36.1.2001.1001.101"
codeSystemName="NCTIS Data Components Code System"
displayName="Verification Status"/>
<value xsi:type="CD" code="confirmed"
codeSystem="2.16.840.1.113883.4.642.1.158"
codeSystemName="ConditionVerificationStatus"
displayName="Confirmed"/>
</observation>
</entryRelationship>
</observation>
</entry>
<!-- section entry -->
<entry typeCode="DRIV">
<!--Procedure-->
<procedure classCode="PROC" moodCode="EVN">
<!-- procedure (Summary Statement of Known Procedure) templateId-->
<templateId root="1.2.36.1.2001.1001.102.101.100055" extension="1.0"/>
<id root="d3be53c7-b81d-4985-b3fb-3995f5ff3ca9"/>
<!--Procedure code-->
<code code="443681002" codeSystem="2.16.840.1.113883.6.96"
codeSystemName="SNOMED CT" displayName="Total replacement of left knee joint"/>
<text>
<reference value="#procedure-tkr"/>
</text>
<statusCode code="completed"/>
<!--Procedure performed[x]-->
<effectiveTime value="20150227"/>
</procedure>
</entry>
</section>
</component>
<!-- Composition section (Immunisations) -->
<component>
<section>
<!-- section (Immunisations) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100042" extension="1.0"/>
<id root="2b7b4c98-ch57-44fe-8d02-8098a1cc0dfc"/>
<!-- section code -->
<code code="11369-6" codeSystem="2.16.840.1.113883.6.1"
displayName="History of Immunization"/>
<!-- section title -->
<title>Immunisations</title>
<!-- section text -->
<text mediaType="text/x-hl7-text+xml">Unknown</text>
<!--section emptyReason-->
<entry>
<observation classCode="OBS" moodCode="EVN">
<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"
displayName="Assertion"/>
<value xsi:type="CD" code="unavailable"
codeSystem="2.16.840.1.113883.4.642.4.1106"
codeSystemName="ListEmptyReasons" displayName="Unavailable">
<originalText>Unknown</originalText>
</value>
</observation>
</entry>
</section>
</component>
<!-- Administrative Observations -->
<component>
<section>
<templateId root="1.2.36.1.2001.1001.102.101.100000" extension="1.0"/>
<id root="6ec7f04d-9a50-4e21-93b2-8e6c90585c19"/>
<!-- section code -->
<code code="102.16080" codeSystem="1.2.36.1.2001.1001.101"
displayName="Administrative Observations"/>
<!-- section title -->
<title>Administrative Observations</title>
<!-- section text -->
<text mediaType="text/x-hl7-text+xml">
<paragraph>Dr Peter Chalmers, AHPRA qualification for General Practitioner
(MED0000932850)</paragraph>
</text>
<!--Practitioner qualification-->
<ext:coverage2 typeCode="COVBY">
<ext:templateId root="1.2.36.1.2001.1001.102.101.100038" extension="1.0"/>
<ext:entitlement classCode="COV" moodCode="EVN">
<ext:id root="1.2.36.1.2001.1005.56" extension="MED0000932850"
assigningAuthorityName="AHPRA"/>
<ext:code code="253111" codeSystem="2.16.840.1.113883.13.62"
```

```
displayName="General Medical Practitioner">
<originalText>AHPRA qualification for General
Practitioner</originalText>
</ext:code>
<ext:participant typeCode="HLD">
<ext:participantRole classCode="ASSIGNED">
<!-- matching technical id for the Practitioner entity --&gt;
&lt;ext:id root="72fb1fca-80fb-463c-bc92-34f2b2cf0ecd"/&gt;
&lt;/ext:participantRole&gt;
&lt;/ext:participant&gt;
&lt;/ext:entitlement&gt;
&lt;/ext:coverage2&gt;
&lt;/section&gt;
&lt;/component&gt;
&lt;/structuredBody&gt;
&lt;/component&gt;
&lt;/clinicalDocument&gt;</pre>
```

DRAFT

B.2 Shared Health Summary example 2

This informative appendix provides an example instance that conforms to the requirements of this implementation guide.

Example B.2. Shared Health Summary example 2

```
<!-- This example is illustrative only. This fragment cannot be treated as clinically valid.  
While every effort has been taken to ensure that the examples are consistent with the message specification, where  
there are conflicts with the written message specification or schema, the specification or schema will take precedence. -->  
<ClinicalDocument classCode="DOCLIN" moodCode="EVN" xmlns="urn:hl7-org:v3"  
xmlns:xsi="urn:hl7-org/v3-example"  
xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"  
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"  
xsi:schemaLocation="urn:hl7-org:v3 ../../library/schema_au_published/CDA-AU-V1_0.xsd">  
<typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>  
<!-- ClinicalDocument templateId -->  
<templateId root="1.2.36.1.2001.1001.102.101.100033" extension="1.0"/>  
<!-- Shared Health Summary document model templateId -->  
<templateId root="1.2.36.1.2001.1001.102.101.100019" extension="1.0"/>  
<!-- CDA Rendering Specification templateId-->  
<templateId root="1.2.36.1.2001.100.226" extension="1.0"/>  
<id root="2.25.134045617645909421812767683577428745500"/>  
<!-- Composition type -->  
<code code="60591-5" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"  
displayName="Patient summary"/>  
<!-- Composition title -->  
<title>Shared Health Summary</title>  
<effectiveTime value="20170621090015+1000"/>  
<confidentialityCode nullFlavor="NA"/>  
<languageCode code="en-AU"/>  
<!-- Composition status -->  
<ext:completionCode code="F" codeSystem="1.2.36.1.2001.1001.101.104.20104"  
codeSystemName="NCTIS Document Status Values" displayName="Final"/>  
<!-- Composition subject -->  
<recordTarget typeCode="RCT">  
<!-- recordTarget (My Health Record Patient) templateId -->  
<templateId root="1.2.36.1.2001.1001.102.101.100091" extension="1.0"/>  
<patientRole classCode="PAT">  
<id root="d62ed811-84ff-4f1f-bb5b-c416d715c386"/>  
<patient>  
<!-- Patient name -->  
<name use="C">  
<given>Adam</given>  
<given qualifier="IN">A.</given>  
<family>Everyman</family>  
</name>  
<!-- Patient gender -->  
<administrativeGenderCode code="male" codeSystem="2.16.840.1.113883.4.642.1.2"  
codeSystemName="AdministrativeGender" displayName="Male"/>  
<!-- Patient birthDate & patient-birthTime -->  
<birthTime value="19550206061700+1000"/>  
<!-- Patient indigenous-status -->  
<ethnicGroupCode code="1" codeSystem="1.2.36.1.2001.1004.200.10012"  
displayName="Aboriginal but not Torres Strait Islander origin"/>  
<!-- Patient identifier -->  
<ext:asEntityIdentifier classCode="IDENT">  
<ext:id root="1.2.36.1.2001.1003.0.8003608833357361"  
assigningAuthorityName="IHI"/>  
<ext:assigningGeographicArea classCode="PLC">  
<ext:name>National Identifier</ext:name>  
</ext:assigningGeographicArea>  
</ext:asEntityIdentifier>  
</patient>  
</patientRole>  
</recordTarget>  
<!-- Composition composition-author-role :: author -->  
<author typeCode="AUT">  
<!-- (PractitionerRole with Practitioner with Mandatory Identifier) templateId -->  
<templateId root="1.2.36.1.2001.1001.102.101.100006" extension="1.0"/>  
<!-- Composition date -->  
<time value="20170621090015+1000"/>  
<assignedAuthor>  
<id root="1dd0da5bc-5137-4181-8533-e5a3a1d0dlc0"/>  
<!-- PractitionerRole code -->  
<code code="253111" codeSystem="2.16.840.1.113883.13.62"  
displayName="General Practitioner">  
<originalText>GP</originalText>  
</code>  
<!-- Practitioner telecom -->  
<telecom use="WP" value="mailto:pchalmers@example.albiongp.com.au"/>  
<!-- PractitionerRole practitioner -->  
<assignedPerson>  
<!-- assignedPerson (Practitioner with Mandatory Identifier) templateId -->  
<templateId root="1.2.36.1.2001.1001.102.101.100040" extension="1.0"/>  
<!-- Practitioner name -->  
<name use="C">  
<prefix>Dr.</prefix>  
<given>Peter</given>  
<family>Chalmers</family>  
</name>  
<!-- PractitionerRole identifier or Practitioner identifier -->
```

