



## Personal Health Records

### CDA Implementation Guide

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## Related Documents

Name	Version/Release Date
<a href="#">Personal Health Records FHIR Implementation Guide</a>	Version 1.0.0 (Draft for internal use), Not yet published
<a href="#">Personal Health Summary - My Health Record Conformance Profile</a>	Version 1.0, Issued 19 May 2016
<a href="#">Personal Health Notes - My Health Record Conformance Profile</a>	Version 1.0, Issued 19 May 2016
<a href="#">Common - Clinical Document</a>	Version 1.5.2, Issued 28 February 2019
<a href="#">CDA Rendering Specification</a>	Version 1.0, Issued 07 March 2012
<a href="#">HL7 Clinical Document Architecture</a>	Release 2, January 2010
<a href="#">Information Requirements - Consumer Entered Notes</a>	Version 0.07, Issued 19 December 2011
<a href="#">Information Requirements - Consumer Entered Health Summary</a>	Version 1.0, Issued 23 November 2011
<a href="#">Representing Coding in CDA Documents Implementation Guidance</a>	Version 1.0, Issued 10 October 2011

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# 1 Introduction

This implementation guide is an [HL7 Clinical Document Architecture \[HL7CDAR2\]](#) specification to represent personal health records including Personal Health Notes (PHN) and Personal Health Summary (PHS). A personal health record is a health document authored by an individual or their authorised representative.

## 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 a personal health record model ([Personal Health Records FHIR Implementation Guide \[DH2020g\]](#)), including Personal Health Notes and Personal Health Summary to a corresponding CDA attribute or element. The resulting CDA document can be used for the electronic exchange of PHN 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 personal health records. These constraints are defined as a set of templates.

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

For implementers interested in Personal Health Summary, the starting point for the CDA templates is [ClinicalDocument \(Personal Health Summary\)](#), 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 Personal Health Notes hierarchy](#) - hierarchical overview of the model for this document-level usage scenario.
- [5 Personal Health Summary hierarchy](#) - hierarchical overview of the model for this document-level usage scenario.
- [6 CDA Header templates](#) - contains the CDA Header templates that apply across all of the supported usage scenarios in this implementation guide.
- [7 Document CDA templates](#) - defines the `ClinicalDocument` template for each logical model of a document-level usage scenario, e.g. Personal Health Notes, in this implementation guide.
- [8 Section CDA templates](#) - defines the `section` templates referenced by a `ClinicalDocument` template in this implementation guide.
- [9 Participation CDA templates](#) - defines the templates for individuals and organisations, called participations, referenced by other templates in this implementation guide.
- [10 Entity CDA templates](#) - defines the templates for entities referenced by a participation template in this implementation guide.
- [11 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. Personal Health Notes, 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 [Consumer Entered Notes - Structured Content Specification \[NEHT2011bn\]](#), [Consumer Entered Health Summary - Structured Content Specification \[NEHT2011bo\]](#), [Consumer Entered Notes CDA Implementation Guide \[NEHT2011ap\]](#), and [Consumer Entered Health Summary CDA Implementation Guide \[NEHT2011as\]](#). 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 <a href="#">Digital Health Icon Library v1.0</a> 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>
Personal Health Records CDA implementation guide roadmap	<p>The objective of this specification is to provide guidance on the implementation in HL7 CDA Release 2 of personal health records documents (defined in HL7 FHIR).</p> <p>The current guide covers implementation in HL7 CDA Release 2 of Personal Health Notes model and Personal Health Summary model defined in FHIR Release 3 (STU) (<a href="#">Personal Health Records FHIR Implementation Guide [DH2020g]</a>).</p> <p>These models are 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>
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 <a href="#">Personal Health Records FHIR Implementation Guide [DH2020g]</a>.</p>

Reference	Description
AllergyIntolerance > onset[x]	onset[x] as a <a href="#">Range</a> is not currently mapped to CDA. Future releases of this implementation guide are expected to include one or more mappings to support a <a href="#">Range</a> .
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 <a href="#">National Clinical Terminology Service (NCTS)</a> with the following canonical URL: <a href="https://healthterminologies.gov.au/fhir/ValueSet/australian-pbs-item-1">https://healthterminologies.gov.au/fhir/ValueSet/australian-pbs-item-1</a> . 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 personal health notes 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 personal health notes. 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: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">
  <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	Logical 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..*	<a href="#">Composition</a>	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 <b>SHALL</b> 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	<a href="#">BackboneElement</a>	ClinicalDocument/component/structuredBody/component[event]	
				ClinicalDocument/component/structuredBody/component[event]/section	section <b>SHALL</b> conform to the template defined in section (Event Overview).
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	<a href="#">BackboneElement</a>	ClinicalDocument/component/structuredBody/component[allergy]	
				ClinicalDocument/component/structuredBody/component[allergy]/section	section <b>SHALL</b> conform to the template defined in section (Allergies).

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. 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>
        <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: <code>/ClinicalDocument/component/structuredBody/component[admin_obs]/section</code>	
Patient > closing-the-gap-registration	Indication for eligibility for the Closing the Gap program.	0..1	<a href="#">boolean</a>	<code>entry[close_gap]</code>	The containing component[admin_obs]/section <b>SHALL</b> conform to the template defined in <a href="#">component (Administrative Observations)</a> .
				<code>entry[close_gap]/observation</code>	
				<code>entry[close_gap]/observation/@classCode="OBS"</code>	
				<code>entry[close_gap]/observation/@moodCode="EVN"</code>	
				<code>entry[close_gap]/observation/code</code>	
				<code>entry[close_gap]/observation/code/@code="103.32011"</code>	
				<code>entry[close_gap]/observation/code/@codeSystem="1.2.36.1.2001.1001.101"</code>	<a href="#">NCTIS Data Components</a>
				<code>entry[close_gap]/observation/code/@displayName</code>	displayName <b>SHOULD</b> be "Closing the Gap Copayment Eligibility Indicator".
				<code>entry[close_gap]/observation/value</code>	closing-the-gap-registration is "true" if eligible for Closing the Gap co-payment. value/@xsi:type <b>SHALL</b> 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 <b>SHALL</b> be from the specified value set.
extensible	To be conformant, codes in this element <b>SHALL</b> 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 **SHALL** 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
<b>SHALL</b>	<p>An absolute requirement.</p> <p>Where <b>SHALL</b> appears in any conformance constraint it indicates a mandatory requirement.</p> <p>Where <b>SHALL</b> 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>
<b>SHOULD</b>	<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 <b>SHOULD</b> 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 <b>SHOULD</b> 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>
<b>MAY</b>	<p>A requirement that can be included or omitted as the author decides with no implications.</p> <p>Where <b>MAY</b> 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>
<b>SHALL NOT</b>	<p>An absolute prohibition.</p> <p>Where <b>SHALL NOT</b> 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 <b>SHOULD NOT</b> 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 <b>SHOULD NOT</b> 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				Context: Comes from linking elements	
section	A set of allergies or intolerances that have been categorised as critical.	Cardinality comes from linking element	<a href="#">BackboneElement</a>	section	section/@nullFlavor <b>SHALL NOT</b> be present.
				section/templateId	
				section/templateId/@root="1.2.36.1.2001.1001.102.101.100092"	

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	<a href="#">string</a>	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	<a href="#">CodeableConcept</a>	section/code	
				section/code/@code="48765-2"	
				section/code/@codeSystem="2.16.840.1.113883.6.1"	<a href="#">LOINC</a>
				section/code/@displayName	displayName <b>SHOULD</b> 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	<a href="#">Narrative</a>	section/text	
section > entry	A reference to the actual resource from which the narrative in the section is derived.	1..*	<a href="#">Reference</a> (Summary Statement of Allergy or Intolerance)	section/entry[adv]	observation <b>SHALL</b> 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:h17-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 [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#)) 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. [9 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	
<p>The logical hierarchical path in the logical model expressed using names of the elements in the logical model.</p> <p>If there is a name in round brackets after the path, this is the label for that element or resource.</p> <p>The text in <b>bold</b> (the last in the path) is the subject for this row in the convention &lt;Parent (Label)&gt; &gt; &lt;Child (Label)&gt;, e.g.</p> <p>Composition &gt; section (Allergies)</p>	<p>The description of the element in the logical model.</p>	<p>The cardinality of the logical element in the logical model (see <a href="#">Cardinality notation</a>).</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>Cardinality comes from linking element</p> <p>A logical cardinality is applied to the mapped CDA schema elements as described in <a href="#">Interpreting cardinality in a CDA mapping table for logical elements</a>:</p> <ul style="list-style-type: none"> <li>The most strict minimum occurrence between the logical cardinality or the CDA schema defined cardinality is applied.</li> <li>The most strict maximum occurrence applies to CDA schema elements without an [index].</li> <li>The maximum occurrence of the logical cardinality applies as a pattern 'like this' to CDA schema elements with an [index].</li> </ul>	<p>The type of the logical element (hyperlinked to the definition of the <a href="#">[HL7FHIR3]</a> type) in the logical model.</p> <p>This may be expressed as a type that is further constrained by a model in the convention &lt;model name&gt;, e.g.</p> <p>Patient with Mandatory Identifier.</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 <i>XPath like notation</i>, e.g.:</p> <p>participant[location]/associatedEntity/<b>code</b></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 <a href="#">Interpreting cardinality in a CDA mapping table for logical elements</a>).</p>	<p>Additional information or guidance on implementing the logical element in CDA to support usage scenarios, e.g.</p> <p>When sending to the My Health Record, an IHI is expected.</p> <p>Constraints on the CDA schema elements, identified by use of <a href="#">Conformance verbs</a>, e.g.</p> <p>code/original-Text or code/@displayName <b>SHALL</b> be included.</p> <p>Terminology binding, e.g.</p> <p><a href="#">Address Type HL7 v3 (required)</a>.</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		Context: The root context that is applied as a prefix to the CDA schema element paths in the mapping rows below	
<p>The CDA schema element(s) in the CDA template using an <a href="#">XPath like notation</a>, e.g.:</p> <p>ClinicalDocument/versionNumber/<b>@value</b></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>The description of the CDA schema element definitions, sourced from HL7 Clinical Document Architecture, Release 2 <a href="#">[HL7CDAR2]</a>.</p>	<p>The cardinality of the CDA schema element in the template (see <a href="#">Cardinality notation</a>).</p> <p>The root element of a template may express an inherited cardinality from the parent element in a parent template by stating:</p> <p>Cardinality comes from linking element</p>	<p>Additional information or guidance on the use of the CDA schema element to support usage scenarios, e.g.</p> <p>The use of templateId signals the imposition of a set of template-defined constraints.</p> <p>Constraints on the CDA schema elements, identified by use of <a href="#">Conformance verbs</a>, e.g.</p> <p>code/originalText or code/@displayName <b>SHALL</b> be included.</p> <p><a href="#">Terminology binding</a>, e.g.</p> <p><a href="#">Address Type HL7 v3 (required)</a>.</p>



## 3 Conformance

Conformance claims are typically made against the templates in this implementation guide and additional conformance profiles documented elsewhere such as [Personal Health Summary - My Health Record Conformance Profile \[DH2016ah\]](#).

### 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.

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



# 4 Personal Health Notes hierarchy

Personal Health Notes is defined as:

A document that contains narrative about the patient's healthcare information recorded by the patient or their authorised representative within the system. This helps the patient or their authorised representative to keep track of patient health information within the system. [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#)

The table below provides a hierarchical view of the Personal Health Notes 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 (Personal Health Notes), published as a set of FHIR profiles, can be found in the [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#).

Logical element		Logical card	Logical type	CDA template
	Composition (Personal Health Notes)		Personal Health Notes	ClinicalDocument (Personal Health Notes)
	identifier	0..1	<a href="#">Identifier</a>	
	status	1..1	<a href="#">code</a>	
	type	1..1	<a href="#">CodeableConcept</a>	
	subject	1..1	<a href="#">Reference</a> (My Health Record Patient)	recordTarget (My Health Record Patient)
	date	1..1	<a href="#">dateTime</a>	
	author	1..1	<a href="#">Reference</a> (My Health Record Patient   RelatedPerson with Mandatory IHI)	author (My Health Record Patient)   author (RelatedPerson with Mandatory IHI)
	title	1..1	<a href="#">string</a>	
	custodian	1..1	<a href="#">Reference</a> (Organization with Mandatory Identifier)	custodian (Organization with Mandatory Identifier)
	section (Notes)	1..1	<a href="#">BackboneElement</a>	section (Notes)
	title	1..1	<a href="#">string</a>	
	code	1..1	<a href="#">CodeableConcept</a>	
	text	1..1	<a href="#">Narrative</a>	



## 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 [6 CDA Header templates](#)).

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# 5 Personal Health Summary hierarchy

Personal Health Summary is defined as:

















A document that is a healthcare summary about the individual's allergies and medications which is recorded by the patient or their authorised representative within the system. [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#)

The table below provides a hierarchical view of the Personal 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.

(Personal Health Notes), published as a set of FHIR profiles, can be found in the [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#).

Logical element			Logical card	Logical type	CDA template	
	Composition (Personal Health Summary)			Personal Health Summary	ClinicalDocument (Personal Health Summary)	
	identifier		0..1	<a href="#">Identifier</a>		
	status		1..1	<a href="#">code</a>		
	type		1..1	<a href="#">CodeableConcept</a>		
	subject		1..1	<a href="#">Reference</a> (My Health Record Patient)	<a href="#">recordTarget</a> (My Health Record Patient)	
	date		1..1	<a href="#">dateTime</a>		
	author		1..1	<a href="#">Reference</a> (My Health Record Patient   RelatedPerson with Mandatory IHI)	<a href="#">author</a> (My Health Record Patient)   <a href="#">author</a> (RelatedPerson with Mandatory IHI)	
	title		1..1	<a href="#">string</a>		
	custodian		1..1	<a href="#">Reference</a> (Organization with Mandatory Identifier)	<a href="#">custodian</a> (Organization with Mandatory Identifier)	
	section (Allergies)		1..1	<a href="#">BackboneElement</a>	<a href="#">section</a> (Allergies)	
		title	1..1	<a href="#">string</a>		
		code	1..1	<a href="#">CodeableConcept</a>		
		text	1..1	<a href="#">Narrative</a>		
		entry	0..*	<a href="#">Reference</a> (Summary Statement of Allergy or Intolerance)	<a href="#">observation</a> (Summary Statement of Allergy or Intolerance)	
			author-related-person	0..1	<a href="#">Reference</a> (Base RelatedPerson)	<a href="#">author</a> (Base RelatedPerson)
			clinicalStatus	0..1	<a href="#">code</a>	
			verificationStatus	1..1	<a href="#">code</a>	

Logical element				Logical card	Logical type	CDA template
			type	0..1	<a href="#">code</a>	
			code	1..1	<a href="#">CodeableConcept</a>	
			patient	1..1	<a href="#">Reference</a> (Patient with Mandatory Identifier)	
		   	onset[x]	0..1	<a href="#">dateTime</a> , <a href="#">Age</a> , <a href="#">Period</a> , <a href="#">Range</a>	
		 	recorder	0..1	<a href="#">Reference</a> (Base Patient   Base Practitioner)	<a href="#">author</a> (Base Patient)   <a href="#">author</a> (Base PractitionerRole)
			note	0..*	<a href="#">Annotation</a>	
			reaction	0..*	<a href="#">BackboneElement</a>	
			substance	0..1	<a href="#">CodeableConcept</a>	
			manifestation	1..*	<a href="#">CodeableConcept</a>	
			emptyReason	0..1	<a href="#">CodeableConcept</a>	
		section (Medications)		1..1	<a href="#">BackboneElement</a>	<a href="#">section</a> (Medications)
			title	1..1	<a href="#">string</a>	
			code	1..1	<a href="#">CodeableConcept</a>	
			text	1..1	<a href="#">Narrative</a>	
			entry	0..*	<a href="#">Reference</a> (Summary Statement of Known Medicine)	<a href="#">observation</a> (Assertion of No Relevant Finding)
			status	1..1	<a href="#">code</a>	
			category	0..1	<a href="#">CodeableConcept</a>	
			medication[x]	1..1	<a href="#">CodeableConcept</a>	
		 	informationSource	0..1	<a href="#">Reference</a> (Base Patient   Base Practitioner   Base RelatedPerson)	<a href="#">informant</a> (Base Patient)   <a href="#">informant</a> (Base Practitioner)   <a href="#">informant</a> (Base RelatedPerson)

Logical element				Logical card	Logical type	CDA template	
				subject	1..1	<a href="#">Reference</a> (Patient with Mandatory Identifier)	
				taken	1..1	<a href="#">code</a>	
				reasonCode	0..1	<a href="#">CodeableConcept</a>	
				note	0..*	<a href="#">Annotation</a>	
				dosage	1..1	<a href="#">Reference</a> (AU Base Dosage)	
			entry		0..1	<a href="#">Reference</a> (Assertion of No Relevant Finding)	observation (Assertion of No Relevant Finding)
				status	1..1	<a href="#">code</a>	
				code	1..1	<a href="#">CodeableConcept</a>	
				subject	1..1	<a href="#">Reference</a> (Patient with Mandatory Identifier)	
			 	effective[x]	0..1	<a href="#">dateTime</a>   <a href="#">Period</a>	
			  	performer	0..*	<a href="#">Reference</a> (Base Practitioner   Base Organization   Base RelatedPerson   Base Patient)	<a href="#">author</a> (Base PractitionerRole)   <a href="#">participant</a> (author Base Organization)   <a href="#">author</a> (Base RelatedPerson)   <a href="#">author</a> (Base Patient)
				value[x]	1..1	<a href="#">CodeableConcept</a>	
			emptyReason		0..1	<a href="#">CodeableConcept</a>	



## 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 [6 CDA Header templates](#)).

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## 6 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 Personal Health Notes model.