```
<ext:asEntityIdentifier classCode="IDENT">
<ext:id root="1.2.36.1.2001.1003.0.8003619900015717"
assigningAuthorityName="HPI-I"/>
<ext:assigningGeographicArea classCode="PLC">
<ext:name>National Identifier</ext:name>
</ext:assigningGeographicArea>
</ext:asEntityIdentifier>
</assignedPerson>
<!-- PractitionerRole organization -->
<representedOrganization>
<!-- representedOrganization (Base Organization) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100039" extension="1.0"/>
<!-- Organization name -->
<name>Albion GP Clinic</name>
<!-- Organization identifier -->
<ext:asEntityIdentifier classCode="IDENT">
<ext:id root="1.2.36.1.2001.1003.0.8003621566684455"
assigningAuthorityName="HPI-O"/>
<ext:assigningGeographicArea classCode="PLC">
<ext:name>National Identifier</ext:name>
</ext:assigningGeographicArea>
</ext:asEntityIdentifier>
</representedOrganization>
</assignedAuthor>
</author>
<!-- Composition custodian -->
<custodian>
<!-- custodian (Organization with Mandatory Identifier) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100002" extension="1.0"/>
<assignedCustodian>
<representedCustodianOrganization>
<id root="0c6d5197-d10d-418e-8b26-37c269c27c30"/>
<!-- Organization name -->
<name>Albion GP Clinic</name>
<!-- Organization identifier -->
<ext:asEntityIdentifier classCode="IDENT">
<ext:id root="1.2.36.1.2001.1003.0.8003621566684455"
assigningAuthorityName="HPI-O"/>
<ext:assigningGeographicArea classCode="PLC">
<ext:name>National Identifier</ext:name>
</ext:assigningGeographicArea>
</ext:asEntityIdentifier>
</representedCustodianOrganization>
</assignedCustodian>
</custodian>
<!-- attester (Legal Attester) -->
<legalAuthenticator>
<templateId root="1.2.36.1.2001.1001.102.101.100012" extension="1.0"/>
<time value="20170621090015+1000"/>
<signatureCode code="S"/>
<assignedEntity>
<!-- attester (Legal Attester) indicating same entity as the author via the same id -->
<id root="1d0da5bc-5137-4181-8533-e5a3ald0d1c0"/>
</assignedEntity>
</legalAuthenticator>

<component>
<structuredBody>
<!-- Composition section (Medications) -->
<component>
<section>
<!-- section (Medications) templateId-->
<templateId root="1.2.36.1.2001.1001.102.101.100011" extension="1.0"/>
<!-- section code -->
<code code="101.32009" codeSystem="1.2.36.1.2001.1001.101"
displayName="Current Medicine"/>
<!-- section title -->
<title>Current Medications</title>
<!-- section text -->
<text mediaType="text/x-hl7-text+xml">
<content ID="MED">None</content>
</text>
<!-- section entry -->
<entry>
<!--observation (Assertion of No Relevant Finding)-->
<observation classCode="OBS" moodCode="EVN">
<templateId root="1.2.36.1.2001.1001.102.101.100032" extension="1.0"/>
<!--Observation code-->
<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>
<!--Observation value-->
<value xsi:type="CD" code="1234391000168107"
codeSystem="2.16.840.1.113883.6.96"
displayName="No known current medications">
<originalText><reference value="MED"/></originalText>
</value>
<!--Observation status-->
<entryRelationship typeCode="COMP">
<observation classCode="OBS" moodCode="EVN">
<code code="103.32010" codeSystem="1.2.36.1.2001.1001.101"
displayName="Observation Result Status"/>
<value xsi:type="CD" code="final"
codeSystem="2.16.840.1.113883.4.642.1.388"/>
</observation>
</entryRelationship>
</observation>
</entry>
</section>
</component>
<!-- Composition section (Allergies) -->
```

```
<component>
  <section>
    <!-- section (Allergies) templateId -->
    <templateId root="1.2.36.1.2001.1001.102.101.100008" extension="1.0"/>
    <!-- section code -->
    <code code="48765-2" codeSystem="2.16.840.1.113883.6.1"
      displayName="Allergies andor adverse reactions"/>
    <!-- section title -->
    <title>Allergies and Adverse Reactions</title>
    <!-- section text -->
    <text mediaType="text/x-hl7-text+xml">
      <table>
        <caption>ALLERGIES</caption>
        <thead>
          <tr>
            <th>Agent</th>
            <th>Reaction Description</th>
          </tr>
        </thead>
        <tbody>
          <tr ID="A1">
            <td ID="A1A">Penicillin</td>
            <td ID="A1M">Rash; Nausea and vomiting</td>
          </tr>
          <tr ID="A2">
            <td ID="A2A">Nuts</td>
            <td ID="A2M">Breathing problems</td>
          </tr>
        </tbody>
      </table>
    </text>
    <!-- section entry -->
    <entry typeCode="DRIV">
      <observation classCode="OBS" moodCode="EVN">
        <!--observation (Summary Statement of Allergy or Intolerance) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100014" extension="1.0"/>
        <id root="84ecf10b-ce7f-4e05-8db85cdffcaff0"/>
        <code code="102.15517" codeSystem="1.2.36.1.2001.1001.101"
          codeSystemName="NCTIS Data Components"
          displayName="Adverse Reaction"/>
        <!-- AllergyIntolerance code -->
        <value xsi:type="CD">
          <originalText>
            <reference value="#A1A"/>
          </originalText>
        </value>
        <!-- AllergyIntolerance verificationStatus -->
        <entryRelationship typeCode="COMP">
          <observation classCode="OBS" moodCode="EVN">
            <code code="103.32012" codeSystem="1.2.36.1.2001.1001.101"
              codeSystemName="NCTIS Data Components Code System"
              displayName="Verification Status"/>
            <value xsi:type="CD" code="unconfirmed"
              codeSystem="2.16.840.1.113883.4.642.1.116"
              codeSystemName="AllergyIntoleranceVerificationStatus"
              displayName="Unconfirmed"/>
          </observation>
        </entryRelationship>
        <!-- AllergyIntolerance reaction -->
        <entryRelationship typeCode="COMP">
          <observation classCode="OBS" moodCode="EVN">
            <code code="102.16474" codeSystem="1.2.36.1.2001.1001.101"
              displayName="Reaction Event"/>
          <!-- AllergyIntolerance substance -->
          <participant typeCode="CAGNT">
            <participantRole>
              <playingEntity>
                <code>
                  <originalText>
                    <reference value="#A1A"/>
                  </originalText>
                </code>
              </playingEntity>
            </participantRole>
          </participant>
          <!-- AllergyIntolerance manifestation -->
          <entryRelationship typeCode="MFST">
            <observation classCode="OBS" moodCode="EVN">
              <code>
                <originalText>
                  <reference value="#A1M"/>
                </originalText>
              </code>
            </observation>
          </entryRelationship>
        </observation>
        <!-- AllergyIntolerance clinicalStatus -->
        <entryRelationship typeCode="COMP">
          <observation classCode="OBS" moodCode="EVN">
            <code code="103.32013" codeSystem="1.2.36.1.2001.1001.101"
              codeSystemName="NCTIS Data Components Code System"
              displayName="Clinical Status"/>
            <value xsi:type="CD" code="active"
              codeSystem="2.16.840.1.113883.4.642.1.118"
              codeSystemName="AllergyIntoleranceClinicalStatus"
              displayName="Active"/>
          </observation>
        </entryRelationship>
      </observation>
    </entry>
  </section>
```

```
</observation>
</entry>
<!-- section entry -->
<entry typeCode="DRIV">
<observation classCode="OBS" moodCode="EVN">
<!--observation (Summary Statement of Allergy or Intolerance) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100014" extension="1.0"/>
<id root="339a6a6f-312a-48c0-984b-2ce94de88297"/>
<code code="102.15517" codeSystem="1.2.36.1.2001.1001.101"
codeSystemName="NCTIS Data Components"
displayName="Adverse Reaction"/>
<!-- AllergyIntolerance code -->
<value xsi:type="CD">
<originalText>
<reference value="#A2A"/>
</originalText>
</value>
<!-- AllergyIntolerance reaction -->
<entryRelationship typeCode="COMP">
<observation classCode="OBS" moodCode="EVN">
<code code="102.16474" codeSystem="1.2.36.1.2001.1001.101"
displayName="Reaction Event"/>
<!-- AllergyIntolerance substance -->
<participant typeCode="CAGNT">
<participantRole>
<playingEntity>
<code>
<originalText>
<reference value="#A2A"/>
</originalText>
</code>
</playingEntity>
</participantRole>
</participant>
<!-- AllergyIntolerance manifestation -->
<entryRelationship typeCode="MFST">
<observation classCode="OBS" moodCode="EVN">
<code>
<originalText>
<reference value="#A2M"/>
</originalText>
</code>
</observation>
</entryRelationship>
</observation>
</entryRelationship>
<!-- AllergyIntolerance verificationStatus -->
<entryRelationship typeCode="COMP">
<observation classCode="OBS" moodCode="EVN">
<code code="103.32012" codeSystem="1.2.36.1.2001.1001.101"
codeSystemName="NCTIS Data Components Code System"
displayName="Verification Status"/>
<value xsi:type="CD" code="unconfirmed"
codeSystem="2.16.840.1.113883.4.642.1.116"
codeSystemName="AllergyIntoleranceVerificationStatus"
displayName="Unconfirmed"/>
</observation>
</entryRelationship>
<!-- AllergyIntolerance clinicalStatus -->
<entryRelationship typeCode="COMP">
<observation classCode="OBS" moodCode="EVN">
<code code="103.32013" codeSystem="1.2.36.1.2001.1001.101"
codeSystemName="NCTIS Data Components Code System"
displayName="Clinical Status"/>
<value xsi:type="CD" code="active"
codeSystem="2.16.840.1.113883.4.642.1.118"
codeSystemName="AllergyIntoleranceClinicalStatus"
displayName="Active"/>
</observation>
</entryRelationship>
</observation>
</entry>
</section>
</component>
<!-- Composition section (Medical History) -->
<component>
<section>
<!-- section (Medical History) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100041" extension="1.0"/>
<!-- section code -->
<code code="101.32009" codeSystem="1.2.36.1.2001.1001.101"
displayName="Medical History"/>
<!-- section title -->
<title>Medical History</title>
<!-- section text -->
<text mediaType="text/x-hl7-text+xml">Unknown</text>
<!--section emptyReason-->
<entry>
<observation classCode="OBS" moodCode="EVN">
<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"
displayName="Assertion"/>
<value xsi:type="CD" code="unavailable"
codeSystem="2.16.840.1.113883.4.642.4.1106"
codeSystemName="ListEmptyReasons" displayName="Unavailable">
<originalText>Unknown</originalText>
</value>
</observation>
</entry>
```

```
</section>

</component>
<!-- Composition section (Immunisations) -->
<component>
<section>
<!-- section (Immunisations) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100042" extension="1.0"/>
<!-- section code -->
<code code="11369-6" codeSystem="2.16.840.1.113883.6.1"
 displayName="History of Immunization"/>
<!-- section title -->
<title>Immunisations</title>
<!-- section text -->
<text mediaType="text/x-hl7-text+xml">
<table>
<caption>IMMUNISATIONS</caption>
<thead>
<tr>
<th>Vaccine</th>
<th>Date Administered</th>
</tr>
</thead>
<tbody>
<tr ID="I1">
<td ID="I1VACCINE">Engerix-B Adult</td>
<td ID="I1DATE">09/10/2017</td>
</tr>
<tr ID="I2">
<td ID="I2VACCINE">Meningitec</td>
<td ID="I2DATE">10/09/2017</td>
</tr>
<tr ID="I3">
<td ID="I3VACCINE">Fluvax 2015</td>
<td ID="I3DATE">03/10/2015</td>
</tr>
</tbody>
</table>
</text>
<!-- section entry -->
<entry>
<!-- Immunization; notGiven=false-->
<substanceAdministration classCode="SBADM" moodCode="EVN">
<!-- substanceAdministration (Summary Statement of Administered Vaccine) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100043" extension="1.0"/>
<id root="a3311473-7c8f-4f04-8f2f-e0ed4dfc4ca5"/>
<!-- Immunization status -->
<statusCode code="completed"/>
<!-- Immunization date -->
<effectiveTime value="20171009"/>
<!-- Immunization vaccineCode -->
<consumable>
<manufacturedProduct>
<manufacturedMaterial>
<code code="33491000168108"
 codeSystem="2.16.840.1.113883.6.96"
 codeSystemName="SNOMED CT">
<originalText><reference value="#I1VACCINE"
 /></originalText>
</code>
</manufacturedMaterial>
</manufacturedProduct>
</consumable>
<!-- Immunization primarySource -->
<entryRelationship typeCode="COMP">
<observation classCode="OBS" moodCode="EVN">
<id root="cd245ffd-0d40-47a2-8703-aa8969ef283e"/>
<code code="103.17061" codeSystem="1.2.36.1.2001.1001.101"
 codeSystemName="NCTIS Data Components"
 displayName="Information from a Primary Source"/>
<value xsi:type="BL" value="true"/>
</observation>
</entryRelationship>
</substanceAdministration>
</entry>
<!-- section entry -->
<entry>
<!-- Immunization; notGiven=false-->
<substanceAdministration classCode="SBADM" moodCode="EVN">
<!-- substanceAdministration (Summary Statement of Administered Vaccine) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100043" extension="1.0"/>
<id root="ae6e0972-8e00-42c9-9117-e0413b44e46a"/>
<!-- Immunization status -->
<statusCode code="completed"/>
<!-- Immunization date -->
<effectiveTime value="20170910"/>
<!-- Immunization vaccineCode -->
<consumable>
<manufacturedProduct>
<manufacturedMaterial>
<code code="73695011000036100"
 codeSystem="2.16.840.1.113883.6.96"
 codeSystemName="SNOMED CT">
<originalText><reference value="#I2VACCINE"
 /></originalText>
</code>
</manufacturedMaterial>
</manufacturedProduct>
</consumable>
```

```
<!-- Immunization primarySource -->
<entryRelationship typeCode="COMP">
<observation classCode="OBS" moodCode="EVN">
<id root="1ba435c5-b29b-4d6f-ab07-61489afb0ee9"/>
<code code="103.17061" codeSystem="1.2.36.1.2001.1001.101"
codeSystemName="NCTIS Data Components"
displayName="Information from a Primary Source"/>
<value xsi:type="BL" value="true"/>
</observation>
</entryRelationship>
</substanceAdministration>
</entry>
<!-- section entry -->
<entry>
<!-- Immunization; notGiven=false-->
<substanceAdministration classCode="SBADM" moodCode="EVN">
<!-- substanceAdministration (Summary Statement of Administered Vaccine) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100043" extension="1.0"/>
<id root="51950fa5-2578-4ab0-ba4e-d23d08e4b9ee"/>
<!-- Immunization status -->
<statusCode code="completed"/>
<!-- Immunization date -->
<effectiveTime value="20151003"/>
<!-- Immunization vaccineCode -->
<consumable>
<manufacturedProduct>
<manufacturedMaterial>
<code code="709541000168107"
codeSystem="2.16.840.1.113883.6.96"
codeSystemName="SNOMED CT">
<originalText><reference value="#I3VACCINE"
/></originalText>
</code>
</manufacturedMaterial>
</manufacturedProduct>
</consumable>
<!-- Immunization primarySource -->
<entryRelationship typeCode="COMP">
<observation classCode="OBS" moodCode="EVN">
<id root="b89e0ald-0b8b-4f84-b610-0a9dd32efc99"/>
<code code="103.17061" codeSystem="1.2.36.1.2001.1001.101"
codeSystemName="NCTIS Data Components"
displayName="Information from a Primary Source"/>
<value xsi:type="BL" value="true"/>
</observation>
</entryRelationship>
</substanceAdministration>
</entry>
</section>
</component>
</structuredBody>
</component>
</ClinicalDocument>
```

B.3 Shared Health Summary example 3

This informative appendix provides an example instance that conforms to the requirements of this implementation guide.

Example B.3. Shared Health Summary example 3

<!-- This example is illustrative only. This fragment cannot be treated as clinically valid.
While every effort has been taken to ensure that the examples are consistent with the message specification, where
there are conflicts with the written message specification or schema, the specification or schema will take precedence. -->