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

### 6.1 ClinicalDocument

This template is referenced by [ClinicalDocument \(Personal Health Notes\)](#), and [ClinicalDocument \(Personal Health Summary\)](#).

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 <b>SHALL</b> be a closed template.</p> <p>All attributes of the ClinicalDocument element defined by the Australian Digital Health Agency CDA schema <b>SHALL</b> be allowed.</p> <p>All instances of a time value <b>SHALL</b> include hours, minutes and a time zone.</p> <p>The CDA document <b>SHALL</b> 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/realCode	A realCode signals the imposition of realm-specific constraints. The value identifies the realm in question.	0..*	All attributes of the realCode element defined by the Australian Digital Health Agency CDA schema <b>SHALL</b> 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/ <b>templateId</b>	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 <b>SHALL</b> be allowed.</p> <p>Exactly one template identifier <b>SHALL</b> 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 <b>SHALL</b> 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 <a href="#">ClinicalDocument (Personal Health Notes)</a>. 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/ <b>id</b>	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 <b>SHALL</b> be allowed with the exception that @nullFlavor <b>SHALL NOT</b> be present.</p> <p>id/@root <b>SHALL</b> be present and it <b>SHALL</b> be a UUID or an OID.</p>
ClinicalDocument/ <b>code</b>	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 <b>SHALL</b> be allowed with the exception that @nullFlavor <b>SHALL NOT</b> be present.
ClinicalDocument/ <b>title</b>	Represents the title of the document.	0..1	
ClinicalDocument/ <b>effectiveTime</b>	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 <b>SHALL</b> be allowed with the exception that @nullFlavor <b>SHALL NOT</b> be present.
ClinicalDocument/ <b>confidentialityCode/@nullFlavor="NA"</b>	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/ <b>languageCode</b>	Specifies the human language of character data (whether they be in contents or attribute values).	0..1	<Language Code> – <DIACLECT> The <Language Code> <b>SHALL</b> be "en". The <DIACLECT> <b>SHOULD</b> be "AU".
ClinicalDocument/ <b>languageCode/@code</b>		1..1	
ClinicalDocument/ <b>setId</b>	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 <b>SHALL</b> be allowed.
ClinicalDocument/ <b>versionNumber</b>	An integer value used to version successive replacement documents.	0..1	
ClinicalDocument/ <b>versionNumber/@value</b>		1..1	
ClinicalDocument/ <b>ext:completionCode</b>	The lifecycle status of a document.	1..1	<p>All attributes of the completionCode element defined by the Australian Digital Health Agency CDA schema <b>SHALL</b> be allowed with the exception that @nullFlavor <b>SHALL NOT</b> be present.</p> <p><a href="#">Australian Healthcare Clinical Document Architecture Document Lifecycle Status (required)</a></p>
ClinicalDocument/ <b>recordTarget</b>	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 <b>SHALL</b> be allowed.
ClinicalDocument/ <b>author</b>	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 <b>SHALL</b> be allowed.
ClinicalDocument/ <b>dataEnterer</b>	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 <b>SHALL</b> be allowed.



CDA schema element	CDA element description	CDA card	CDA constraints and comments
ClinicalDocument/ <b>informant</b>	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 <b>SHALL</b> be allowed.
ClinicalDocument/ <b>custodian</b>	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 <b>SHALL</b> be allowed.
ClinicalDocument/ <b>informationRecipient</b>	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 <b>SHALL</b> be allowed.
ClinicalDocument/ <b>legalAuthenticator</b>	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 <b>SHALL</b> be allowed.
ClinicalDocument/ <b>authenticator</b>	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 <b>SHALL</b> be allowed.
ClinicalDocument/ <b>participant</b>	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 <b>SHALL</b> be allowed.
ClinicalDocument/ <b>inFulfillmentOf</b>	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 <b>SHALL</b> be allowed.
ClinicalDocument/ <b>documentationOf</b>	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 <b>SHALL</b> be allowed.
ClinicalDocument/ <b>relatedDocument</b>	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 <b>SHALL</b> be allowed.
ClinicalDocument/ <b>authorization</b>	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 <b>SHALL</b> be allowed.
ClinicalDocument/ <b>componentOf</b>	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 <b>SHALL</b> be allowed.
ClinicalDocument/ <b>component</b>	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 <b>SHALL</b> be allowed.

## 6.2 component (Administrative Observations)

This template is referenced by [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 <b>SHALL</b> contain at most one Administrative Observation section.  The Administrative Observations section <b>SHALL NOT</b> be populated if there are no entries or text to go in it.
component[admin_obs]/section		1..1	
component[admin_obs]/section/templateId	Administrative Observations is a CDA section that is created to hold these elements in preference to creating extensions for them.	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 <b>SHALL</b> be present and it <b>SHALL</b> 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	<a href="#">NCTIS Data Components</a>
component[admin_obs]/section/code/@displayName		0..1	displayName <b>SHOULD</b> be "Administrative Observations".
component[admin_obs]/section/title="Administrative Observations"		0..1	
component[admin_obs]/section/text		0..1	

## 7 Document CDA templates

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

### 7.1 ClinicalDocument (Personal Health Notes)

The following are the usage scenarios expected:

- An individual or their authorised representative authors a personal health notes document to be exchanged with the My Health Record system

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

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: /	
Composition	A document that contains narrative about the patient's healthcare information recorded by the patient or their authorised representative within the system. This helps the patient or their authorised representative to keep track of patient health information within the system.	0..*	<a href="#">Composition</a>	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 <b>SHALL</b> conform to the template defined in <a href="#">ClinicalDocument</a> .
				ClinicalDocument/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				ClinicalDocument/templateId/@root="1.2.36.1.2001.1001.102.101.100017"	
Composition > identifier	Logical identifier for the composition, assigned when created. This identifier stays constant as the composition is changed over time.	0..1	<a href="#">Identifier</a>	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	<a href="#">code</a>	ClinicalDocument/ext:completionCode	<a href="#">Australian Healthcare Clinical Document Architecture Document Lifecycle Status (required)</a> <sup>1</sup>

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Composition > <b>type</b>	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	<a href="#">CodeableConcept</a>	ClinicalDocument/code	
				ClinicalDocument/code/@code="100.16681"	
				ClinicalDocument/code/@codeSystem="1.2.36.1.2001.1001.101"	<a href="#">NCTIS Data Components</a>
				ClinicalDocument/code/@displayName	displayName <b>SHOULD</b> be "Personal Health Notes".
Composition > <b>subject</b>	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	<a href="#">Reference</a> (My Health Record Patient)	ClinicalDocument/recordTarget	recordTarget <b>SHALL</b> conform to the template defined in <a href="#">recordTarget (My Health Record Patient)</a> .
Composition > <b>date</b>	The composition editing time, when the composition was last logically changed by the author.	1..1	<a href="#">dateTime</a>	ClinicalDocument/author/time	
Composition > <b>author</b>	Identifies who is responsible for the information in the composition, not necessarily who typed it in.	1..1	<a href="#">Reference</a> (My Health Record Patient   RelatedPerson with Mandatory IHI)	ClinicalDocument/author	author <b>SHALL</b> conform to one of the templates defined in: <a href="#">author (My Health Record Patient)</a> or <a href="#">author (Base Related-Person)</a> .
Composition > <b>title</b>	Official human-readable label for the composition.	1..1	<a href="#">string</a>	ClinicalDocument/title="Personal Health Notes"	
Composition > <b>custodian</b>	Identifies the organization or group who is responsible for ongoing maintenance of and access to the composition/document information.	1..1	<a href="#">Reference</a> (Organization with Mandatory Identifier)	ClinicalDocument/custodian	When the list is a prescription and dispense view it is expected that the custodian will be the My Health Record system operator.  custodian <b>SHALL</b> conform to the template defined in <a href="#">custodian (Organization with Mandatory Identifier)</a> .
Composition > <b>section (Notes)</b>	Healthcare narratives about an individual's health and related matters.	1..1	<a href="#">BackboneElement</a>	ClinicalDocument/component/structuredBody/component[ <a href="#">note</a> ]	
				ClinicalDocument/component/structuredBody/component[ <a href="#">note</a> ]/section	section <b>SHALL</b> conform to the template defined in <a href="#">section (Notes)</a> .

<sup>1</sup>This value set differs from the value set bound to status in the Agency logical model (see [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#)) 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.

## 7.2 ClinicalDocument (Personal Health Summary)

The following are the usage scenarios expected:

- An individual or their authorised representative authors a personal health summary document to be exchanged with 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	Logical card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements				Context: /	
Composition	A document that contains narrative about the patient's healthcare information recorded by the patient or their authorised representative within the system. This helps the patient or their authorised representative to keep track of patient health information within the system.	0..*	<a href="#">Composition</a>	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 <b>SHALL</b> conform to the template defined in <a href="#">ClinicalDocument</a> .
				ClinicalDocument/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				ClinicalDocument/templateId/@root="1.2.36.1.2001.1001.102.101.100017"	
Composition > identifier	Logical identifier for the composition, assigned when created. This identifier stays constant as the composition is changed over time.	0..1	<a href="#">Identifier</a>	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	<a href="#">code</a>	ClinicalDocument/ext:completionCode	<a href="#">Australian Healthcare Clinical Document Architecture Document Lifecycle Status (required)</a> <sup>1</sup>
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	<a href="#">CodeableConcept</a>	ClinicalDocument/code	
				ClinicalDocument/code/@code="100.16681"	
				ClinicalDocument/code/@codeSystem="1.2.36.1.2001.1001.101"	<a href="#">NCTIS Data Components</a>
				ClinicalDocument/code/@displayName	displayName <b>SHOULD</b> be "Personal Health Notes".

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Composition > <b>subject</b>	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	<a href="#">Reference</a> (My Health Record Patient)	ClinicalDocument/ <b>recordTarget</b>	recordTarget <b>SHALL</b> conform to the template defined in <a href="#">recordTarget (My Health Record Patient)</a> .
Composition > <b>date</b>	The composition editing time, when the composition was last logically changed by the author.	1..1	<a href="#">dateTime</a>	ClinicalDocument/ <b>author/time</b>	
Composition > <b>author</b>	Identifies who is responsible for the information in the composition, not necessarily who typed it in.	1..1	<a href="#">Reference</a> (My Health Record Patient   RelatedPerson with Mandatory IHI)	ClinicalDocument/ <b>author</b>	author <b>SHALL</b> conform to one of the templates defined in: <a href="#">author (My Health Record Patient)</a> or <a href="#">author (Base Related-Person)</a> .
Composition > <b>title</b>	Official human-readable label for the composition.	1..1	<a href="#">string</a>	ClinicalDocument/ <b>title="Personal Health Notes"</b>	
Composition > <b>custodian</b>	Identifies the organization or group who is responsible for ongoing maintenance of and access to the composition/document information.	1..1	<a href="#">Reference</a> (Organization with Mandatory Identifier)	ClinicalDocument/ <b>custodian</b>	When the list is a prescription and dispense view it is expected that the custodian will be the My Health Record system operator.  custodian <b>SHALL</b> conform to the template defined in <a href="#">custodian (Organization with Mandatory Identifier)</a> .
Composition > <b>section (Notes)</b>	Healthcare narratives about an individual's health and related matters.	1..1	<a href="#">BackboneElement</a>	ClinicalDocument/component/structuredBody/ <b>component[note]</b>	
				ClinicalDocument/component/structuredBody/component[note]/ <b>section</b>	section <b>SHALL</b> conform to the template defined in <a href="#">section (Notes)</a> .

<sup>1</sup>This value set differs from the value set bound to status in the Agency logical model (see [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#)) 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.

## 8 Section CDA templates

This chapter defines the `section` templates referenced by a `ClinicalDocument` template for a document-level model in [7 Document CDA templates](#).

### 8.1 section (Notes)

This template is referenced by [ClinicalDocument \(Personal Health Notes\)](#).

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 Body Level 3 Data Elements				Context: Comes from linking elements	
section	A section that captures healthcare narratives about a patient's health and related matters.	Cardinality comes from linking element	<a href="#">BackboneElement</a>	section	
				section/templated	The use of templated signals the imposition of a set of template-defined constraints.
				section/templated/@root="1.2.36.1.2001.1001.102.101.100010"	
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	<a href="#">string</a>	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	<a href="#">CodeableConcept</a>	section/code	
				section/code/@code="102.15513"	
				section/code/@codeSystem="1.2.36.1.2001.1001.101"	<a href="#">NCTIS Data Components</a>
				section/code/@displayName	displayName <b>SHOULD</b> be "Clinical Synopses".
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	<a href="#">Narrative</a>	section/text	

## 8.2 section (Allergies)

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

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 about adverse reactions that need to be positively recorded as absent or excluded.	Cardinality comes from linking element	<a href="#">BackboneElement</a>	section	This section <b>SHALL</b> contain at least one entry (entry[adv]) or an emptyReason (entry[adv_empty]) but <b>SHALL NOT</b> 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	<a href="#">string</a>	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	<a href="#">CodeableConcept</a>	section/code	
				section/code/@code="48765-2"	
				section/code/@codeSystem="2.16.840.1.113883.6.1"	<a href="#">LOINC</a>
				section/code/@displayName	displayName <b>SHOULD</b> 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	<a href="#">Narrative</a>	section/text	
section > entry	A reference to the actual resource from which the narrative in the section is derived.	0..*	<a href="#">Reference</a> (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 . observation <b>SHALL</b> conform to the template defined in <a href="#">observation (Summary Statement of Allergy or Intolerance)</a> .
				section/entry[adv]/observation	



Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
section > <b>emptyReason</b>	If the section is empty, why the list is empty. An empty section typically has some text explaining the empty reason.	0..1	<a href="#">CodeableConcept</a>	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"	<a href="#">v3 Code System ActCode</a>
				section/entry[adv_empty]/observation/code/@displayName	displayName <b>SHOULD</b> be "Assertion".
				section/entry[adv_empty]/observation/value	value/@xsi:type <b>SHALL</b> be "CD". value/originalText or value/@displayName <b>SHALL</b> be included. <a href="#">Health Summary Non-Clinical Empty Reason (required)</a>

<sup>1</sup>This value set differs from the value set bound to status in the Agency logical model (see [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#)) due to pre-adoption of FHIR Release 4 terminology.