```
<ClinicalDocument classCode="DOCLIN" moodCode="EVN" xmlns="urn:h17-org:v3"  
    xmlns:ex="urn:h17-org/v3-example"  
    xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"  
    xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"  
    xsi:schemaLocation="urn:h17-org:v3 ../../library/schema_au_published/CDA-AU-V1_0.xsd">  
    <typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>  
    <!-- ClinicalDocument templateId -->  
    <templateId root="1.2.36.1.2001.1001.102.101.100033" />  
    <!-- Shared Health Summary document model templateId -->  
    <templateId root="1.2.36.1.2001.1001.102.101.100019" />  
    <!-- CDA Rendering Specification templateId-->  
    <templateId root="1.2.36.1.2001.1001.100.226" />  
    <id root="f9effc84-a5ea-4517-877d-626b4d6a2f71"/>  
    <!-- Composition type -->  
    <code code="60591-5" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"  
        displayName="Patient summary"/>  
    <!-- Composition title -->  
    <title>Shared Health Summary</title>  
    <effectiveTime value="20170621090015+1000"/>  
    <confidentialityCode nullFlavor="NA"/>  
    <languageCode code="en-AU"/>  
    <!-- Composition status -->  
    <ext:completionCode code="F" codeSystem="1.2.36.1.2001.1001.101.104.20104"  
        codeSystemName="NCTIS Document Status Values" displayName="Final"/>  
    <!-- Composition subject -->  
    <recordTarget typeCode="RCT">  
        <!-- recordTarget (My Health Record Patient) templateId -->  
        <templateId root="1.2.36.1.2001.1001.102.101.100091" />  
        <patientRole classCode="PAT">  
            <id root="97b3a411-ed17-435e-b15f-066f2db223f4"/>  
            <patient>  
                <!-- Patient name -->  
                <name use="C">  
                    <given>Adam</given>  
                    <given qualifier="IN">A.</given>  
                    <family>Everyman</family>  
                </name>  
                <!-- Patient gender -->  
                <administrativeGenderCode code="male" codeSystem="2.16.840.1.113883.4.642.1.2"  
                    codeSystemName="AdministrativeGender" displayName="Male"/>  
                <!-- Patient birthDate & patient-birthTime -->  
                <birthTime value="19550206061700+1000"/>  
                <!-- Patient indigenous-status -->  
                <ethnicGroupCode code="3" codeSystem="1.2.36.1.2001.1004.200.10012"  
                    displayName="Both Aboriginal and Torres Strait Islander origin"/>  
                <!-- Patient identifier -->  
                <ext:asEntityIdentifier classCode="IDENT">  
                    <ext:id root="1.2.36.1.2001.1003.0.8003608833357361" />  
                    <assigningAuthorityName>IHI</assigningAuthorityName>  
                    <ext:assigningGeographicArea classCode="PLC">  
                        <ext:name>National Identifier</ext:name>  
                    </ext:assigningGeographicArea>  
                </ext:asEntityIdentifier>  
            </patient>  
            <!-- Patient managingOrganization -->  
            <providerOrganization classCode="ORG">  
                <asOrganizationPartOf>  
                    <wholeOrganization>  
                        <id root="954f6d71-2b94-4f5d-8f20-515179170b95" />  
                        <name>Devonport Family Medicine Clinic</name>  
                    </wholeOrganization>  
                </asOrganizationPartOf>  
            </providerOrganization>  
        </patientRole>  
    </recordTarget>  
    <!-- Composition composition-author-role :: author -->  
    <author typeCode="AUT">  
        <!-- (PractitionerRole with Practitioner with Mandatory Identifier) templateId -->  
        <templateId root="1.2.36.1.2001.1001.102.101.100006" />  
        <templateId root="1.2.36.1.2001.1001.102.101.100006" />  
        <!-- Composition date -->  
        <time value="20170621090015+1000"/>  
        <assignedAuthor>  
            <id root="989b0a54-9d29-4080-bd2e-126a3200b462" />  
            <!-- PractitionerRole code -->  
            <code code="253111" codeSystem="2.16.840.1.113883.13.62"  
                displayName="General Practitioner">  
                <originalText>GP</originalText>  
            </code>  
            <!-- PractitionerRole telecom -->  
            <telecom use="WP" value="mailto:pchalmers@example.albiongp.com.au"/>  
        </assignedAuthor>  
    </author>  
</Composition>
```

```

<!-- PractitionerRole practitioner -->
<assignedPerson>
  <!-- assignedPerson (Practitioner with Mandatory Identifier) templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100040" />
  <!-- Practitioner name -->
  <name use="">
    <prefix>Dr.</prefix>
    <given>Peter</given>
    <family>Chalmers</family>
  </name>
  <!-- PractitionerRole identifier or Practitioner identifier -->
  <ext:asEntityIdentifier classCode="IDENT">
    <ext:id root="1.2.36.1.2001.1003.0.8003619900015717"
      assigningAuthorityName="HPI-I"/>
    <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
    </ext:assigningGeographicArea>
  </ext:asEntityIdentifier>
  <ext:asEntityIdentifier classCode="IDENT">
    <ext:id root="1.2.36.174030967.0.2" extension="5544887B"
      assigningAuthorityName="Medicare Provider number"/>
    <ext:code code="PRN" codeSystem="2.16.840.1.113883.12.203"/>
    <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
    </ext:assigningGeographicArea>
  </ext:asEntityIdentifier>
</assignedPerson>
<!-- PractitionerRole organization -->
<representedOrganization>
  <!-- representedOrganization (Base Organization) templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100039" />
  <id root="954f6d71-2b94-4f5d-8f20-515179170b95"/>
  <!-- Organization name -->
  <name>Devonport Family Medicine Clinic</name>
  <!-- Organization telecom -->
  <telecom use="WP" value="mailto:reception@example.dfdc.com.au"/>
  <telecom use="WP" value="fax:0385435557"/>
  <telecom use="WP" value="tel:0385435556"/>
  <!-- Organization address -->
  <addr use="PST">
    <streetAddressLine>LPO Box 235</streetAddressLine>
    <city>Strahan</city>
    <state>TAS</state>
    <postalCode>7468</postalCode>
  </addr>
  <!-- Organization identifier -->
  <ext:asEntityIdentifier classCode="IDENT">
    <ext:id root="1.2.36.51824754455"
      assigningAuthorityName="Devonport Family Medicine Clinic"/>
    <ext:code code="XX" codeSystem="2.16.840.1.113883.12.203"
      codeSystemName="Identifier Type (HL7)"/>
  </ext:asEntityIdentifier>
</representedOrganization>
</assignedAuthor>
</author>
<!-- Composition custodian -->
<custodian>
  <!-- custodian (Organization with Mandatory Identifier) templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100002" />
  <assignedCustodian>
    <representedCustodianOrganization>
      <id root="954f6d71-2b94-4f5d-8f20-515179170b95"/>
      <!-- Organization name -->
      <name>Devonport Family Medicine Clinic</name>
      <!-- Organization identifier -->
      <ext:asEntityIdentifier classCode="IDENT">
        <ext:id root="1.2.36.51824754455"
          assigningAuthorityName="Devonport Family Medicine Clinic"/>
        <ext:code code="XX" codeSystem="2.16.840.1.113883.12.203"
          codeSystemName="Identifier Type (HL7)"/>
      </ext:asEntityIdentifier>
    </representedCustodianOrganization>
    </assignedCustodian>
  </custodian>
  <!-- attester (Legal Attester) -->
  <legalAuthenticator>
    <templateId root="1.2.36.1.2001.1001.102.101.100012" />
    <time value="20170621090015+1000"/>
    <signatureCode code="S"/>
    <assignedEntity>
      <!-- attester (Legal Attester) indicating same entity as the author via the same id -->
      <id root="989b0a54-9d29-4080-bd2e-126a3200b462"/>
    </assignedEntity>
  </legalAuthenticator>
<!-- Patient generalPractitioner (Base Practitioner)-->
<participant typeCode="PART">
  <functionCode code="PCP"/>
  <associatedEntity classCode="PROV">
    <!-- indicating same entity as the author via the same id -->
    <id root="989b0a54-9d29-4080-bd2e-126a3200b462"/>
    <code code="253111" codeSystem="2.16.840.1.113883.13.62"
      codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
      displayName="General Medical Practitioner"/>
    <associatedPerson classCode="PSN">
      <!-- Practitioner identifier -->
      <ext:asEntityIdentifier classCode="IDENT">
        <ext:id assigningAuthorityName="HPI-I"
          root="1.2.36.1.2001.1003.0.8003619900015717"/>
        <ext:assigningGeographicArea classCode="PLC">

```

```
<ext:name>National Identifier</ext:name>
</ext:assigningGeographicArea>
</ext:asEntityIdentifier>
</associatedPerson>
</associatedEntity>
</participant>
<component>
<structuredBody>
<!-- Composition section (Medications) -->
<component>
<section>
<templateId root="1.2.36.1.2001.1001.102.101.100011" />
<id root="c9d993fd-f34c-4472-973d-643a071148a0"/>
<!-- section code -->
<code code="101.32009" codeSystem="1.2.36.1.2001.1001.101">
  displayName="Current Medicine"
<!-- section title -->
<title>Current Medications</title>
<!-- section text -->
<text mediaType="text/x-hl7-text+xml">
  <table>
    <thead>
      <tr>
        <th>Medication</th>
        <th>Dose</th>
        <th>Purpose/Comment</th>
      </tr>
    </thead>
    <tbody>
      <tr ID="medication-ferroussulphate">
        <td>Ferrous sulphate & vitamin C</td>
        <td>1 d</td>
        <td/>
      </tr>
      <tr ID="medication-fluticasonesalmetrol">
        <td>Fluticasone/salmeterol 250/25</td>
        <td>2 bd</td>
        <td/>
      </tr>
      <tr ID="medication-sodiumchloride">
        <td>Sodium chloride 600mg</td>
        <td>3 m, 3 midi, 2 n</td>
        <td/>
      </tr>
      <tr ID="medication-megabcomplex">
        <td>Mega B complex</td>
        <td>1 d</td>
        <td/>
      </tr>
      <tr ID="medication-multivitamin">
        <td>Multivitamin</td>
        <td>1 d</td>
        <td/>
      </tr>
      <tr ID="medication-bromhexine">
        <td>Bromhexine 0.8mg/ml</td>
        <td>10ml bd</td>
        <td/>
      </tr>
    </tbody>
  </table>
</text>
<!-- section entry -->
<entry>
  <!-- MedicationStatement; taken=y-->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!-- substanceAdministration (Summary Statement of Known Medicine) templateId-->
    <templateId root="1.2.36.1.2001.1001.102.101.100015" />
    <id root="8b0161b3-08c3-4a76-b019-7cbcf2af5335"/>
    <!-- MedicationStatement.dosage -->
    <text>
      <reference value="#medication-ferroussulphate"/>
    </text>
    <!-- MedicationStatement.status -->
    <statusCode code="active"/>
    <!-- MedicationStatement.medication -->
    <consumable>
      <manufacturedProduct>
        <manufacturedMaterial>
          <code>
            <originalText>Ferrous sulphate & vitamin
            C</originalText>
          </code>
        </manufacturedMaterial>
      </manufacturedProduct>
    </consumable>
  </substanceAdministration>
</entry>
<!-- section entry -->
<entry>
  <!-- MedicationStatement; taken=y-->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!-- substanceAdministration (Summary Statement of Known Medicine) templateId-->
    <templateId root="1.2.36.1.2001.1001.102.101.100015" />
    <id root="428d0222-88ad-4c6f-b377-91ef8e3e06c1"/>
    <!-- MedicationStatement.dosage -->
    <text>
      <reference value="#medication-fluticasonesalmetrol"/>
    </text>
  </substanceAdministration>
</entry>
```

```
<!-- MedicationStatement.status -->
<statusCode code="active"/>
<!-- MedicationStatement.medication -->
<consumable>
  <manufacturedProduct>
    <manufacturedMaterial>
      <code>
        <originalText>Fluticasone/salmeterol
          250/25</originalText>
      </code>
    </manufacturedMaterial>
  </manufacturedProduct>
</consumable>
</substanceAdministration>
</entry>
<!-- section entry -->
<entry>
  <!-- MedicationStatement; taken=y-->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!-- substanceAdministration (Summary Statement of Known Medicine) templateId-->
    <templateId root="1.2.36.1.2001.1001.102.101.100015" />
    <id root="660afeb3-aaea-42a5-a180-885b64087409"/>
  <!-- MedicationStatement.dosage -->
  <text>
    <reference value="#medication-sodiumchloride"/>
  </text>
  <!-- MedicationStatement.status -->
  <statusCode code="active"/>
  <!-- MedicationStatement.medication -->
  <consumable>
    <manufacturedProduct>
      <manufacturedMaterial>
        <code>
          <originalText>Sodium chloride 600mg</originalText>
        </code>
      </manufacturedMaterial>
    </manufacturedProduct>
  </consumable>
  </substanceAdministration>
</entry>
<!-- section entry -->
<entry>
  <!-- MedicationStatement; taken=y-->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!-- substanceAdministration (Summary Statement of Known Medicine) templateId-->
    <templateId root="1.2.36.1.2001.1001.102.101.100015" />
    <id root="c753a031-0079-4dd5-bfc0-d6e50bb16f79"/>
  <!-- MedicationStatement.dosage -->
  <text>
    <reference value="#medication-megabcomplex"/>
  </text>
  <!-- MedicationStatement.status -->
  <statusCode code="active"/>
  <!-- MedicationStatement.medication -->
  <consumable>
    <manufacturedProduct>
      <manufacturedMaterial>
        <code>
          <originalText>Mega B complex</originalText>
        </code>
      </manufacturedMaterial>
    </manufacturedProduct>
  </consumable>
  </substanceAdministration>
</entry>
<!-- section entry -->
<entry>
  <!-- MedicationStatement; taken=y-->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!-- substanceAdministration (Summary Statement of Known Medicine) templateId-->
    <templateId root="1.2.36.1.2001.1001.102.101.100015" />
    <id root="94b1fc83-28b4-47ad-b362-9c9b088d69aa"/>
  <!-- MedicationStatement.dosage -->
  <text>
    <reference value="#medication-multivitamin"/>
  </text>
  <!-- MedicationStatement.status -->
  <statusCode code="active"/>
  <!-- MedicationStatement.medication -->
  <consumable>
    <manufacturedProduct>
      <manufacturedMaterial>
        <code>
          <originalText>Multivitamin</originalText>
        </code>
      </manufacturedMaterial>
    </manufacturedProduct>
  </consumable>
  </substanceAdministration>
</entry>
<!-- section entry -->
<entry>
  <!-- MedicationStatement; taken=y-->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!-- substanceAdministration (Summary Statement of Known Medicine) templateId-->
    <templateId root="1.2.36.1.2001.1001.102.101.100015" />
    <id root="elac39df-26bb-40ac-ba3d-9b888acb1f06"/>
  <!-- MedicationStatement.dosage -->
  <text>
```