## 8.3 section (Medications)

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

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 the patient is taking including self-prescribed, clinician prescribed and nonprescription medicines.	Cardinality comes from linking element	<a href="#">BackboneElement</a>	section	This section <b>SHALL</b> contain: <ul style="list-style-type: none"><li>at least one entry (section/entry[meds]) or an emptyReason (section/entry[meds_empty_rsn])</li></ul> This section <b>SHALL NOT</b> contain: <ul style="list-style-type: none"><li>both an entry (section/entry[meds]) and an emptyReason (section/entry[meds_empty_rsn])</li><li>both an entry (section/entry[meds]) that conforms to <a href="#">substanceAdministration (Summary Statement of Known Medicine)</a> and an entry that conforms to <a href="#">observation (Assertion of No Relevant Finding)</a></li><li>more than one entry (section/entry[meds]) that conforms to <a href="#">observation (Assertion of No Relevant Finding)</a></li></ul>
				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	<a href="#">string</a>	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	<a href="#">CodeableConcept</a>	section/code	
				section/code/@code="101.32009"	
				section/code/@codeSystem="1.2.36.1.2001.1001.101"	<a href="#">NCTIS Data Components</a>
				section/code/@displayName	displayName <b>SHOULD</b> be "Current Medicine".

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
section > <b>text</b>	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	<a href="#">Narrative</a>	section/text	
section > <b>entry</b>	A reference to the actual resource from which the narrative in the section is derived.	0..*	<a href="#">Reference</a> (Summary Statement of Known Medicine   Assertion of No Relevant Finding)	section/entry[meds]	A section entry (section/entry[meds]) <b>SHALL</b> be instantiated as an: <ul style="list-style-type: none"> <li>act (section/entry[meds]/act) conforming to <a href="#">substanceAdministration (Summary Statement of Known Medicine)</a>, or</li> <li>observation (section/entry[meds]/observation) conforming to <a href="#">observation (Assertion of No Relevant Finding)</a> asserting that there are no known current medications (observation/value/@code="1234391000168107")</li> </ul>
section > <b>emptyReason</b>	If the section is empty, why the list is empty. An empty section typically has some text explaining the empty reason.	0..1	<a href="#">CodeableConcept</a>	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="2.16.840.1.113883.5.4"	<a href="#">v3 Code System ActCode</a>
				section/entry[meds_empty]/observation/code/@displayName	displayName <b>SHOULD</b> be "Assertion".
				section/entry[meds_empty]/observation/value	value/@xsi:type <b>SHALL</b> be "CD".  value/originalText or value/@displayName <b>SHALL</b> be included.  <a href="#">Health Summary Non-Clinical Empty Reason (required)</a>

<sup>1</sup>This value set differs from the value set bound to status in the Agency logical model (see [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#)) due to pre-adoption of FHIR Release 4 terminology.



## 9 Participation CDA templates

This chapter defines the participation templates referenced other templates such as those in [8 Section CDA templates](#) and [7 Document CDA templates](#).

### 9.1 recordTarget (My Health Record Patient)

This template is referenced by [ClinicalDocument \(Personal Health Notes\)](#), and [ClinicalDocument \(Personal Health Summary\)](#).

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	<a href="#">Patient</a>	recordTarget	recordTarget/patientRole/telecom <b>SHALL NOT</b> be present. recordTarget/patientRole/addr <b>SHALL NOT</b> 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 <b>SHALL</b> be present and it <b>SHALL</b> 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	<a href="#">Address</a>	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: <a href="#">Address</a>   <a href="#">AU Base Address</a> .
Patient > indigenous-status	National Health Data Dictionary (NHDD) based indigenous status for a patient.	1..1	<a href="#">Coding</a>	recordTarget/patientRole/patient/ethnicGroupCode	<a href="#">Australian Indigenous Status (required)</a>

Logical element	Logical element description	Logi- al 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-regis- tration	Indication for eligibility for the Closing the Gap program.	0..1	boolean	entry[close_gap]	The containing component[admin_obs]/section <b>SHALL</b> conform to the template defined in <a href="#">component (Administrative Observations)</a> .
				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"	<a href="#">NCTIS Data Components</a>
				entry[close_gap]/observation/code/@displayName	displayName <b>SHOULD</b> 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 <b>SHALL</b> be "BL".
Patient > patient-mothersMaid- enName	Mother's maiden (unmarried) name, commonly collected to help verify patient identity.	0..1	string	entry[mothers_name]	The containing component[admin_obs]/section <b>SHALL</b> conform to the template defined in <a href="#">component (Administrative Observations)</a> .
				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"	<a href="#">NCTIS Data Components</a>
				entry[mothers_name]/observation/code/@displayName	displayName <b>SHOULD</b> be "Mother's Original Family Name".
				entry[mothers_name]/observation/value	value/@xsi:type <b>SHALL</b> 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 <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .

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

Logical element	Logical element description	Logi- al card	Logical type	CDA schema element	CDA constraints and comments
CDA Header Data Elements				Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/	
Patient > birthDate > <b>date-accuracy-indicator</b>	General date accuracy indicator coding.	0..1	<a href="#">Coding</a>	entry[dob_acc]	The containing component[admin_obs]/section <b>SHALL</b> conform to the template defined in <a href="#">component (Administrative Observations)</a> .
				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"	<a href="#">NCTIS Data Components</a>
				entry[dob_acc]/observation/code/@displayName	displayName <b>SHOULD</b> be "Date of Birth Accuracy Indicator".
				entry[dob_acc]/observation/value	value/@xsi:type <b>SHALL</b> be "CD". <a href="#">Date Accuracy Indicator (required)</a>
CDA Header Data Elements				Context: /ClinicalDocument/	
Patient > birthDate > <b>patient-birthTime</b>	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	<a href="#">dateTime</a>	n/a	Not mapped separately, encompassed in patientRole/patient/birthTime.
Patient > <b>deceased[x]</b>	Indicates if the individual is deceased or not. Deceased date accuracy indicator is optional.	0..1	<a href="#">boolean</a>   <a href="#">dateTime</a>	recordTarget/patientRole/patient/ext:deceasedInd	Only one of ext:deceasedInd or ext:deceasedTime <b>SHOULD</b> be instantiated.
				recordTarget/patientRole/patient/ext:deceasedTime	
CDA Header Data Elements				Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/	
Patient > deceased[x] > <b>date-accuracy-indicator</b>	General date accuracy indicator coding.	0..1	<a href="#">Coding</a>	entry[dod_acc]	The containing component[admin_obs]/section <b>SHALL</b> conform to the template defined in <a href="#">component (Administrative Observations)</a> .
				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"	<a href="#">NCTIS Data Components</a>
				entry[dod_acc]/observation/code/@displayName	displayName <b>SHOULD</b> be "Date of Death Accuracy Indicator".
				entry[dod_acc]/observation/value	value/@xsi:type <b>SHALL</b> be "CD". <a href="#">Date Accuracy Indicator (required)</a>



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

<sup>1</sup>This 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.

## 9.2 participant (Patient contact)

This template is referenced by [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 > <b>contact</b>	A contact party (e.g. guardian, partner, friend) for the patient.	Cardinality comes from linking element	<a href="#">BackboneElement</a>	<b>participant[pat_contact]</b>	The patient's contact <b>SHALL</b> have at least: <ul style="list-style-type: none"> <li>name (participant[pat_contact]/associatedEntity/associatedPerson/name), or</li> <li>telecom (participant[pat_contact]/associatedEntity/telecom), or</li> <li>address (participant[pat_contact]/associatedEntity/address), or</li> <li>organization (participant[pat_contact]/associatedEntity/scopingOrganization)</li> </ul>
				participant[pat_contact]/@typeCode="IND"	
				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 > <b>relationship</b>	The nature of the relationship between the patient and the contact person.	0..*	<a href="#">CodeableConcept</a>	participant[pat_contact]/associatedEntity/associatedPerson/ext:personalRelationship	The common pattern <a href="#">Personal Relationship</a> <b>SHALL</b> be applied.
				participant[pat_contact]/associatedEntity/associatedPerson/ext:personalRelationship/ext:code	ext:code/originalText or ext:code/@displayName <b>SHALL</b> be included. <a href="#">Contact Relationship Type (extensible)</a>
Patient > contact > <b>name</b>	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: <a href="#">Base HumanName</a> .

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

<sup>1</sup>This 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.

## 9.3 participant (Organization contact)

This template is referenced by [participant \(generalPractitioner Base Organization\)](#), [custodian \(Organization with Mandatory Identifier\)](#), [providerOrganization \(Base Organization\)](#), [represente-dOrganization \(Base Organization\)](#), [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 > <b>contact</b>	Contact for the organization for a certain purpose.	Cardinality comes from linking element	<a href="#">Organization</a>	<b>participant[org_contact]</b>	
				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 <b>SHALL</b> hold the same value as the organization this is a contact for (the value in this id element <b>SHALL</b> be present in a separate participation).  id/@root <b>SHALL</b> be present and it <b>SHALL</b> be a UUID or an OID.
Organization > contact > <b>purpose</b>	Indicates a purpose for which the contact can be reached.	0..1	<a href="#">CodeableConcept</a>	participant[org_contact]/associatedEntity/code	code/originalText or code/@displayName <b>SHALL</b> be included.  <a href="#">Contact entity type (extensible)</a> <sup>1</sup>
Organization > contact > <b>name</b>	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: <a href="#">Base HumanName</a> .
Organization > contact > <b>telecom</b>	A contact detail (e.g. a telephone number or an email address) by which the party may be contacted.	0..*	<a href="#">ContactPoint</a>	participant[org_contact]/associatedEntity/telecom	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">ContactPoint</a> .

Logical element	Logical element descrip- tion	Logical card	Logical type	CDA schema element	CDA constraints and comments
Organization > contact > <b>address</b>	Visiting or postal addresses for the contact.	0..1	<a href="#">Address</a>	participant[org_contact]/associatedEntity/ <b>addr</b>	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Address</a>   <a href="#">AU Base Address</a> .

<sup>1</sup>This value set differs from the value set bound to contact purpose in the Agency logical model (see [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#)) due to pre-adoption of FHIR Release 4 terminology.

## 9.4 participant (generalPractitioner Base Organization)

This template is referenced by [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/	
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	<a href="#">Organization</a>	participant[gen_prac]	Organization <b>SHALL</b> have at least: <ul style="list-style-type: none"> <li>identifier (participant[gen_prac]/associatedEntity/scopingOrganization/ext:asEntityIdentifier), or</li> <li>name (participant[gen_prac]/associatedEntity/scopingOrganization/name)</li> </ul>
				participant[gen_prac]/@typeCode="PART"	
				participant[gen_prac]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				participant[gen_prac]/templateId/@root="1.2.36.1.2001.1001.102.101.100036"	
				participant[gen_prac]/functionCode/@code="PCP"	
				participant[gen_prac]/associatedEntity	
				participant[gen_prac]/associatedEntity/@classCode="PROV"	
				participant[gen_prac]/associatedEntity/id	id/@root <b>SHALL</b> be present and it <b>SHALL</b> be a UUID or an OID.
Organization > <b>identifier</b>	Identifier for the organization that is used to identify the organization across multiple disparate systems.	0..*	<a href="#">Identifier</a>	participant[gen_prac]/associatedEntity/scopingOrganization/ext:asEntityIdentifier	The common pattern <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
Organization > <b>active</b>	Whether the organization's record is still in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
Organization > <b>type</b>	The kind(s) of organization that this is.	0..*	<a href="#">CodeableConcept</a>	participant[gen_prac]/associatedEntity/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/originalText or code/@displayName <b>SHALL</b> be included.  <a href="#">OrganizationType (example)</a>

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

<sup>1</sup>This 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.

<sup>2</sup>This 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.

## 9.5 participant (generalPractitioner Base Practitioner)

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



Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Practitioner > <b>telecom</b>	A contact detail for the practitioner, e.g. a telephone number or an email address.	0..*	<a href="#">ContactPoint</a>	participant[gen_prac]/associatedEntity/ <b>telecom</b>	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">ContactPoint</a> .
Practitioner > <b>address</b>	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..*	<a href="#">Address</a>	participant[gen_prac]/associatedEntity/ <b>addr</b>	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Address</a>   <a href="#">AU Base Address</a> .
Practitioner > <b>gender</b>	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	<a href="#">code</a>	n/a	This logical element has no mapping to CDA.
Practitioner > <b>birthDate</b>	The date of birth for the practitioner.	0..1	<a href="#">date</a>	n/a	This logical element has no mapping to CDA.
Practitioner > <b>qualification</b>	Qualifications obtained by training and certification.	0..*	<a href="#">BackboneElement</a>	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><b>instantiation choices:</b></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 <a href="#">Qualification</a> <b>SHALL</b> 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 <b>SHALL</b> conform to the template defined in <a href="#">ext:coverage2 (Practitioner qualification)</a>.</p>
Practitioner > <b>communication</b>	A language the practitioner is able to use in patient communication.	0..*	<a href="#">CodeableConcept</a>	participant[gen_prac]/associatedEntity/associatedPerson/ <b>ext:languageCommunication</b>	The common pattern <a href="#">Language Communication</a> <b>SHALL</b> be applied.

## 9.6 author (My Health Record Patient)

This template is referenced by [ClinicalDocument \(Personal Health Notes\)](#), and [ClinicalDocument \(Personal Health Summary\)](#).

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	
<b>Patient</b>	Demographics and other administrative information about an individual receiving care or other health-related services.	Cardinality comes from linking element	<a href="#">Patient</a>	<b>author</b>	author/assignedAuthor/telecom <b>SHALL NOT</b> be present. author/assignedAuthor/addr <b>SHALL NOT</b> be present.
				author/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				author/templateId/@root="1.2.36.1.2001.1001.102.101.100029"	
				author/assignedAuthor	
				author/assignedAuthor/id	author (patient) is represented in CDA by an author with the same id as the patient that is the subject of this document. This id <b>SHALL</b> hold the same value as patientRole/id.
				author/assignedAuthor/code	
				author/assignedAuthor/code/@code="ONESELF"	
				author/assignedAuthor/code/@codeSystem="2.16.840.1.113883.5.111"	<a href="#">v3 Code System RoleCode</a>
				author/assignedAuthor/assignedPerson	
Patient > <b>birthPlace</b>	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	<a href="#">Address</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/birthPlace/place/addr.
Patient > <b>indigenous-status</b>	National Health Data Dictionary (NHDD) based indigenous status for a patient.	0..1	<a href="#">Coding</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ethnicGroupCode.
Patient > <b>closing-the-gap-registration</b>	Indication for eligibility for the Closing the Gap program.	0..1	<a href="#">boolean</a>	n/a	Not mapped directly for this participant; this is implicit in entry[close_gap]/observation/value.
Patient > <b>patient-mothersMaiden-Name</b>	Mother's maiden (unmarried) name, commonly collected to help verify patient identity.	0..1	<a href="#">string</a>	n/a	Not mapped directly for this participant; this is implicit in entry[mothers_name]/observation/value.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Patient > <b>identifier</b>	An identifier for this patient.	1..*	<a href="#">Identifier</a>	author/assignedAuthor/assignedPerson/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 <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
Patient > <b>identifier (National Individual Healthcare Identifier (IHI))</b>	National Healthcare Identifier (IHI) for the patient.	1..1	<a href="#">Identifier</a>	author/assignedAuthor/assignedPerson/ext:asEntityIdentifier[ihi]	In CDA, an Individual Healthcare Identifier (IHI) is sent as the last arc of an OID.
				author/assignedAuthor/assignedPerson/ext:asEntityIdentifier[ihi]/@classCode="IDENT"	For example an IHI of 8003608833357361 would be sent as 1.2.36.1.2001.1003.0.8003608833357361.  If present, ext:asEntityIdentifier[ihi]/ext:assigningGeographicArea/ext:name <b>SHALL</b> be "National Identifier".
				author/assignedAuthor/assignedPerson/ext:asEntityIdentifier[ihi]/ext:id	ext:id/@extension <b>SHALL NOT</b> be present.
				author/assignedAuthor/assignedPerson/ext:asEntityIdentifier[ihi]/ext:id/@root	root <b>SHALL</b> be an OID.  root <b>SHALL</b> 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 <b>SHALL</b> be "800360".  The IHI value (last arc of the root OID) <b>SHALL</b> pass the Luhn algorithm check.
				author/assignedAuthor/assignedPerson/ext:asEntityIdentifier[ihi]/ext:id/@assigningAuthorityName="IHI"	
Patient > <b>active</b>	Whether this patient record is in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
Patient > <b>name</b>	A name associated with the individual.	1..*	Base HumanName	author/assignedAuthor/assignedPerson/name	The model Base HumanName is not applied to name.  At least one name <b>SHALL</b> contain a family name (name/family).  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Base HumanName</a> .
Patient > <b>gender</b>	Administrative Gender - the gender that the patient is considered to have for administration and record keeping purposes.	0..1	<a href="#">code</a>	author/assignedAuthor/assignedPerson/ext:administrativeGenderCode	<a href="#">AdministrativeGender (required)</a> <sup>1</sup>
Patient > <b>birthDate</b>	The date of birth for the individual.	0..1	<a href="#">date</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/birthTime.
Patient > <b>deceased[x]</b>	Indicates if the individual is deceased or not. Deceased date accuracy indicator is optional.	0..1	<a href="#">boolean</a>   <a href="#">dateTime</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ext:deceasedTime or patientRole/patient/ext:deceasedInd.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Patient > <b>maritalStatus</b>	This field contains a patient's most recent marital (civil) status.	0..1	<a href="#">CodeableConcept</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/maritalStatusCode.
Patient > <b>multipleBirth[x]</b>	Indicates whether the patient is part of a multiple (bool) or indicates the actual birth order (integer).	0..1	<a href="#">boolean</a>   <a href="#">integer</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ext:multipleBirthInd or patientRole/patient/multipleBirthOrderNumber.
Patient > <b>contact</b>	A contact party (e.g. guardian, partner, friend) for the patient.	0..*	<a href="#">BackboneElement</a>	n/a	This logical element has no mapping to CDA.
Patient > <b>communication</b>	Languages which may be used to communicate with the patient about his or her health.	0..*	<a href="#">BackboneElement</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/languageCommunication.
Patient > <b>generalPractitioner</b>	Patient's nominated care provider.	0..*	<a href="#">Reference</a> (Base Organization   Base Practitioner)	n/a	This logical element has no mapping to CDA.
Patient > <b>managingOrganization</b>	Organization that is the custodian of the patient record.	0..1	<a href="#">Reference</a> (Base Organization)	n/a	This logical element has no mapping to CDA.

<sup>1</sup>This 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.

## 9.7 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	<a href="#">Organization</a>	participant[aut]	Organization <b>SHALL</b> have at least: <ul style="list-style-type: none"> <li>identifier (participant[aut]/participantRole/scopingEntity/ext:asEntityIdentifier), or</li> <li>name (participant[aut]/participantRole/scopingEntity/ext:name)</li> </ul>
				participant[aut]/@typeCode="AUT"	
				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 <b>SHALL</b> be "ASSIGNED".
				participant[aut]/participantRole/id	id/@root <b>SHALL</b> be present and it <b>SHALL</b> 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..*	<a href="#">Identifier</a>	participant[aut]/participantRole/scopingEntity/ext:asEntityIdentifier	When sending to the My Health Record, an HPI-O is expected.  The common pattern <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
Organization > active	Whether the organization's record is still in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
Organization > type	The kind(s) of organization that this is.	0..*	<a href="#">CodeableConcept</a>	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 <b>SHALL</b> be included.  <a href="#">OrganizationType (example)</a>
Organization > name	A name associated with the organization.	0..1	<a href="#">string</a>	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..*	<a href="#">string</a>	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 > <b>telecom</b>	A contact detail for the organization.	0..*	<a href="#">ContactPoint</a>	participant[aut]/participantRole/ <b>telecom</b>	telecom/@use <a href="#">Organization Telecom Use HL7 V3 (required)</a> <sup>1</sup> .  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">ContactPoint</a> .
Organization > <b>address</b>	An address for the organization.	0..*	<a href="#">Address</a>	participant[aut]/participantRole/ <b>addr</b>	addr/@use <a href="#">Organization Address Use HL7 V3 (required)</a> <sup>2</sup> .  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Address</a>   <a href="#">AU Base Address</a> .
Organization > <b>partOf</b>	The organization of which this organization forms a part.	0..1	<a href="#">Reference</a> (Base Organization)	participant[aut]/participantRole/scopingEntity/ <b>ext:asOrganizationPartOf</b>	Organization partOf <b>SHALL</b> have at least:
				participant[aut]/participantRole/scopingEntity/ ext:asOrganizationPartOf/ <b>ext:wholeEntity</b>	<ul style="list-style-type: none"> <li>an identifier (ext:asOrganizationPartOf/ext:wholeEntity/ext:asEntityIdentifier), or</li> <li>a name (ext:asOrganizationPartOf/ext:wholeEntity/ext:name)</li> </ul>
				participant[aut]/participantRole/scopingEntity/ext:asOrganizationPartOf/ ext:wholeEntity/ <b>ext:id</b>	id/@root <b>SHALL</b> be present and it <b>SHALL</b> be a UUID or an OID.
				participant[aut]/participantRole/scopingEntity/ext:asOrganizationPartOf/ ext:wholeEntity/ <b>ext:code</b>	In this template the cardinality of ext:wholeEntity/ext:code <b>SHALL</b> be interpreted as 0..1.  ext:code/originalText or ext:code/displayName <b>SHALL</b> be included.  <a href="#">OrganizationType (example)</a>
				participant[aut]/participantRole/scopingEntity/ext:asOrganizationPartOf/ ext:wholeEntity/ <b>ext:name</b>	In this template the cardinality of ext:wholeEntity/ext:name <b>SHALL</b> be interpreted as 0..*.
				participant[aut]/participantRole/scopingEntity/ext:asOrganizationPartOf/ ext:wholeEntity/ <b>ext:telecom</b>	In this template the cardinality of ext:wholeEntity/ext:telecom <b>SHALL</b> be interpreted as 0..*.  ext:telecom/@use <a href="#">Organization Telecom Use HL7 V3 (required)</a> <sup>3</sup> .  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">ContactPoint</a> .
				participant[aut]/participantRole/scopingEntity/ext:asOrganizationPartOf/ ext:wholeEntity/ <b>ext:addr</b>	In this template the cardinality of ext:wholeEntity/ext:addr <b>SHALL</b> be interpreted as 0..*.  ext:addr/@use <a href="#">Organization Address Use HL7 V3 (required)</a> <sup>4</sup> .  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Address</a>   <a href="#">AU Base Address</a> .
				participant[aut]/participantRole/scopingEntity/ext:asOrganizationPartOf/ ext:wholeEntity/ <b>ext:asEntityIdentifier</b>	In this template the cardinality of ext:wholeEntity/ext:asEntityIdentifier <b>SHALL</b> be interpreted as 0..*.  The common pattern <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .

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

<sup>1</sup>This 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.

<sup>2</sup>This 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.

<sup>3</sup>This 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.

<sup>4</sup>This 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.

## 9.8 author (Base Patient)

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	
<b>Patient</b>	Demographics and other administrative information about an individual receiving care or other health-related services.	Cardinality comes from linking element	<a href="#">Patient</a>	<b>author</b>	Patient <b>SHALL</b> have at least: <ul style="list-style-type: none"> <li>name (author/assignedAuthor/assignedPerson/name), or</li> <li>identifier (author/assignedAuthor/assignedPerson/ext:asEntityIdentifier)</li> </ul>
				author/templatedId	The use of templatedId signals the imposition of a set of template-defined constraints.
				author/templatedId/@root="1.2.36.1.2001.1001.102.101.100084"	
				author/assignedAuthor	
				author/assignedAuthor/id	author (patient) is represented in CDA by an author with the same id as the patient that is the subject of this document.  This id <b>SHALL</b> hold the same value as patientRole/id.
				author/assignedAuthor/code	
				author/assignedAuthor/code/@code="ONESELF"	
				author/assignedAuthor/code/@codeSystem="2.16.840.1.113883.5.111"	<a href="#">v3 Code System RoleCode</a>
				author/assignedAuthor/assignedPerson	
Patient > <b>birthPlace</b>	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	<a href="#">Address</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/birthPlace/place/addr.
Patient > <b>indigenous-status</b>	National Health Data Dictionary (NHDD) based indigenous status for a patient.	0..1	<a href="#">Coding</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ethnicGroupCode.
Patient > <b>closing-the-gap-registration</b>	Indication for eligibility for the Closing the Gap program.	0..1	<a href="#">boolean</a>	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 > <b>patient-mothersMaiden-Name</b>	Mother's maiden (unmarried) name, commonly collected to help verify patient identity.	0..1	<a href="#">string</a>	n/a	Not mapped directly for this participant; this is implicit in entry[mothers_name]/observation/value.
Patient > <b>identifier</b>	An identifier for this patient.	1..*	<a href="#">Identifier</a>	author/assignedAuthor/assignedPerson/ <b>ext:asEntityIdentifier</b>	When sending to the My Health Record, an IHI is expected.  The common pattern <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.  Recommended mappings for the complex data type to CDA (R2): <a href="#">Identifier</a> .
Patient > <b>active</b>	Whether this patient record is in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
Patient > <b>name</b>	A name associated with the individual.	0..*	Base HumanName	author/assignedAuthor/assignedPerson/ <b>name</b>	The model Base HumanName is not applied to name.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Base HumanName</a> .
Patient > <b>telecom</b>	A contact detail (e.g. a telephone number or an email address) by which the individual may be contacted.	0..*	<a href="#">ContactPoint</a>	author/assignedAuthor/ <b>telecom</b>	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: <a href="#">ContactPoint</a> .
Patient > <b>gender</b>	Administrative Gender - the gender that the patient is considered to have for administration and record keeping purposes.	0..1	<a href="#">code</a>	author/assignedAuthor/assignedPerson/ <b>ext:administrativeGenderCode</b>	<a href="#">AdministrativeGender</a> (required) <sup>1</sup>
Patient > <b>birthDate</b>	The date of birth for the individual.	0..1	<a href="#">date</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/birthTime.
Patient > <b>deceased[x]</b>	Indicates if the individual is deceased or not. Deceased date accuracy indicator is optional.	0..1	<a href="#">boolean</a>   <a href="#">dateTime</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ext:deceasedTime or patientRole/patient/ext:deceasedInd.
Patient > <b>address</b>	Addresses for the individual.	0..*	<a href="#">Address</a>	author/assignedAuthor/ <b>addr</b>	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: <a href="#">Address</a>   <a href="#">AU Base Address</a> .
Patient > <b>maritalStatus</b>	This field contains a patient's most recent marital (civil) status.	0..1	<a href="#">CodeableConcept</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/maritalStatusCode.
Patient > <b>multipleBirth[x]</b>	Indicates whether the patient is part of a multiple (bool) or indicates the actual birth order (integer).	0..1	<a href="#">boolean</a>   <a href="#">integer</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ext:multipleBirthInd or patientRole/patient/multipleBirthOrderNumber.
Patient > <b>contact</b>	A contact party (e.g. guardian, partner, friend) for the patient.	0..*	<a href="#">BackboneElement</a>	n/a	This logical element has no mapping to CDA.
Patient > <b>communication</b>	Languages which may be used to communicate with the patient about his or her health.	0..*	<a href="#">BackboneElement</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/languageCommunication.
Patient > <b>generalPractitioner</b>	Patient's nominated care provider.	0..*	<a href="#">Reference</a> (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 > <b>managingOrganization</b>	Organization that is the custodian of the patient record.	0..1	<a href="#">Reference</a> (Base Organization)	n/a	This logical element has no mapping to CDA.

<sup>1</sup>This 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.

## 9.9 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	
<b>RelatedPerson</b>	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	<a href="#">RelatedPerson</a>	<b>author</b>	
				author/ <b>templateId</b>	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 <b>SHALL</b> be present and it <b>SHALL</b> 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"	<a href="#">v3 Code System RoleClass</a>
				author/assignedAuthor/assignedPerson	
RelatedPerson > <b>identifier</b>	Identifier for a person within a particular scope.	1..*	<a href="#">Identifier</a>	author/assignedAuthor/assignedPerson/ext:asEntityIdentifier	The common pattern <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
RelatedPerson > <b>active</b>	Whether this related person record is in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
RelatedPerson > <b>patient</b>	The patient this person is related to.	1..1	<a href="#">Reference</a> (Base Patient)	n/a	Not mapped directly for this participant; this is implicit in patientRole.
RelatedPerson > <b>relationship</b>	The nature of the relationship between a patient and the related person.	0..1	<a href="#">CodeableConcept</a>	author/assignedAuthor/assignedPerson/ext:personalRelationship	The common pattern <a href="#">Personal Relationship</a> <b>SHALL</b> be applied.
				author/assignedAuthor/assignedPerson/ext:personalRelationship/ext:code	ext:code/originalText or ext:code/@displayName <b>SHALL</b> be included.  <a href="#">Related Person Relationship Type</a> (extensible)

Logical element	Logical element description	Logic- al card	Logical type	CDA schema element	CDA constraints and comments
RelatedPerson > <b>name</b>	A name associated with the person.	0..*	Base HumanName	author/assignedAuthor/assignedPerson/ <b>name</b>	The model Base HumanName is not applied to name.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Base HumanName</a> .
RelatedPerson > <b>telecom</b>	A contact detail for the person, e.g. a telephone number or an email address.	0..*	<a href="#">ContactPoint</a>	author/assignedAuthor/ <b>telecom</b>	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">ContactPoint</a> .
RelatedPerson > <b>gender</b>	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	<a href="#">code</a>	author/assignedAuthor/assignedPerson/ <b>ext:administrativeGenderCode</b>	<a href="#">AdministrativeGender (required)</a> <sup>1</sup>
RelatedPerson > <b>birthDate</b>	The date on which the related person was born.	0..1	<a href="#">date</a>	author/assignedAuthor/assignedPerson/ <b>ext:birthTime</b>	
RelatedPerson > <b>address</b>	Address where the related person can be contacted or visited.	0..*	<a href="#">Address</a>	author/assignedAuthor/ <b>addr</b>	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Address</a>   <a href="#">AU Base Address</a> .
RelatedPerson > <b>period</b>	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	<a href="#">Period</a>	n/a	Not mapped separately, implicit in ext:personalRelationship/ext:effectiveTime.

<sup>1</sup>This 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.

## 9.10 author (RelatedPerson with Mandatory IHI)

This template is referenced by [ClinicalDocument \(Personal Health Notes\)](#), and [ClinicalDocument \(Personal Health Summary\)](#).