```
<reference value="#medication-bromhexine"/>
</text>
<!-- MedicationStatement.status -->
<statusCode code="active"/>
<!-- MedicationStatement.medication -->
<consumable>
<manufacturedProduct>
<manufacturedMaterial>
<code>
<originalText>Bromhexine 0.8mg/ml</originalText>
</code>
</manufacturedMaterial>
</manufacturedProduct>
</consumable>
</substanceAdministration>
</entry>
</section>
</component>
<!-- Composition section (Allergies) -->
<component>
<section>
<!-- section (Allergies) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100008" />
<id root="2260d865-d094-49f7-aaa1-01044b6266b6"/>
<!-- section code -->
<code code="48765-2" codeSystem="2.16.840.1.113883.6.1"
displayName="Allergies andor adverse reactions"/>
<!-- section title -->
<title>Allergies and Adverse Reactions</title>
<!-- section text -->
<text mediaType="text/x-hl7-text+xml">
<content ID="ALLERGY">No known medication allergies.</content>
</text>
<!-- section entry -->
<entry>
<observation classCode="OBS" moodCode="EVN">
<!--observation (Summary Statement of Allergy or Intolerance) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100014" />
<id root="309cc6f1-5e2f-4f64-886b-018df19918d"/>
<code code="102.15517" codeSystem="1.2.36.1.2001.1001.101"
displayName="Adverse Reaction"/>
<!--AllergyIntolerance code-->
<value xsi:type="CD" code="409137002"
codeSystem="2.16.840.1.113883.6.96"
displayName="No known drug allergy">
<originalText><reference value="#ALLERGY"/></originalText>
</value>
<!-- AllergyIntolerance verificationStatus -->
<entryRelationship typeCode="COMP">
<observation classCode="OBS" moodCode="EVN">
<code code="103.32012" codeSystem="1.2.36.1.2001.1001.101"
codeSystemName="NCTIS Data Components Code System"
displayName="Verification Status"/>
<value xsi:type="CD" code="unconfirmed"
codeSystem="2.16.840.1.113883.4.642.1.116"
codeSystemName="AllergyIntoleranceVerificationStatus"
displayName="Unconfirmed"/>
</observation>
</entryRelationship>
<!-- AllergyIntolerance clinicalStatus -->
<entryRelationship typeCode="COMP">
<observation classCode="OBS" moodCode="EVN">
<code code="103.32013" codeSystem="1.2.36.1.2001.1001.101"
codeSystemName="NCTIS Data Components Code System"
displayName="Clinical Status"/>
<value xsi:type="CD" code="active"
codeSystem="2.16.840.1.113883.4.642.1.118"
codeSystemName="AllergyIntoleranceClinicalStatus"
displayName="Active"/>
</observation>
</entryRelationship>
</observation>
</entry>
</section>
</component>
<!-- Composition section (Medical History) -->
<component>
<section>
<!-- section (Medical History) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100041" />
<id root="352a3e69-edd5-4a0f-8e7d-edd1ba6905fd"/>
<!-- section code -->
<code code="101.32009" codeSystem="1.2.36.1.2001.1001.101"
displayName="Medical History"/>
<!-- section title -->
<title>Medical History</title>
<!-- section text -->
<text mediaType="text/x-hl7-text+xml">Unknown</text>
<!--section emptyReason-->
<entry>
<observation classCode="OBS" moodCode="EVN">
<code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"
displayName="Assertion"/>
<value xsi:type="CD" code="unavailable"
codeSystem="2.16.840.1.113883.4.642.4.1106"
codeSystemName="ListEmptyReasons" displayName="Unavailable">
<originalText>Unknown</originalText>
</value>
</observation>
```

```
</entry>
</section>
</component>
<!-- Composition section (Immunisations) --&gt;
&lt;component&gt;
&lt;section&gt;
<!-- section (Immunisations) templateId --&gt;
&lt;templateId root="1.2.36.1.2001.1001.102.101.100042" /&gt;
&lt;id root="dc7d3690-994a-4b7e-a7f8-748efcee9349" /&gt;
<!-- section code --&gt;
&lt;code code="11369-6" codeSystem="2.16.840.1.113883.6.1"
displayName="History of Immunization"/&gt;
<!-- section title --&gt;
&lt;title&gt;Immunisations&lt;/title&gt;
<!-- section text --&gt;
&lt;text mediaType="text/x-hl7-text+xml"&gt;
&lt;table&gt;
&lt;caption&gt;IMMUNISATIONS&lt;/caption&gt;
&lt;thead&gt;
&lt;tr&gt;
&lt;th&gt;Vaccine&lt;/th&gt;
&lt;th&gt;Date Administered&lt;/th&gt;
&lt;/tr&gt;
&lt;/thead&gt;
&lt;tbody&gt;
&lt;tr ID="Ia"&gt;
&lt;td ID="IaVACCINE"&gt;Engerix-B Adult&lt;/td&gt;
&lt;td ID="IaDATE"&gt;09/10/2017&lt;/td&gt;
&lt;/tr&gt;
&lt;tr ID="Ib"&gt;
&lt;td ID="IbVACCINE"&gt;Fluvax 2015&lt;/td&gt;
&lt;td ID="IbDATE"&gt;03/10/2015&lt;/td&gt;
&lt;/tr&gt;
&lt;/tbody&gt;
&lt;/table&gt;
&lt;/text&gt;
&lt;!-- section entry --&gt;
&lt;entry&gt;
<!-- Immunization; notGiven=false--&gt;
&lt;substanceAdministration classCode="SBADM" moodCode="EVN"&gt;
&lt;!-- substanceAdministration (Summary Statement of Administered Vaccine) templateId --&gt;
&lt;templateId root="1.2.36.1.2001.1001.102.101.100043" /&gt;
&lt;id root="7067b010-6a48-42a9-b8ce-e33c0c8f8898" /&gt;
&lt;!-- Immunization status --&gt;
&lt;statusCode code="completed"/&gt;
&lt;!-- Immunization date --&gt;
&lt;effectiveTime value="20171009"/&gt;
&lt;!-- Immunization vaccineCode --&gt;
&lt;consumable&gt;
&lt;manufacturedProduct&gt;
&lt;manufacturedMaterial&gt;
&lt;code code="33491000168108"
codeSystem="2.16.840.1.113883.6.96"
codeSystemName="SNOMED CT"&gt;
&lt;originalText&gt;&lt;reference value="#IaVACCINE"
/&gt;&lt;/originalText&gt;
&lt;/code&gt;
&lt;/manufacturedMaterial&gt;
&lt;/manufacturedProduct&gt;
&lt;/consumable&gt;
&lt;!-- Immunization primarySource --&gt;
&lt;entryRelationship typeCode="COMP"&gt;
&lt;observation classCode="OBS" moodCode="EVN"&gt;
&lt;code code="103.17061" codeSystem="1.2.36.1.2001.1001.101"
codeSystemName="NCTIS Data Components"
displayName="Information from a Primary Source"/&gt;
&lt;value xsi:type="BL" value="true"/&gt;
&lt;/observation&gt;
&lt;/entryRelationship&gt;
&lt;/substanceAdministration&gt;
&lt;/entry&gt;
&lt;!-- section entry --&gt;
&lt;entry&gt;
<!-- Immunization; notGiven=false--&gt;
&lt;substanceAdministration classCode="SBADM" moodCode="EVN"&gt;
&lt;!-- substanceAdministration (Summary Statement of Administered Vaccine) templateId --&gt;
&lt;templateId root="1.2.36.1.2001.1001.102.101.100043" /&gt;
&lt;id root="9a9f270f-6783-4f91-b38c-15144b251e41" /&gt;
&lt;!-- Immunization status --&gt;
&lt;statusCode code="completed"/&gt;
&lt;!-- Immunization date --&gt;
&lt;effectiveTime value="20151003"/&gt;
&lt;!-- Immunization vaccineCode --&gt;
&lt;consumable&gt;
&lt;manufacturedProduct&gt;
&lt;manufacturedMaterial&gt;
&lt;code code="709541000168107"
codeSystem="2.16.840.1.113883.6.96"
codeSystemName="SNOMED CT"&gt;
&lt;originalText&gt;&lt;reference value="#IbVACCINE"
/&gt;&lt;/originalText&gt;
&lt;/code&gt;
&lt;/manufacturedMaterial&gt;
&lt;/manufacturedProduct&gt;
&lt;/consumable&gt;
&lt;!-- Immunization primarySource --&gt;
&lt;entryRelationship typeCode="COMP"&gt;
&lt;observation classCode="OBS" moodCode="EVN"&gt;
&lt;code code="103.17061" codeSystem="1.2.36.1.2001.1001.101"</pre>
```

```
codeSystemName="NCTIS Data Components"
displayName="Information from a Primary Source"/>
<value xsi:type="BL" value="true"/>
</observation>
</entryRelationship>
</substanceAdministration>
</entry>
</section>
</component>
<!-- Administrative Observations -->
<component>
<section>
<templateId root="1.2.36.1.2001.1001.102.101.100000" />
<id root="54020cd9-02f7-4abe-bade-dc3fc980bbfe"/>
<!-- section code -->
<code code="102.16080" codeSystem="1.2.36.1.2001.1001.101."
displayName="Administrative Observations"/>
<!-- section title -->
<title>Administrative Observations</title>
<!-- section text -->
<text mediaType="text/x-hl7-text+xml">
<paragraph>Dr Peter Chalmers, AHPRA qualification for General Practitioner
(MED0000932850)</paragraph>
</text>
<!--Practitioner qualification-->
<ext:coverage2 typeCode="COVBY">
<ext:templateId root="1.2.36.1.2001.1001.102.101.100038" />
<ext:entitlement classCode="COV" moodCode="EVN">
<ext:id root="1.2.36.1.2001.1005.56" extension="MED0000932850"
assigningAuthorityName="AHPRA"/>
<ext:code code="253111" codeSystem="2.16.840.1.113883.13.62"
displayName="General Medical Practitioner">
<originalText>AHPRA qualification for General
Practitioner</originalText>
</ext:code>
<ext:participant typeCode="HLD">
<ext:participantRole classCode="ASSIGNED">
<!-- matching technical id for the Practitioner entity -->
<ext:id root="989b0a54-9d29-4080-bd2e-126a3200b462"/>
</ext:participantRole>
</ext:participant>
</ext:entitlement>
</ext:coverage2>
</section>
</component>
</structuredBody>
</component>
</ClinicalDocument>
```

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Appendix C. Mapping from requirements

This implementation guide is intended to support multiple usage scenarios; some templates described within this implementation guide are reused across usage scenarios and other implementation guides.

This informative appendix provides a mapping from the requirements of each end-product clinical specification to a logical element (profiled FHIR resource) and its corresponding mapping to a CDA schema element (in a CDA template).

The mapping from requirements tables in this appendix demonstrates the logical decomposition of each requirement to the lowest possible element in the applicable logical model and CDA template.

Legend for mapping from requirements

Data item	Req No.	Logical element	CDA schema element	Additional notes
The heading text of the requirement as taken from the requirements specification.	The requirement number as taken from the requirement specification.	<p>Either the name of the lowest element in a profiled FHIR resource that addresses the requirement or n/a where the requirement has been deemed not applicable.</p> <p>If the lowest possible decomposition is to the resource then only the resource name (e.g. Patient) is present. If the lowest possible decomposition is to one or more child elements of a FHIR resource then a ">" notation is used to indicate the hierarchical relationship.</p> <p>For example Patient > communication > language indicates the requirement maps to the language element, that is a child of the communication element, in the Patient FHIR resource.</p> <p>Where a requirement is addressed by multiple elements, the elements are presented in order of appearance in the profiled FHIR resource.</p>	<p>Either the path to the lowest level CDA schema element in a template that addresses the requirement or n/a where the requirement has been deemed not applicable to a CDA template.</p> <p>The syntax for this uses an XPath like notation and starts as the root element ClinicalDocument e.g.</p> <p style="text-align: center;">ClinicalDocument/recordTarget/patientRole/patient/name</p> <p>Where an element is addressed by multiple CDA schema element paths, each path is presented.</p>	<p>Additional notes are provided where a gap between a requirement, or parts of a requirement, and the profiles is identified.</p> <p>Where a requirement is fully addressed by the mapped elements then no entry in this column is expected.</p>

C.1 Mapping from SHS information requirements

The table below provides mapping from the requirements in *Shared Health Summary Information Requirements [NEHT2015e]* to the corresponding supported element in the Composition (Shared Health Summary) model and their corresponding CDA schema element(s) in the *ClinicalDocument (Shared Health Summary)* template from the root *ClinicalDocument*.

See [C.1 Legend for mapping from requirements](#) for an explanation of requirements mapping table presentation.

Data item	Req No.	Logical element	CDA schema element	Additional notes
Individual Healthcare Identifier (mandatory)	022082	Patient > identifier	/ClinicalDocument/recordTarget/patientRole/patient/ext:asEntityIdentifier	
Individual's Title (optional)	022081	Patient > name	/ClinicalDocument/recordTarget/patientRole/patient/name	
Individual's Given Name (optional)	023056	Patient > name	/ClinicalDocument/recordTarget/patientRole/patient/name	
Individual's family name (mandatory)	023058	Patient > name	/ClinicalDocument/recordTarget/patientRole/patient/name	This requirement mandates inclusion of the individual's family name. This requirement may be enforced in a conformance profile by mandating conformance to <i>recordTarget (My Health Record Patient)</i> .
Individual's Name Suffix (optional)	023059	Patient > name	/ClinicalDocument/recordTarget/patientRole/patient/name	
Individual's Sex (mandatory)	024032	n/a; related to Patient > gender	/ClinicalDocument/recordTarget/patientRole/patient/administrativeGenderCode	Not supported as stated in a FHIR model or CDA template. This implementation guide supports including a patient's gender as part of a patient's demographics for identification purposes in line with the Australian Government recommendations in Australian Government Guidelines on the Recognition of Sex and Gender . Work is underway with HL7 AU to define a nationally agreed model for the capture of biological sex as a clinically relevant observation, see https://git-hub.com/hl7au/au-fhir-base/issues/321 .
Individual's Date of Birth (mandatory)	023060	Patient > birthDate	/ClinicalDocument/recordTarget/patientRole/patient/birthTime	This requirement mandates inclusion of the individual's date of birth. This requirement may be enforced in a conformance profile by mandating conformance to <i>recordTarget (My Health Record Patient)</i> .
Date of Birth accuracy indicator (optional)	024026	Patient > birthDate > date-accuracy-indicator	/ClinicalDocument/component/structuredBody/component[admin_obs]/section/entry[dob_acc]/observation/value	

Data item	Req No.	Logical element	CDA schema element	Additional notes
Individual's Address (mandatory)	024041	Patient > address	/ClinicalDocument/recordTarget/patientRole/addr	<p>This requirement states a document shall contain the individual's address.</p> <p>The CDA template recordTarget (Patient with Mandatory IHI) supports address as an optional element.</p> <p>The CDA template recordTarget (My Health Record Patient) prohibits address.</p> <p>This requirement is best enforced in a conformance profile.</p>
Individual's Electronic Communication Details (optional)	024042	Patient > telecom	/ClinicalDocument/recordTarget/patientRole/telecom	
Indigenous Status (mandatory)	024033	Patient > indigenous-status	/ClinicalDocument/recordTarget/patientRole/patient/ethnicGroupCode	<p>This requirement mandates inclusion of the individual's indigenous status.</p> <p>This requirement may be enforced in a conformance profile by mandating conformance to recordTarget (My Health Record Patient).</p>
Healthcare Provider Professional Role (mandatory)	024040	PractitionerRole > code	/ClinicalDocument/author/code	
Healthcare provider organisation name (mandatory)	023070	Organization > name	/ClinicalDocument/author/assignedAuthor/representedOrganization/name	<p>This requirement states a document shall contain the name of the organisation that the author is representing.</p> <p>The CDA template allows for an organisation name - it does not mandate the inclusion of the organisation or that an organisation if provided includes the name.</p> <p>This part of the requirement is best enforced in a conformance profile.</p>
Healthcare Provider Employer Organisation Address	025064	Organization > address	/ClinicalDocument/author/assignedAuthor/representedOrganization/address	<p>This requirement states a document shall contain the address of the organisation that the author is representing.</p> <p>The CDA template allows for an organisation address - it does not mandate the inclusion of the organisation or that an organisation if provided includes the address.</p> <p>This part of the requirement is best enforced in a conformance profile.</p>

Data item	Req No.	Logical element	CDA schema element	Additional notes
Healthcare Provider Employer Organisation Electronic Communication Detail	025063	Organization > telecom	/ClinicalDocument/author/assignedAuthor/representedOrganization/telecom	<p>This requirement states a document shall contain the electronic communication details of the organisation that the author is representing.</p> <p>The CDA template allows for an organisation's electronic communication details - it does not mandate the inclusion of the organisation or that an organisation if provided includes electronic communication details.</p> <p>This part of the requirement is best enforced in a conformance profile.</p>