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	
<b>RelatedPerson</b>	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	<a href="#">RelatedPerson</a>	<b>author</b>	
				author/ <b>templateId</b>	The use of templateId signals the imposition of a set of template-defined constraints.
				author/templateId/@root="1.2.36.1.2001.1001.102.101.100030"	
				author/assignedAuthor	
				author/assignedAuthor/id	id/@root <b>SHALL</b> be present and it <b>SHALL</b> 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"	<a href="#">v3 Code System RoleClass</a>
				author/assignedAuthor/assignedPerson	
RelatedPerson > <b>identifier</b>	Identifier for a person within a particular scope.	1..*	<a href="#">Identifier</a>	author/assignedAuthor/assignedPerson/ext:asEntityIdentifier	<p>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]).</p> <p>The common pattern <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.</p> <p>Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a>.</p>

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
RelatedPerson > <b>identifier (National Individual Healthcare Identifier (IHI))</b>	National Healthcare Identifier (IHI) for the patient.	1..1	<a href="#">Identifier</a>	author/assignedAuthor/assignedPerson/ext:asEntityIdentifier[ihi]	<p>In CDA, an Individual Healthcare Identifier (IHI) is sent as the last arc of an OID.</p> <p>For example an IHI of 8003608833357361 would be sent as 1.2.36.1.2001.1003.0.8003608833357361.</p> <p>If present, ext:asEntityIdentifier[ihi]/ext:assigningGeographicArea/ext:name <b>SHALL</b> be "National Identifier".</p> <p>ext:id/@extension <b>SHALL NOT</b> be present.</p> <p>root <b>SHALL</b> be an OID.</p> <p>root <b>SHALL</b> have the OID arcs "1.2.36.1.2001.1003.0" preceding the IHI value.</p> <p>The IHI value (last arc of the root OID) prefix <b>SHALL</b> be "800360".</p> <p>The IHI value (last arc of the root OID) <b>SHALL</b> pass the Luhn algorithm check.</p>
				author/assignedAuthor/assignedPerson/ext:asEntityIdentifier[ihi]/@classCode="IDENT"	
				author/assignedAuthor/assignedPerson/ext:asEntityIdentifier[ihi]/ext:id	
				author/assignedAuthor/assignedPerson/ext:asEntityIdentifier[ihi]/ext:id/@root	
				author/assignedAuthor/assignedPerson/ext:asEntityIdentifier[ihi]/ext:id/@assigningAuthorityName="IHI"	
RelatedPerson > <b>active</b>	Whether this related person record is in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
RelatedPerson > <b>patient</b>	The patient this person is related to.	1..1	<a href="#">Reference</a> (Base Patient)	n/a	Not mapped directly for this participant; this is implicit in patientRole.
RelatedPerson > <b>relationship</b>	The nature of the relationship between a patient and the related person.	0..1	<a href="#">CodeableConcept</a>	author/assignedAuthor/assignedPerson/ext:personalRelationship	The common pattern <a href="#">Personal Relationship</a> <b>SHALL</b> be applied.
				author/assignedAuthor/assignedPerson/ext:personalRelationship/ext:code	<p>ext:code/originalText or ext:code/@displayName <b>SHALL</b> be included.</p> <p><a href="#">Related Person Relationship Type (extensible)</a></p>
RelatedPerson > <b>name</b>	A name associated with the person.	0..*	Base HumanName	author/assignedAuthor/assignedPerson/name	<p>The model Base HumanName is not applied to name.</p> <p>Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Base HumanName</a>.</p>
RelatedPerson > <b>telecom</b>	A contact detail for the person, e.g. a telephone number or an email address.	0..*	<a href="#">ContactPoint</a>	author/assignedAuthor/telecom	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">ContactPoint</a> .
RelatedPerson > <b>gender</b>	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	<a href="#">code</a>	author/assignedAuthor/assignedPerson/ext:administrativeGenderCode	<a href="#">AdministrativeGender (required)</a> <sup>1</sup>
RelatedPerson > <b>birthDate</b>	The date on which the related person was born.	0..1	<a href="#">date</a>	author/assignedAuthor/assignedPerson/ext:birthTime	
RelatedPerson > <b>address</b>	Address where the related person can be contacted or visited.	0..*	<a href="#">Address</a>	author/assignedAuthor/addr	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Address</a>   <a href="#">AU Base Address</a> .

Logical element	Logical element description	Logic- al card	Logical type	CDA schema element	CDA constraints and comments
RelatedPerson > <b>period</b>	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	<a href="#">Period</a>	n/a	Not mapped separately, implicit in ext:personalRelationship/ext:effectiveTime.

<sup>1</sup>This 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.

## 9.11 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	
<b>PractitionerRole</b>	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	<a href="#">PractitionerRole</a>	<b>author</b>	PractitionerRole <b>SHALL</b> have at least: <ul style="list-style-type: none"> <li>practitioner role or practitioner identifier (author/assignedAuthor/assignedPerson/ext:asEntityIdentifier), or</li> <li>practitioner name (author/assignedAuthor/assignedPerson/name)</li> </ul>
				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 <b>SHALL</b> be present and it <b>SHALL</b> be a UUID or an OID.
PractitionerRole > <b>identifier</b>	Business identifiers for practitioner in a role.	0..*	<a href="#">Identifier</a>	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 <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
PractitionerRole > <b>active</b>	Whether this practitioner's record is in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
PractitionerRole > <b>period</b>	The period during which the person is authorized to act as a practitioner in these role(s) for the organization.	0..1	<a href="#">Period</a>	n/a	This logical element has no mapping to CDA.
PractitionerRole > <b>practitioner</b>	Practitioner that is able to provide the defined services for the organization.	0..1	<a href="#">Reference</a> (Base Practitioner)	author/assignedAuthor/assignedPerson	assignedPerson <b>SHALL</b> conform to the template defined in <a href="#">assignedPerson (Base Practitioner)</a> .
PractitionerRole > <b>organization</b>	The organization where the Practitioner performs the roles associated.	0..1	<a href="#">Reference</a> (Base Organization)	author/assignedAuthor/representedOrganization	representedOrganization <b>SHALL</b> conform to the template defined in <a href="#">representedOrganization (Base Organization)</a> .



Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
PractitionerRole > <b>code</b>	Roles which this practitioner is authorized to perform for the organization.	0..*	<a href="#">CodeableConcept</a>	author/assignedAuthor/ <b>code</b>	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.  <a href="#">Australian and New Zealand Standard Classification of Occupations (preferred)</a> or <a href="#">Practitioner Role (preferred)</a> <sup>1</sup>
PractitionerRole > <b>specialty</b>	Specific specialty of the practitioner.	0..*	<a href="#">CodeableConcept</a>	n/a	This logical element has no mapping to CDA.
PractitionerRole > <b>location</b>	The location(s) at which this practitioner provides care.	0..*	<a href="#">Reference(Location)</a>	n/a	This logical element has no mapping to CDA.
PractitionerRole > <b>healthcareService</b>	The list of healthcare services that this worker provides for this role's Organization/Location(s).	0..*	<a href="#">Reference(Health-careService)</a>	n/a	Not currently mapped to CDA. See <a href="#">Known issues</a> .
PractitionerRole > <b>telecom</b>	Contact details that are specific to the role/location/service.	0..*	<a href="#">ContactPoint</a>	author/assignedAuthor/ <b>telecom</b>	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: <a href="#">ContactPoint</a> .
PractitionerRole > <b>availableTime</b>	A collection of times that the Service Site is available.	0..*	<a href="#">BackboneElement</a>	n/a	This logical element has no mapping to CDA.
PractitionerRole > <b>notAvailable</b>	The HealthcareService is not available during this period of time due to the provided reason.	0..*	<a href="#">BackboneElement</a>	n/a	This logical element has no mapping to CDA.
PractitionerRole > <b>availabilityExceptions</b>	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	<a href="#">string</a>	n/a	This logical element has no mapping to CDA.

<sup>1</sup>Note: The source representation of this terminology binding on code in [\[DH2020g\]](#) 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.

## 9.12 custodian (Organization with Mandatory Identifier)

This template is referenced by [ClinicalDocument \(Personal Health Notes\)](#), and [ClinicalDocument \(Personal Health Summary\)](#).

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/	
<b>Organization</b>	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	<a href="#">Organization</a>	<b>custodian</b>	
				custodian/ <b>templateId</b>	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/ <b>assignedCustodian</b>	
				custodian/assignedCustodian/ <b>representedCustodianOrganization</b>	
				custodian/assignedCustodian/representedCustodianOrganization/ <b>id</b>	id/@root <b>SHALL</b> be present and it <b>SHALL</b> be a UUID or an OID.
Organization > <b>identifier</b>	Identifier for the organization that is used to identify the organization across multiple disparate systems.	1..*	<a href="#">Identifier</a>	custodian/assignedCustodian/representedCustodianOrganization/ <b>ext:asEntityIdentifier</b>	When sending to the My Health Record, an HPI-O is expected.  The common pattern <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
Organization > <b>active</b>	Whether the organization's record is still in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
Organization > <b>type</b>	The kind(s) of organization that this is.	0..*	<a href="#">CodeableConcept</a>	n/a	This logical element has no mapping to CDA.
Organization > <b>name</b>	A name associated with the organization.	0..1	<a href="#">string</a>	custodian/assignedCustodian/representedCustodianOrganization/ <b>name</b>	
Organization > <b>alias</b>	A list of alternate names that the organization is known as, or was known as in the past.	0..*	<a href="#">string</a>	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 > <b>telecom</b>	A contact detail for the organization.	0..*	<a href="#">ContactPoint</a>	custodian/assignedCustodian/representedCustodianOrganization/ <b>telecom</b>	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 <a href="#">Organization Telecom Use HL7 V3 (required)</a> <sup>1</sup> .  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">ContactPoint</a> .
Organization > <b>address</b>	An address for the organization.	0..*	<a href="#">Address</a>	custodian/assignedCustodian/representedCustodianOrganization/ <b>addr</b>	addr/@use <a href="#">Organization Address Use HL7 V3 (required)</a> <sup>2</sup> .  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: <a href="#">Address</a>   <a href="#">AU Base Address</a> .
Organization > <b>partOf</b>	The organization of which this organization forms a part.	0..1	<a href="#">Reference</a> (Base Organization)	n/a	This logical element has no mapping to CDA.
Organization > <b>contact</b>	Contact for the organization for a certain purpose.	0..*	<a href="#">BackboneElement</a>	<b>participant[org_contact]</b>	participant[org_contact] <b>SHALL</b> conform to the template defined in <a href="#">participant (Organization contact)</a> .

<sup>1</sup>This 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.

<sup>2</sup>This 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.

## 9.13 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	<a href="#">Patient</a>	informant	Patient <b>SHALL</b> have at least: <ul style="list-style-type: none"> <li>name (informant/assignedEntity/assignedPerson/name), or</li> <li>identifier (informant/assignedEntity/assignedPerson/ext:asEntityIdentifier)</li> </ul>
				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 <b>SHALL</b> 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"	<a href="#">v3 Code System RoleCode</a>
				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	<a href="#">Address</a>	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	<a href="#">Coding</a>	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	<a href="#">boolean</a>	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 > <b>patient-mothersMaid-enName</b>	Mother's maiden (unmarried) name, commonly collected to help verify patient identity.	0..1	<a href="#">string</a>	n/a	Not mapped directly for this participant; this is implicit in entry[mothers_name]/observation/value.
Patient > <b>identifier</b>	An identifier for this patient.	0..*	<a href="#">Identifier</a>	informant/assignedEntity/assignedPerson/ <b>ext:asEntityIdentifier</b>	The common pattern <a href="#">Entity Identifier</a> SHALL be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
Patient > <b>active</b>	Whether this patient record is in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
Patient > <b>name</b>	A name associated with the individual.	0..*	Base HumanName	informant/assignedEntity/assignedPerson/ <b>name</b>	The model Base HumanName is not applied to name.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Base HumanName</a> .
Patient > <b>telecom</b>	A contact detail (e.g. a telephone number or an email address) by which the individual may be contacted.	0..*	<a href="#">ContactPoint</a>	informant/assignedEntity/ <b>telecom</b>	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: <a href="#">ContactPoint</a> .
Patient > <b>gender</b>	Administrative Gender - the gender that the patient is considered to have for administration and record keeping purposes.	0..1	<a href="#">code</a>	informant/assignedEntity/assignedPerson/ <b>ext:administrativeGenderCode</b>	<a href="#">AdministrativeGender (required)</a> <sup>1</sup>
Patient > <b>birthDate</b>	The date of birth for the individual.	0..1	<a href="#">date</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/birthTime.
Patient > <b>deceased[x]</b>	Indicates if the individual is deceased or not. Deceased date accuracy indicator is optional.	0..1	<a href="#">boolean</a>   <a href="#">dateTime</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ext:deceasedTime or patientRole/patient/ext:deceasedInd.
Patient > <b>address</b>	Addresses for the individual.	0..*	<a href="#">Address</a>	informant/assignedEntity/ <b>addr</b>	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: <a href="#">Address</a>   <a href="#">AU Base Address</a> .
Patient > <b>maritalStatus</b>	This field contains a patient's most recent marital (civil) status.	0..1	<a href="#">CodeableConcept</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/maritalStatusCode.
Patient > <b>multipleBirth[x]</b>	Indicates whether the patient is part of a multiple (bool) or indicates the actual birth order (integer).	0..1	<a href="#">boolean</a>   <a href="#">integer</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ext:multipleBirthInd or patientRole/patient/multipleBirthOrderNumber.
Patient > <b>contact</b>	A contact party (e.g. guardian, partner, friend) for the patient.	0..*	<a href="#">BackboneElement</a>	n/a	This logical element has no mapping to CDA.
Patient > <b>communication</b>	Languages which may be used to communicate with the patient about his or her health.	0..*	<a href="#">BackboneElement</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/languageCommunication.
Patient > <b>generalPractitioner</b>	Patient's nominated care provider.	0..*	<a href="#">Reference</a> (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 > <b>managingOrganization</b>	Organization that is the custodian of the patient record.	0..1	<a href="#">Reference</a> (Base Or- ganization)	n/a	This logical element has no mapping to CDA.

<sup>1</sup>This 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.

## 9.14 informant (Base RelatedPerson)

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 elements	
<b>RelatedPerson</b>	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 element	<a href="#">RelatedPerson</a>	<b>informant</b>	RelatedPerson <b>SHALL</b> have at least: <ul style="list-style-type: none"> <li>name (informant/relatedEntity/relatedPerson/name), or</li> <li>identifier (informant/relatedEntity/relatedPerson/ext:asEntityIdentifier), or</li> <li>relationship (informant/relatedEntity/relatedPerson/ext:personalRelationship)</li> </ul>
				informant/ <b>templateId</b>	The use of templateId signals the imposition of a set of template-defined constraints.
				informant/templateId/@root="1.2.36.1.2001.1001.102.101.100052"	
				informant/ <b>relatedEntity</b>	
				informant/relatedEntity/@classCode="PRS"	
				informant/relatedEntity/code	The cardinality of code <b>SHALL</b> be interpreted as 0..1.
				informant/relatedEntity/relatedPerson	
RelatedPerson > <b>identifier</b>	Identifier for a person within a particular scope.	0..*	<a href="#">Identifier</a>	informant/relatedEntity/relatedPerson/ext:asEntityIdentifier	The common pattern <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
RelatedPerson > <b>active</b>	Whether this related person record is in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
RelatedPerson > <b>patient</b>	The patient this person is related to.	1..1	<a href="#">Reference</a> (Base Patient)	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient.
RelatedPerson > <b>relationship</b>	The nature of the relationship between a patient and the related person.	0..1	<a href="#">CodeableConcept</a>	informant/relatedEntity/relatedPerson/ext:personalRelationship	The common pattern <a href="#">Personal Relationship</a> <b>SHALL</b> be applied.
				informant/relatedEntity/relatedPerson/ext:personalRelationship/ext:code	ext:code/originalText or ext:code/@displayName <b>SHALL</b> be included.  <a href="#">Related Person Relationship Type (extensible)</a>

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
RelatedPerson > <b>name</b>	A name associated with the person.	0..*	Base HumanName	informant/relatedEntity/relatedPerson/ <b>name</b>	The model Base HumanName is not applied to name.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Base HumanName</a> .
RelatedPerson > <b>telecom</b>	A contact detail for the person, e.g. a telephone number or an email address.	0..*	<a href="#">ContactPoint</a>	informant/relatedEntity/ <b>telecom</b>	
RelatedPerson > <b>gender</b>	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	<a href="#">code</a>	informant/relatedEntity/relatedPerson/ <b>ext:administrativeGenderCode</b>	<a href="#">AdministrativeGender (required)</a> <sup>1</sup>
RelatedPerson > <b>birthDate</b>	The date on which the related person was born.	0..1	<a href="#">date</a>	informant/relatedEntity/relatedPerson/ <b>ext:birthTime</b>	
RelatedPerson > <b>address</b>	Address where the related person can be contacted or visited.	0..*	<a href="#">Address</a>	informant/relatedEntity/ <b>addr</b>	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Address</a>   <a href="#">AU Base Address</a> .
RelatedPerson > <b>period</b>	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	<a href="#">Period</a>	n/a	Not mapped separately, implicit in ext:personalRelationship/ext:effectiveTime.