Healthcare Provider Identifier-Individual (mandatory)	023066	PractitionerRole > identifier Practitioner > identifier	/ClinicalDocument/author/assignedAuthor/assignedPerson[prac]/ext:asEntityIdentifier	<p>This requirement states a document shall contain the individual's HPI-I.</p> <p>The CDA template mandates an identifier but does not force that identifier to be an HPI-I. Implementation guidance is included in the CDA template to direct implementers to instantiate an HPI-I when sending to the My Health Record.</p> <p>This part of the requirement is best enforced in a conformance profile.</p>
Healthcare Provider Identifier-Organisation (mandatory)	023071	Organization > identifier	/ClinicalDocument/author/assignedAuthor/representedOrganization/ext:asEntityIdentifier	<p>This requirement states a document shall contain the individual's HPI-O.</p> <p>The CDA template mandates an identifier but does not force that identifier to be an HPI-O. Implementation guidance is included in the CDA template to direct implementers to instantiate an HPI-O when sending to the My Health Record.</p> <p>This part of the requirement is best enforced in a conformance profile.</p>
Healthcare Provider's Title (optional)	023061	Practitioner > name	/ClinicalDocument/author/assignedAuthor/assignedPerson/name	
Healthcare Provider Given Name (optional)	023062	Practitioner > name	/ClinicalDocument/author/assignedAuthor/assignedPerson/name	
Healthcare Provider Family Name (mandatory)	023064	Practitioner > name	/ClinicalDocument/author/assignedAuthor/assignedPerson/name	<p>This requirement states a document shall contain the individual's family name.</p> <p>The CDA template allows for a family name - it does not mandate the inclusion of a name or that a name if provided includes family name.</p> <p>This part of the requirement is best enforced in a conformance profile.</p>
Healthcare provider name suffix (optional)	023065	Practitioner > name	/ClinicalDocument/author/assignedAuthor/assignedPerson/name	
Healthcare Provider Individual's Work-place Address (optional)	024035	Practitioner > address	/ClinicalDocument/author/assignedAuthor/addr	

Data item	Req No.	Logical element	CDA schema element	Additional notes
Healthcare Provider Individual's Work-place Electronic Communication Details (optional)	024036	Practitioner > telecom	/ClinicalDocument/author/assignedAuthor/telecom	
Component	022870	section (Allergies) section (Allergies) > entry section (Allergies) > emptyReason	/ClinicalDocument/component/structuredBody/component[allergy]/section/	
	024962	section (Allergies) > entry section (Allergies) > emptyReason	/ClinicalDocument/component/structuredBody/component[allergy]/section/@nullFlavor /ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]	
	022871	AllergyIntolerance > code AllergyIntolerance > reaction > substance	/ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/observation/code /ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/observation/entryRelationship[react]/observation/participant[agent]/participantRole/playingEntity/code	This requirement specifies a set of allowed values for allergy and adverse reaction agent. The CDA template allows these and other values - it does not constrain the element to only those values defined in the requirements specification.
Agent Description	023235			This part of the requirement is best enforced in a conformance profile.
Reaction Type	024963	AllergyIntolerance > type	/ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/observation/entryRelationship[react]/observation/value	This requirement specifies a set of allowed values for reaction type.
	024964			The CDA template constrains the set to match the FHIR model.
Reaction Description	023239	AllergyIntolerance > reaction > manifestation	/ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/observation/entryRelationship[react]/observation/entryRelationship[mfst]/observation/code	
	022887			
	023240			
	023241			
Component	022746	section (Medications) section (Medications) > entry section (Medications) > emptyReason	/ClinicalDocument/component/structuredBody/component[meds]/section/	
	024965	section (Medications) > entry section (Medications) > emptyReason	/ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds] /ClinicalDocument/component/structuredBody/component[meds]/section/@nullFlavor	

Data item	Req No.	Logical element	CDA schema element	Additional notes
Item Description	023242	MedicationStatement > medication[x]	/ClinicalDocument/component/structuredBody/component[allergy]/section/entry[meds]/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/code /ClinicalDocument/component/structuredBody/component[allergy]/section/entry[meds]/substanceAdministration/text	
	023243		/ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/code	
	023244		/ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/code	
Dose Instructions	023245	MedicationStatement > dosage	/ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/substanceAdministration/text	
Reason for Medicine	023246	MedicationStatement > reasonCode	/ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/substanceAdministration/entryRelationship[reason]/observation/value	
	023247			
Additional comments	023248	MedicationStatement > note	/ClinicalDocument/component/structuredBody/component[meds]/section/entry[med_stat]/substanceAdministration/entryRelationship[note]/act/text	
	023249			
Component	023250	section (Medical History) section (Medical History) > entry section (Medical History) > emptyReason	/ClinicalDocument/component/structuredBody/component[med_hist]/section/	
	023251	section (Medical History) > entry	/ClinicalDocument/component/structuredBody/component[med_hist]/section/entry[med_hist]	
	024966	section (Medical History) > entry section (Medical History) > emptyReason	/ClinicalDocument/component/structuredBody/component[med_hist]/section/@nullFlavor /ClinicalDocument/component/structuredBody/component[med_hist]/section/entry[med_hist]	
	023252	Condition > code Procedure > code	/ClinicalDocument/component/structuredBody/component[med_hist]/section/entry[med_hist]/observation/value /ClinicalDocument/component/structuredBody/component[med_hist]/section/entry[med_hist]/procedure/code	
Medical History Description	023253	Condition > code Procedure > code	/ClinicalDocument/component/structuredBody/component[med_hist]/section/entry[med_hist]/observation/value /ClinicalDocument/component/structuredBody/component[med_hist]/section/entry[med_hist]/procedure/code	
	023236	n/a	n/a	

Data item	Req No.	Logical element	CDA schema element	Additional notes
Medical History DateTime Range	024947	Condition > onset[x]	/ClinicalDocument/component/structuredBody/component[med_hist]/section/entry[med_hist]/observation/effectiveTime/low@value	
	024948	Condition > abatement[x]	/ClinicalDocument/component/structuredBody/component[med_hist]/section/entry[med_hist]/observation/effectiveTime/high@value	
	024949	Condition > onset[x]	/ClinicalDocument/component/structuredBody/component[med_hist]/section/entry[med_hist]/observation/effectiveTime/low@value	
		Condition > abatement[x]	/ClinicalDocument/component/structuredBody/component[med_hist]/section/entry[med_hist]/observation/effectiveTime/high@value	
Medical History comments	024950	Condition > note	/ClinicalDocument/component/structuredBody/component[med_hist]/section/entry[med_hist]/observation/entryRelationship[note]/act/text	
		Procedure > note	/ClinicalDocument/component/structuredBody/component[med_hist]/section/entry[med_hist]/procedure/entryRelationship[note]/act/text	
Component	023254	section (Immunisations)	/ClinicalDocument/component/structuredBody/component[imms]/section/	
	024924	section (Immunisations) > entry	/ClinicalDocument/component/structuredBody/component[imms]/section/entry[imm]	
		section (Immunisations) > emptyReason	/ClinicalDocument/component/structuredBody/component[imms]/section/entry[imm]	
	024967	section (Immunisations) > entry	/ClinicalDocument/component/structuredBody/component[imms]/section/entry[imm]	
Vaccine Name	024925	Immunization > vaccineCode	/ClinicalDocument/component/structuredBody/component[imms]/section/entry[imm]/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/code	
	024926			
	024927			
DateTime Administration	024928	Immunization > date	/ClinicalDocument/component/structuredBody/component[imms]/section/entry[imm]/substanceAdministration/effectiveTime	
	024929			
Sequence Number	024930	Immunization > vaccinationProtocol > doseSequence	/ClinicalDocument/component/structuredBody/component[imms]/section/entry[imm]/substanceAdministration/entryRelationship[sply]/sequenceNumber/@value	
	024931			
Date/Time Attested (mandatory)	024038	Composition > attester (Legal Attester) > time	/ClinicalDocument/legalAuthenticator/time/@value	

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