<sup>1</sup>This 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.



## 9.15 informant (Base Practitioner)

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 elements	
Practitioner	A person who is directly or indirectly involved in the provisioning of healthcare.	Cardinality comes from linking element	<a href="#">Practitioner</a>	informant	Practitioner <b>SHALL</b> have at least: <ul style="list-style-type: none"><li>• identifier (informant/assignedEntity/assignedPerson/ext:asEntityIdentifier), or</li><li>• name (informant/assignedEntity/assignedPerson/name)</li></ul>
				informant/ <b>templateId</b>	The use of templateId signals the imposition of a set of template-defined constraints.
				informant/templateId/@root="1.2.36.1.2001.1001.102.101.100053"	
				informant/ <b>assignedEntity</b>	
				informant/assignedEntity/ <b>id</b>	id/@root <b>SHALL</b> be present and it <b>SHALL</b> be a UUID or an OID.
				informant/assignedEntity/ <b>code</b>	The cardinality of code <b>SHALL</b> be interpreted as 0..1. <a href="#">Australian and New Zealand Standard Classification of Occupations (preferred)</a>
				informant/assignedEntity/ <b>assignedPerson</b>	
Practitioner > <b>identifier</b>	An identifier that applies to this person in this role.	0..*	<a href="#">Identifier</a>	informant/assignedEntity/assignedPerson/ <b>ext:asEntityIdentifier</b>	The common pattern <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
Practitioner > <b>active</b>	Whether this practitioner's record is in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
Practitioner > <b>name</b>	The name(s) associated with the practitioner.	0..*	Base HumanName	informant/assignedEntity/assignedPerson/ <b>name</b>	The model Base HumanName is not applied to name.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Base HumanName</a> .
Practitioner > <b>telecom</b>	A contact detail for the practitioner, e.g. a telephone number or an email address.	0..*	<a href="#">ContactPoint</a>	informant/assignedEntity/ <b>telecom</b>	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">ContactPoint</a> .

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Practitioner > <b>address</b>	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..*	<a href="#">Address</a>	informant/assignedEntity/ <b>addr</b>	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Address</a>   <a href="#">AU Base Address</a> .
Practitioner > <b>gender</b>	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	<a href="#">code</a>	n/a	This logical element has no mapping to CDA.
Practitioner > <b>birthDate</b>	The date of birth for the practitioner.	0..1	<a href="#">date</a>	n/a	This logical element has no mapping to CDA.
Practitioner > <b>qualification</b>	Qualifications obtained by training and certification.	0..*	<a href="#">BackboneElement</a>	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><b>instantiation choices:</b></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 <a href="#">Qualification</a> <b>SHALL</b> 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 <b>SHALL</b> conform to the template defined in <a href="#">ext:coverage2 (Practitioner qualification)</a>:</p> <ul style="list-style-type: none"> <li>qualification for a Practitioner <b>SHALL</b> 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</li> <li>qualification for a CDA Header Practitioner (e.g. ClinicalDocument author) <b>SHALL</b> be instantiated as ClinicalDocument/component/structuredBody/component[admin_obs]/section/ext:coverage2[prac_qual]</li> </ul>
Practitioner > <b>communication</b>	A language the practitioner is able to use in patient communication.	0..*	<a href="#">CodeableConcept</a>	informant/assignedEntity/assignedPerson/ <b>ext:languageCommunication</b>	The common pattern <a href="#">Language Communication</a> <b>SHALL</b> be applied.

## 9.16 author (Base Patient)

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	
Patient	Demographics and other administrative information about an individual receiving care or other health-related services.	Cardinality comes from linking element	<a href="#">Patient</a>	author	Patient <b>SHALL</b> have at least: <ul style="list-style-type: none"> <li>name (author/assignedAuthor/assignedPerson/name), or</li> <li>identifier (author/assignedAuthor/assignedPerson/ext:asEntityIdentifier)</li> </ul>
				author/templatedId	The use of templatedId signals the imposition of a set of template-defined constraints.
				author/templatedId/@root="1.2.36.1.2001.1001.102.101.100084"	
				author/assignedAuthor	
				author/assignedAuthor/id	author (patient) is represented in CDA by an author with the same id as the patient that is the subject of this document.  This id <b>SHALL</b> hold the same value as patientRole/id.
				author/assignedAuthor/code	
				author/assignedAuthor/code/@code="ONESELF"	
				author/assignedAuthor/code/@codeSystem="2.16.840.1.113883.5.111"	<a href="#">v3 Code System RoleCode</a>
				author/assignedAuthor/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	<a href="#">Address</a>	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	<a href="#">Coding</a>	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	<a href="#">boolean</a>	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 > <b>patient-mothersMaiden-Name</b>	Mother's maiden (unmarried) name, commonly collected to help verify patient identity.	0..1	<a href="#">string</a>	n/a	Not mapped directly for this participant; this is implicit in entry[mothers_name]/observation/value.
Patient > <b>identifier</b>	An identifier for this patient.	1..*	<a href="#">Identifier</a>	author/assignedAuthor/assignedPerson/ <b>ext:asEntityIdentifier</b>	When sending to the My Health Record, an IHI is expected.  The common pattern <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.  Recommended mappings for the complex data type to CDA (R2): <a href="#">Identifier</a> .
Patient > <b>active</b>	Whether this patient record is in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
Patient > <b>name</b>	A name associated with the individual.	0..*	Base HumanName	author/assignedAuthor/assignedPerson/ <b>name</b>	The model Base HumanName is not applied to name.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Base HumanName</a> .
Patient > <b>telecom</b>	A contact detail (e.g. a telephone number or an email address) by which the individual may be contacted.	0..*	<a href="#">ContactPoint</a>	author/assignedAuthor/ <b>telecom</b>	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: <a href="#">ContactPoint</a> .
Patient > <b>gender</b>	Administrative Gender - the gender that the patient is considered to have for administration and record keeping purposes.	0..1	<a href="#">code</a>	author/assignedAuthor/assignedPerson/ <b>ext:administrativeGenderCode</b>	<a href="#">AdministrativeGender</a> (required) <sup>1</sup>
Patient > <b>birthDate</b>	The date of birth for the individual.	0..1	<a href="#">date</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/birthTime.
Patient > <b>deceased[x]</b>	Indicates if the individual is deceased or not. Deceased date accuracy indicator is optional.	0..1	<a href="#">boolean</a>   <a href="#">dateTime</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ext:deceasedTime or patientRole/patient/ext:deceasedInd.
Patient > <b>address</b>	Addresses for the individual.	0..*	<a href="#">Address</a>	author/assignedAuthor/ <b>addr</b>	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: <a href="#">Address</a>   <a href="#">AU Base Address</a> .
Patient > <b>maritalStatus</b>	This field contains a patient's most recent marital (civil) status.	0..1	<a href="#">CodeableConcept</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/maritalStatusCode.
Patient > <b>multipleBirth[x]</b>	Indicates whether the patient is part of a multiple (bool) or indicates the actual birth order (integer).	0..1	<a href="#">boolean</a>   <a href="#">integer</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ext:multipleBirthInd or patientRole/patient/multipleBirthOrderNumber.
Patient > <b>contact</b>	A contact party (e.g. guardian, partner, friend) for the patient.	0..*	<a href="#">BackboneElement</a>	n/a	This logical element has no mapping to CDA.
Patient > <b>communication</b>	Languages which may be used to communicate with the patient about his or her health.	0..*	<a href="#">BackboneElement</a>	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/languageCommunication.
Patient > <b>generalPractitioner</b>	Patient's nominated care provider.	0..*	<a href="#">Reference</a> (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 > <b>managingOrganization</b>	Organization that is the custodian of the patient record.	0..1	<a href="#">Reference</a> (Base Organization)	n/a	This logical element has no mapping to CDA.

<sup>1</sup>This 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.

## 9.17 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	
<b>PractitionerRole</b>	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	<a href="#">PractitionerRole</a>	<b>author</b>	PractitionerRole <b>SHALL</b> have at least: <ul style="list-style-type: none"> <li>practitioner role or practitioner identifier (author/assignedAuthor/assignedPerson/ext:asEntityIdentifier), or</li> <li>practitioner name (author/assignedAuthor/assignedPerson/name)</li> </ul>
				author/templated	The use of templated signals the imposition of a set of template-defined constraints.
				author/templated/@root="1.2.36.1.2001.1001.102.101.100085"	
				author/assignedAuthor	
				author/assignedAuthor/id	id/@root <b>SHALL</b> be present and it <b>SHALL</b> be a UUID or an OID.
PractitionerRole > <b>identifier</b>	Business identifiers for practitioner in a role.	0..*	<a href="#">Identifier</a>	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 <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
PractitionerRole > <b>active</b>	Whether this practitioner's record is in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
PractitionerRole > <b>period</b>	The period during which the person is authorized to act as a practitioner in these role(s) for the organization.	0..1	<a href="#">Period</a>	n/a	This logical element has no mapping to CDA.
PractitionerRole > <b>practitioner</b>	Practitioner that is able to provide the defined services for the organization.	0..1	<a href="#">Reference</a> (Base Practitioner)	author/assignedAuthor/assignedPerson	assignedPerson <b>SHALL</b> conform to the template defined in <a href="#">assignedPerson (Base Practitioner)</a> .
PractitionerRole > <b>organization</b>	The organization where the Practitioner performs the roles associated.	0..1	<a href="#">Reference</a> (Base Organization)	author/assignedAuthor/representedOrganization	representedOrganization <b>SHALL</b> conform to the template defined in <a href="#">representedOrganization (Base Organization)</a> .

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
PractitionerRole > <b>code</b>	Roles which this practitioner is authorized to perform for the organization.	0..*	<a href="#">CodeableConcept</a>	author/assignedAuthor/ <b>code</b>	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.  <a href="#">Australian and New Zealand Standard Classification of Occupations (preferred)</a> or <a href="#">Practitioner Role (preferred)</a> <sup>1</sup>
PractitionerRole > <b>specialty</b>	Specific specialty of the practitioner.	0..*	<a href="#">CodeableConcept</a>	n/a	This logical element has no mapping to CDA.
PractitionerRole > <b>location</b>	The location(s) at which this practitioner provides care.	0..*	<a href="#">Reference(Location)</a>	n/a	This logical element has no mapping to CDA.
PractitionerRole > <b>healthcareService</b>	The list of healthcare services that this worker provides for this role's Organization/Location(s).	0..*	<a href="#">Reference(Health-careService)</a>	n/a	Not currently mapped to CDA. See <a href="#">Known issues</a> .
PractitionerRole > <b>telecom</b>	Contact details that are specific to the role/location/service.	0..*	<a href="#">ContactPoint</a>	author/assignedAuthor/ <b>telecom</b>	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: <a href="#">ContactPoint</a> .
PractitionerRole > <b>availableTime</b>	A collection of times that the Service Site is available.	0..*	<a href="#">BackboneElement</a>	n/a	This logical element has no mapping to CDA.
PractitionerRole > <b>notAvailable</b>	The HealthcareService is not available during this period of time due to the provided reason.	0..*	<a href="#">BackboneElement</a>	n/a	This logical element has no mapping to CDA.
PractitionerRole > <b>availabilityExceptions</b>	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	<a href="#">string</a>	n/a	This logical element has no mapping to CDA.

<sup>1</sup>Note: The source representation of this terminology binding on code in [\[DH2020g\]](#) 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.

## 9.18 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	
<b>RelatedPerson</b>	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	<a href="#">RelatedPerson</a>	<b>author</b>	
				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 <b>SHALL</b> be present and it <b>SHALL</b> 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"	<a href="#">v3 Code System RoleClass</a>
				author/assignedAuthor/assignedPerson	
RelatedPerson > <b>identifier</b>	Identifier for a person within a particular scope.	1..*	<a href="#">Identifier</a>	author/assignedAuthor/assignedPerson/ext:asEntityIdentifier	The common pattern <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
RelatedPerson > <b>active</b>	Whether this related person record is in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
RelatedPerson > <b>patient</b>	The patient this person is related to.	1..1	<a href="#">Reference</a> (Base Patient)	n/a	Not mapped directly for this participant; this is implicit in patientRole.
RelatedPerson > <b>relationship</b>	The nature of the relationship between a patient and the related person.	0..1	<a href="#">CodeableConcept</a>	author/assignedAuthor/assignedPerson/ext:personalRelationship	The common pattern <a href="#">Personal Relationship</a> <b>SHALL</b> be applied.
				author/assignedAuthor/assignedPerson/ext:personalRelationship/ext:code	ext:code/originalText or ext:code/@displayName <b>SHALL</b> be included.  <a href="#">Related Person Relationship Type</a> (extensible)



Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
RelatedPerson > <b>name</b>	A name associated with the person.	0..*	Base HumanName	author/assignedAuthor/assignedPerson/ <b>name</b>	The model Base HumanName is not applied to name.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Base HumanName</a> .
RelatedPerson > <b>telecom</b>	A contact detail for the person, e.g. a telephone number or an email address.	0..*	<a href="#">ContactPoint</a>	author/assignedAuthor/ <b>telecom</b>	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">ContactPoint</a> .
RelatedPerson > <b>gender</b>	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	<a href="#">code</a>	author/assignedAuthor/assignedPerson/ <b>ext:administrativeGenderCode</b>	<a href="#">AdministrativeGender (required)</a> <sup>1</sup>
RelatedPerson > <b>birthDate</b>	The date on which the related person was born.	0..1	<a href="#">date</a>	author/assignedAuthor/assignedPerson/ <b>ext:birthTime</b>	
RelatedPerson > <b>address</b>	Address where the related person can be contacted or visited.	0..*	<a href="#">Address</a>	author/assignedAuthor/ <b>addr</b>	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Address</a>   <a href="#">AU Base Address</a> .
RelatedPerson > <b>period</b>	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	<a href="#">Period</a>	n/a	Not mapped separately, implicit in ext:personalRelationship/ext:effectiveTime.

<sup>1</sup>This 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.



# 10 Entity CDA templates

This chapter contains the entity templates referenced by a participation template in [9 Participation CDA templates](#).

## 10.1 providerOrganization (Base Organization)

This template is referenced by [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	<a href="#">Organization</a>	providerOrganization	Organization <b>SHALL</b> have at least: <ul style="list-style-type: none"> <li>• identifier (providerOrganization/ext:asEntityIdentifier), or</li> <li>• name (providerOrganization/name)</li> </ul>
				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 <b>SHALL</b> be present and it <b>SHALL</b> be a UUID or an OID.
Organization > identifier	Identifier for the organization that is used to identify the organization across multiple disparate systems.	0..*	<a href="#">Identifier</a>	providerOrganization/ext:asEntityIdentifier	The common pattern <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
Organization > active	Whether the organization's record is still in active use.	0..1	<a href="#">boolean</a>	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 > <b>type</b>	The kind(s) of organization that this is.	0..*	<a href="#">CodeableConcept</a>	providerOrganization/ <b>standardIndustryClassCode</b>	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 <b>SHALL</b> be included.  <a href="#">OrganizationType</a> (example)
Organization > <b>name</b>	A name associated with the organization.	0..1	<a href="#">string</a>	providerOrganization/ <b>name[org_name]</b>	In CDA name and alias are represented by providerOrganization/name.
Organization > <b>alias</b>	A list of alternate names that the organization is known as, or was known as in the past.	0..*	<a href="#">string</a>	providerOrganization/ <b>name[alias]</b>	In CDA name and alias are represented by providerOrganization/name.
Organization > <b>telecom</b>	A contact detail for the organization.	0..*	<a href="#">ContactPoint</a>	providerOrganization/ <b>telecom</b>	telecom/@use <a href="#">Organization Telecom Use HL7 V3 (required)</a> <sup>1</sup> .  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">ContactPoint</a> .
Organization > <b>address</b>	An address for the organization.	0..*	<a href="#">Address</a>	providerOrganization/ <b>addr</b>	addr/@use <a href="#">Organization Address Use HL7 V3 (required)</a> <sup>2</sup> .  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Address</a>   <a href="#">AU Base Address</a> .
Organization > <b>partOf</b>	The organization of which this organization forms a part.	0..1	<a href="#">Reference</a> (Base Organization)	providerOrganization/ <b>asOrganizationPartOf</b> providerOrganization/asOrganizationPartOf/ <b>wholeOrganization</b>	wholeOrganization <b>SHALL</b> conform to the template defined in <a href="#">wholeOrganization (Base Organization)</a> .
<b>CDA Header Data Elements</b>				Context: /ClinicalDocument/	
Organization > <b>contact</b>	Contact for the organization for a certain purpose.	0..*	<a href="#">BackboneElement</a>	<b>participant[org_contact]</b>	participant[org_contact] <b>SHALL</b> conform to the template defined in <a href="#">participant (Organization contact)</a> .

<sup>1</sup>This 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.

<sup>2</sup>This 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.

## 10.2 representedOrganization (Base Organization)

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	Logical card	Logical type	CDA schema element	CDA constraints and comments
Conformance level comes from linking elements				Context: Comes from linking elements	
<b>Organization</b>	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	<a href="#">Organization</a>	<b>representedOrganization</b>	Organization <b>SHALL</b> have at least: <ul style="list-style-type: none"> <li>name (representedOrganization/name), or</li> <li>identifier (representedOrganization/ext:asEntityIdentifier)</li> </ul>
				representedOrganization/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				representedOrganization/templateId/@root="1.2.36.1.2001.1001.102.101.100039"	
				representedOrganization/id	id/@root <b>SHALL</b> be present and it <b>SHALL</b> be a UUID or an OID.
Organization > <b>identifier</b>	Identifier for the organization that is used to identify the organization across multiple disparate systems.	0..*	<a href="#">Identifier</a>	representedOrganization/ext:asEntityIdentifier	The common pattern <b>Entity Identifier SHALL</b> be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
Organization > <b>active</b>	Whether the organization's record is still in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
Organization > <b>type</b>	The kind(s) of organization that this is.	0..*	<a href="#">CodeableConcept</a>	representedOrganization/standardIndustryClassCode	In CDA the maximum occurrences of representedOrganization/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 <b>SHALL</b> be included.  <a href="#">OrganizationType (example)</a>
Organization > <b>name</b>	A name associated with the organization.	0..1	<a href="#">string</a>	representedOrganization/name[org_name]	In CDA name and alias are represented by representedOrganization/name.
Organization > <b>alias</b>	A list of alternate names that the organization is known as, or was known as in the past.	0..*	<a href="#">string</a>	representedOrganization/name[alias]	In CDA name and alias are represented by representedOrganization/name.

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

<sup>1</sup>This 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.

## 10.3 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	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	<a href="#">Practitioner</a>	assignedPerson	Practitioner <b>SHALL</b> have at least: <ul style="list-style-type: none"> <li>• identifier (assignedPerson/ext:asEntityIdentifier), or</li> <li>• name (assignedPerson/name)</li> </ul>
				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..*	<a href="#">Identifier</a>	assignedPerson/ext:asEntityIdentifier	The common pattern <a href="#">Entity Identifier</a> <b>SHALL</b> be applied. Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
Practitioner > active	Whether this practitioner's record is in active use.	0..1	<a href="#">boolean</a>	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: <a href="#">Base HumanName</a> .
Practitioner > telecom	A contact detail for the practitioner, e.g. a telephone number or an email address.	0..*	<a href="#">ContactPoint</a>	telecom	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">ContactPoint</a> .
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..*	<a href="#">Address</a>	addr	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Address</a>   <a href="#">AU Base Address</a> .
Practitioner > gender	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	<a href="#">code</a>	n/a	This logical element has no mapping to CDA.
Practitioner > birthDate	The date of birth for the practitioner.	0..1	<a href="#">date</a>	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 > <b>qualification</b>	Qualifications obtained by training and certification.	0..*	<a href="#">BackboneElement</a>	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><b>instantiation choices:</b></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 assignedPerson/ext:asQualifications/@classCode="QUAL". The common pattern <a href="#">Qualification</a> <b>SHALL</b> 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 <b>SHALL</b> conform to the template defined in <a href="#">ext:coverage2 (Practitioner qualification)</a>:</p> <ul style="list-style-type: none"> <li>qualification for a Practitioner <b>SHALL</b> 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</li> <li>qualification for a CDA Header Practitioner (e.g. ClinicalDocument author) <b>SHALL</b> be instantiated as ClinicalDocument/component/structuredBody/component[admin_obs]/section/ext:coverage2[prac_qual]</li> </ul>
Practitioner > <b>communication</b>	A language the practitioner is able to use in patient communication.	0..*	<a href="#">CodeableConcept</a>	assignedPerson/ext:languageCommunication	The common pattern <a href="#">Language Communication</a> <b>SHALL</b> be applied.



## 10.4 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	
<b>Organization</b>	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	<a href="#">Organization</a>	<b>wholeOrganization</b>	Organization <b>SHALL</b> have at least: <ul style="list-style-type: none"> <li>name (wholeOrganization/name), or</li> <li>identifier (wholeOrganization/ext:asEntityIdentifier)</li> </ul>
				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 <b>SHALL</b> be present and it <b>SHALL</b> be a UUID or an OID.
Organization > <b>identifier</b>	Identifier for the organization that is used to identify the organization across multiple disparate systems.	0..*	<a href="#">Identifier</a>	wholeOrganization/ext:asEntityIdentifier	The common pattern <a href="#">Entity Identifier</a> <b>SHALL</b> be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
Organization > <b>active</b>	Whether the organization's record is still in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
Organization > <b>type</b>	The kind(s) of organization that this is.	0..*	<a href="#">CodeableConcept</a>	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 <b>SHALL</b> be included.  <a href="#">OrganizationType (example)</a>
Organization > <b>name</b>	A name associated with the organization.	0..1	<a href="#">string</a>	wholeOrganization/name[org_name]	In CDA name and alias are represented by wholeOrganization/name.
Organization > <b>alias</b>	A list of alternate names that the organization is known as, or was known as in the past.	0..*	<a href="#">string</a>	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 > <b>telecom</b>	A contact detail for the organization.	0..*	<a href="#">ContactPoint</a>	wholeOrganization/ <b>telecom</b>	telecom/@use <a href="#">Organization Telecom Use HL7 V3 (required)</a> <sup>1</sup> .  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">ContactPoint</a> .
Organization > <b>address</b>	An address for the organization.	0..*	<a href="#">Address</a>	wholeOrganization/ <b>addr</b>	addr/@use <a href="#">Organization Address Use HL7 V3 (required)</a> <sup>2</sup> .  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Address</a>   <a href="#">AU Base Address</a> .
Organization > <b>partOf</b>	The organization of which this organization forms a part.	0..1	<a href="#">Reference</a> (Base Organization)	wholeOrganization/ <b>asOrganizationPartOf</b>	wholeOrganization/asOrganizationPartOf/wholeOrganization <b>SHALL</b> conform to the template defined in <a href="#">wholeOrganization (Base Organization)</a> .
				wholeOrganization/asOrganizationPartOf/ <b>wholeOrganization</b>	
CDA Header Data Elements				Context: /ClinicalDocument/	
Organization > <b>contact</b>	Contact for the organization for a certain purpose.	0..*	<a href="#">BackboneElement</a>	<b>participant[org_contact]</b>	participant[org_contact] <b>SHALL</b> conform to the template defined in <a href="#">participant (Organization contact)</a> .

<sup>1</sup>This 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.

<sup>2</sup>This 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.

## 10.5 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	
<b>Organization</b>	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	<a href="#">Organization</a>	<b>scopingOrganization</b>	Organization <b>SHALL</b> have at least: <ul style="list-style-type: none"> <li>name (scopingOrganization/name), or</li> <li>identifier (scopingOrganization/ext:asEntityIdentifier)</li> </ul>
				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 <b>SHALL</b> be present and it <b>SHALL</b> be a UUID or an OID.
Organization > <b>identifier</b>	Identifier for the organization that is used to identify the organization across multiple disparate systems.	0..*	<a href="#">Identifier</a>	scopingOrganization/ext:asEntityIdentifier	The common pattern <b>Entity Identifier</b> <b>SHALL</b> be applied.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
Organization > <b>active</b>	Whether the organization's record is still in active use.	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
Organization > <b>type</b>	The kind(s) of organization that this is.	0..*	<a href="#">CodeableConcept</a>	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 <b>SHALL</b> be included.  <a href="#">OrganizationType (example)</a>
Organization > <b>name</b>	A name associated with the organization.	0..1	<a href="#">string</a>	scopingOrganization/name[org_name]	In CDA name and alias are represented by scopingOrganization/name.
Organization > <b>alias</b>	A list of alternate names that the organization is known as, or was known as in the past.	0..*	<a href="#">string</a>	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 > <b>telecom</b>	A contact detail for the organization.	0..*	<a href="#">ContactPoint</a>	scopingOrganization/ <b>telecom</b>	telecom/@use <a href="#">Organization Telecom Use HL7 V3 (required)</a> <sup>1</sup> .  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">ContactPoint</a> .
Organization > <b>address</b>	An address for the organization.	0..*	<a href="#">Address</a>	scopingOrganization/ <b>addr</b>	addr/@use <a href="#">Organization Address Use HL7 V3 (required)</a> <sup>2</sup> .  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Address</a>   <a href="#">AU Base Address</a> .
Organization > <b>partOf</b>	The organization of which this organization forms a part.	0..1	<a href="#">Reference</a> (Base Organization)	scopingOrganization/ <b>asOrganizationPartOf</b>	wholeOrganization <b>SHALL</b> conform to the template defined in <a href="#">wholeOrganization (Base Organization)</a> .
				scopingOrganization/asOrganizationPartOf/ <b>wholeOrganization</b>	
CDA Header Data Elements				Context: /ClinicalDocument/	
Organization > <b>contact</b>	Contact for the organization for a certain purpose.	0..*	<a href="#">BackboneElement</a>	<b>participant[org_contact]</b>	participant[org_contact] <b>SHALL</b> conform to the template defined in <a href="#">participant (Organization contact)</a> .

<sup>1</sup>This 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.

<sup>2</sup>This 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.

# 11 Act CDA templates

This chapter contains the entry-level templates, called acts (machine readable structured content), referenced by other templates such as those in [8 Section CDA templates](#).

## 11.1 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	Logi- cal 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.	Cardinal- ity comes from linking element	<a href="#">AllergyIntolerance</a>	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) <b>SHALL</b> 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 <b>SHALL</b> 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 > <b>author-related-person</b>	Reference to related person that recorded the record and takes responsibility for its content.	0..1	<a href="#">Reference</a> (Base RelatedPerson)	observation/ <b>author</b>	If author is not instantiated, the data is considered to be included via induction in ClinicalDocument/author.  author <b>SHALL</b> conform to one of the templates defined in: <a href="#">author (Base RelatedPerson)</a> or <a href="#">author (Base Patient)</a> or <a href="#">author (Base PractitionerRole)</a> .
AllergyIntolerance > <b>clinical-Status</b>	The clinical status of the allergy or intolerance.	0..1	<a href="#">code</a>	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"	<a href="#">NCTIS Data Components</a>
				observation/entryRelationship[clin_status]/observation/code/@displayName	displayName <b>SHOULD</b> be "Clinical Status".
				observation/entryRelationship[clin_status]/observation/value	value/@xsi:type <b>SHALL</b> be "CD". value/@value <b>SHOULD</b> be "active". <a href="#">AllergyIntolerance Clinical Status Codes (required)</a> <sup>1</sup>
AllergyIntolerance > <b>verification-Status</b>	Assertion about certainty associated with the propensity, or potential risk, of a reaction to the identified substance (including pharmaceutical product).	1..1	<a href="#">code</a>	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"	<a href="#">NCTIS Data Components</a>
				observation/entryRelationship[ver_status]/observation/code/@displayName	displayName <b>SHOULD</b> be "Verification Status".
				observation/entryRelationship[ver_status]/observation/value	value/@xsi:type <b>SHALL</b> be "CD". value/@value <b>SHOULD</b> be "unconfirmed" or "confirmed". <a href="#">AllergyIntolerance Verification Status Codes (required)</a> <sup>2</sup>

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
AllergyIntolerance > <b>type</b>	Identification of the underlying physiological mechanism for the reaction risk.	0..1	<a href="#">code</a>	observation/ <b>code</b>	<a href="#">AllergyIntoleranceType</a> ( <b>required</b> ) <sup>3</sup>
AllergyIntolerance > <b>code</b>	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	<a href="#">CodeableConcept</a>	observation/ <b>value</b>	value/@xsi:type <b>SHALL</b> be "CD".  value/originalText or value/@displayName <b>SHALL</b> be included.  <a href="#">Indicator of Hypersensitivity or Intolerance to Substance</a> ( <b>preferred</b> )
AllergyIntolerance > <b>patient</b>	The patient who has the allergy or intolerance.	1..1	<a href="#">Reference</a> (Patient with Mandatory Identifier)	n/a	Not mapped directly for this model; this is implicit in patientRole.
AllergyIntolerance > <b>onset[x]</b>	Estimated or actual date, date-time, or age when allergy or intolerance was identified.	0..1	<a href="#">dateTime</a>   <a href="#">Age</a>   <a href="#">Period</a>   <a href="#">Range</a>	See: instantiation choices	onset[x] as a <a href="#">Range</a> is not currently mapped to CDA. See <a href="#">Known issues</a> .  <b>instantiation choices:</b>  If onset[x] is a <a href="#">dateTime</a> or a <a href="#">Period</a> then it <b>SHALL</b> be instantiated as observation/effectiveTime/low/@value.  If onset[x] is an <a href="#">Age</a> then it <b>SHALL</b> be instantiated as observation/entryRelationship[onset]/observation/value. value/@xsi:type <b>SHALL</b> be "PQ". The code for observation/entryRelationship[onset]/observation/code <b>SHALL</b> be code/@code="445518008" and code/@codeSystem="2.16.840.1.113883.6.96".
AllergyIntolerance > <b>recorder</b>	Individual who recorded the record and takes responsibility for its content.	0..1	<a href="#">Reference</a> (Base Patient   Base Practitioner)	observation/ <b>author</b>	If author is not instantiated, the data is considered to be included via induction in ClinicalDocument/author.  In CDA an author (Practitioner) is part of an author (PractitionerRole).  author <b>SHALL</b> conform to one of the templates defined in: <a href="#">author (Base RelatedPerson)</a> or <a href="#">author (Base Patient)</a> or <a href="#">author (Base PractitionerRole)</a> .

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



Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
AllergyIntolerance > reaction > <b>substance</b>	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	<a href="#">CodeableConcept</a>	observation/entryRelationship[react]/observation/ <b>participant[agent]</b>	
				observation/entryRelationship[react]/observation/participant[agent]/ <b>@typeCode="CAGNT"</b>	
				observation/entryRelationship[react]/observation/participant[agent]/ <b>participantRole</b>	
				observation/entryRelationship[react]/observation/participant[agent]/ <b>participantRole/playingEntity</b>	
				observation/entryRelationship[react]/observation/participant[agent]/participantRole/ <b>playingEntity/code</b>	code/originalText or code/@displayName <b>SHALL</b> be included. <a href="#">Adverse Reaction Agent (preferred)</a>
AllergyIntolerance > reaction > <b>manifestation</b>	Clinical symptoms and/or signs that are observed or associated with the adverse reaction event.	1..*	<a href="#">CodeableConcept</a>	observation/entryRelationship[react]/observation/ <b>entryRelationship[mfst]</b>	
				observation/entryRelationship[react]/observation/entryRelationship[mfst]/ <b>@typeCode="MFST"</b>	
				observation/entryRelationship[react]/observation/entryRelationship[mfst]/ <b>@inversionInd="true"</b>	
				observation/entryRelationship[react]/observation/entryRelationship[mfst]/ <b>observation</b>	
				observation/entryRelationship[react]/observation/entryRelationship[mfst]/ <b>observation/@classCode="OBS"</b>	
				observation/entryRelationship[react]/observation/entryRelationship[mfst]/ <b>observation/@moodCode="EVN"</b>	
				observation/entryRelationship[react]/observation/entryRelationship[mfst]/ <b>observation/code</b>	code/originalText or code/@displayName <b>SHALL</b> be included. <a href="#">Clinical Finding (preferred)</a>

<sup>1</sup>This value set differs from the value set bound to clinicalStatus in the Agency logical model (see [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#)) due to pre-adoption of FHIR Release 4 terminology.

<sup>2</sup>This value set differs from the value set bound to verificationStatus in the Agency logical model (see [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#)) due to pre-adoption of FHIR Release 4 terminology.

<sup>3</sup>This value set differs from the value set bound to type in the Agency logical model (see [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#)) due to pre-adoption of FHIR Release 4 terminology.

## 11.2 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	
<b>MedicationStatement</b>	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	<a href="#">MedicationStatement</a>	<b>substanceAdministration</b>	
				substanceAdministration/@classCode="SBADM"	
				substanceAdministration/@moodCode	When sending a Personal Health Notes, this is expected to be "EVN".  This CDA schema element is of type CodedSimpleValue (CS). moodCode <b>SHALL NOT</b> be "RQO". <a href="#">HL7 v3 Value Set ActMood (required)</a>
				substanceAdministration/templateId substanceAdministration/templateId/@root="1.2.36.1.2001.1001.102.101.100015"	The use of templateId signals the imposition of a set of template-defined constraints.
MedicationStatement > <b>status</b>	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	<a href="#">code</a>	substanceAdministration/statusCode	This CDA schema element is of type CodedSimpleValue (CS). <a href="#">Medication Act Status HL7 V3 value set (required)</a> <sup>1</sup>

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
MedicationStatement > <b>category</b>	Indicates where type of medication statement and where the medication is expected to be consumed or administered.	0..1	<a href="#">CodeableConcept</a>	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"	<a href="#">SNOMED CT</a>
				substanceAdministration/entryRelationship[category]/observation/code/@displayName	displayName <b>SHOULD</b> be "Environment".
MedicationStatement > <b>medication[x]</b>	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	<a href="#">CodeableConcept</a>	substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/code	value/@xsi:type <b>SHALL</b> be "CD".  value/originalText or value/@displayName <b>SHALL</b> be included.  <a href="#">Medication usage category codes (preferred)</a> <sup>2</sup>
					code/originalText or code/@displayName <b>SHALL</b> be included.
					<a href="#">Australian Medication (preferred)</a>
					<a href="#">Australian Pharmaceutical Benefits Scheme Schedule Item (example)</a> <sup>3</sup>
					<a href="#">MIMS Terminology (example)</a>
					<a href="#">GTIN for Medicines (example)</a>
					Recommended mappings for this logical type to CDA (R2) are available: <a href="#">CodeableConcept as a Medicine Item Code</a> .
MedicationStatement > <b>informationSource</b>	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	<a href="#">Reference</a> (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 <b>SHALL</b> conform to one of the templates defined in: <a href="#">informant (Base RelatedPerson)</a> or <a href="#">informant (Base Patient)</a> or <a href="#">informant (Base Practitioner)</a> .

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
MedicationStatement > <b>subject</b>	The person, animal or group who is/was taking the medication.	1..1	<a href="#">Reference</a> (Patient with Mandatory Identifier)	n/a	Not mapped directly for this model; this is implicit in patientRole.
MedicationStatement > <b>taken</b>	Indicator of the certainty of whether the medication was taken by the patient.	1..1	<a href="#">code</a>	See: instantiation choices	<p>This logical element may have a value of y   n   unk   na as per <a href="#">MedicationStatementTaken</a> (required)</p> <p><b>instantiation choices:</b></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 <b>SHALL</b> be instantiated as substanceAdministration/@negationInd="true" unless status is "new" or "suspended" in which case this is implicit in the statusCode; a negationInd <b>SHALL NOT</b> be present where substanceAdministration/statusCode/@code is "new" or "suspended".</p> <p>When the logical assertion is "unk" or "na", taken <b>SHALL</b> be instantiated as substanceAdministration/@nullFlavor="UNK" or substanceAdministration/@nullFlavor="NA" respectively.</p>
MedicationStatement > <b>reason-Code</b>	A reason for why the medication is being/was taken.	0..1	<a href="#">CodeableConcept</a>	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"	
				substanceAdministration/entryRelationship[reason]/observation/code/@codeSystem="1.2.36.1.2001.1001.101"	<a href="#">NCTIS Data Components</a>
				substanceAdministration/entryRelationship[reason]/observation/code/@displayName	displayName <b>SHOULD</b> be "Clinical Indication".
				substanceAdministration/entryRelationship[reason]/observation/value	<p>value/@xsi:type <b>SHALL</b> be "CD".</p> <p>value/originalText or value/@displayName <b>SHALL</b> be included.</p> <p><a href="#">Medication Reason Taken</a> (preferred)</p>

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
MedicationStatement > <b>note</b>	Provides extra information about the medication statement that is not conveyed by the other attributes.	0..*	<a href="#">Annotation</a>	substanceAdministration/entryRelationship[ <b>note</b> ]	
				substanceAdministration/entryRelationship[ <b>note</b> ]/@typeCode="COMP"	
				substanceAdministration/entryRelationship[ <b>note</b> ]/act	
				substanceAdministration/entryRelationship[ <b>note</b> ]/act/@classCode="ACT"	
				substanceAdministration/entryRelationship[ <b>note</b> ]/act/@moodCode="EVN"	
				substanceAdministration/entryRelationship[ <b>note</b> ]/act/code	
				substanceAdministration/entryRelationship[ <b>note</b> ]/act/code/@code="103.16044"	
				substanceAdministration/entryRelationship[ <b>note</b> ]/act/code/@codeSystem="1.2.36.1.2001.1001.101"	<a href="#">NCTIS Data Components</a>
				substanceAdministration/entryRelationship[ <b>note</b> ]/act/code/@displayName	displayName <b>SHOULD</b> be "Additional Comments".
				substanceAdministration/entryRelationship[ <b>note</b> ]/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[ <b>note</b> ]/act/author is 0..*. In this template the cardinality of author <b>SHALL</b> be limited to 0..1.
				substanceAdministration/entryRelationship[ <b>note</b> ]/act/effectiveTime	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[ <b>note</b> ]/act/effectiveTime is 0..*. In this template the cardinality of effectiveTime <b>SHALL</b> be limited to 0..1.
				substanceAdministration/entryRelationship[ <b>note</b> ]/act/text	text/@xsi:type <b>SHALL</b> be "ST".
MedicationStatement > <b>dosage</b>	Indicates how the medication is/was or should be taken by the patient.	1..1	<a href="#">AU Base Dosage</a>	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 <b>SHALL</b> at least include text or patient instructions instantiated as substanceAdministration/text.  Recommended mappings for this logical type to CDA (R2) are available: <a href="#">AU Base Dosage</a> .

<sup>1</sup>This value set differs from the value set bound to status in the Agency logical model (see [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#)) 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.

<sup>2</sup>This value set differs from the value set bound to category in the Agency logical model (see [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#)) due to pre-adoption of FHIR Release 4 terminology.

<sup>3</sup>The binding strength for the value sets additional to [Australian Medication](#) differs from the binding strength in the Agency logical model (see *Personal Health Records FHIR Implementation Guide [DH2020g]*); this is due to normalising the representation of multiple optional terminology slices in a FHIR profile to this CDA mapping table.

## 11.3 observation (Assertion of No Relevant Finding)

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	
<b>Observation</b>	Statement of clinical judgement that there are no items of specific interest after a reasonable investigation.	Cardinality comes from linking element	<a href="#">Observation</a>	<b>observation</b>	
				observation/@classCode="OBS"	
				observation/@moodCode="EVN"	
				observation/templated	The use of templated signals the imposition of a set of template-defined constraints.
				observation/templated/@root="1.2.36.1.2001.1001.102.101.100032"	
Observation > <b>status</b>	The status of the result value.	1..1	<a href="#">code</a>	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"	<a href="#">NCTIS Data Components</a>
				observation/entryRelationship[status]/observation/code/@displayName	displayName <b>SHOULD</b> be "Observation Result Status".
				observation/entryRelationship[status]/observation/value	value/@xsi:type <b>SHALL</b> be "CD". <a href="#">ObservationStatus (required)</a>
Observation > <b>code</b>	Describes what was observed. Sometimes this is called the observation 'name'.	1..1	<a href="#">CodeableConcept</a>	observation/code	
				observation/code/@code="ASSERTION"	
				observation/code/@codeSystem="2.16.840.1.113883.5.4"	<a href="#">v3 Code System ActCode</a>
				observation/code/@displayName	displayName <b>SHOULD</b> be "Assertion".

Logical element	Logical element description	Logic- al card	Logical type	CDA schema element	CDA constraints and comments
Observation > <b>subject</b>	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	<a href="#">Reference</a> (Patient with Mandatory Identifier)	n/a	Not mapped directly for this model; this is implicit in patientRole.
Observation > <b>effective[x]</b>	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	<a href="#">dateTime</a>   <a href="#">Period</a>	observation/ <b>effectiveTime</b>	
Observation > <b>performer</b>	Who was responsible for asserting the observed value as 'true'.	0..*	<a href="#">Reference</a> (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><b>instantiation choices:</b></p> <p>If performer is an <a href="#">Organization</a> then it <b>SHALL</b> be instantiated as observation/participant/@typeCode="AUT". participant <b>SHALL</b> conform to the template defined in <a href="#">participant (author Base Organization)</a>.</p> <p>In CDA an author (Practitioner) is part of an author (PractitionerRole).</p> <p>If performer is a <a href="#">Practitioner</a> or <a href="#">RelatedPerson</a> or <a href="#">Patient</a> then it <b>SHALL</b> be instantiated as observation/author. author <b>SHALL</b> conform to one of the templates defined in: <a href="#">author (Base PractitionerRole)</a> or <a href="#">author (Base RelatedPerson)</a> or <a href="#">author (Base Patient)</a>.</p>
Observation > <b>value[x]</b>	The information determined as a result of making the observation, if the information has a simple value.	1..1	<a href="#">CodeableConcept</a>	observation/ <b>value</b>	<p>value/@xsi:type <b>SHALL</b> be "CD".</p> <p>value/originalText or value/@displayName <b>SHALL</b> be included.</p> <p>value/@nullFlavor <b>SHALL NOT</b> be instantiated.</p> <p><a href="#">Assertion Of Absence value set (required)</a></p>

<sup>1</sup>This value set differs from the value set bound to status in the Agency logical model (see [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#)) due to pre-adoption of FHIR Release 4 terminology.



## 11.4 ext:coverage2 (Practitioner qualification)

This template is referenced by [participant \(generalPractitioner Base Practitioner\)](#), [informant \(Base Practitioner\)](#), and [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 > <b>qualification</b>	Qualifications obtained by training and certification.	Cardinality comes from linking element	<a href="#">BackboneElement</a>	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	
				ext:coverage2[prac_qual]/ext:entitlement/ext:participant[prac]/ext:participantRole/@classCode="ASSIGNED"	
				ext:coverage2[prac_qual]/ext:entitlement/ext:participant[prac]/ext:participantRole/ext:id	This ext:id <b>SHALL</b> hold the same value as practitioner that this qualification is associated with (the value in this id element <b>SHALL</b> be present in separate participation).
Practitioner > qualification > <b>identifier</b>	An identifier that applies to this person's qualification in this role.	0..*	<a href="#">Identifier</a>	ext:coverage2[prac_qual]/ext:entitlement/ext:id	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Identifier</a> .
Practitioner > qualification > <b>code</b>	Coded representation of the qualification.	1..1	<a href="#">CodeableConcept</a>	ext:coverage2[prac_qual]/ext:entitlement/ext:code	ext:code/originalText or ext:code/@displayName <b>SHALL</b> be included. <a href="#">v2 table 0360, Version 2.7 (example)</a>
Practitioner > qualification > <b>period</b>	Period during which the qualification is valid.	0..1	<a href="#">Period</a>	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 > <b>issuer</b>	Organization that regulates and issues the qualification.	0..1	<a href="#">Reference(Organization)</a>	ext:coverage2[prac_qual]/ext:entitlement/ext: <b>participant[issuer]</b>	
				ext:coverage2[prac_qual]/ext:entitlement/ext:participant[issuer]/ <b>@typeCode="AUT"</b>	
				ext:coverage2[prac_qual]/ext:entitlement/ext:participant[issuer]/ <b>ext:participantRole</b>	
				ext:coverage2[prac_qual]/ext:entitlement/ext:participant[issuer]/ ext:participantRole/ <b>@classCode="COMPAR"</b>	

# 12 Common patterns

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

## 12.1 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 <b>SHALL</b> be an OID and <b>SHALL NOT</b> 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 <b>SHOULD</b> 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 <b>SHOULD</b> be instantiated. <a href="#">Healthcare Identifier Geographic Area (preferred)</a> This CDA schema element is expected to be populated with the display, e.g. "National Identifier".

# Examples

## Example 12.1. Entity Identifier - Australian IHI

```
<!-- Australian IHI -->
<xs:asEntityIdentifier classCode="IDENT">
  <xs:id root="1.2.36.1.2001.1003.0.8003608833357361" assigningAuthorityName="IHI" />
  <xs:assigningGeographicArea classCode="PLC">
    <xs:name>National Identifier</xs:name>
  </xs:assigningGeographicArea>
</xs:asEntityIdentifier>
```

## Example 12.2. 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 12.3. 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 12.4. 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>
```

## 12.2 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	<a href="#">v3 Code System RoleStatus (required)</a>
	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 <b>SHALL</b> hold the same value as patientRole/id.
	ext:personalRelationship/ext:asPersonalRelationship/administrativeGenderCode/@nullFlavor="NA"		1..1	Included for CDA conformance only.

# Examples

## Example 12.5. 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>
```

## Example 12.6. 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" />
      </ext:personalRelationship>
    </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>
```

## 12.3 Qualification

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
Qualification	ext:asQualifications	A list of professional certifications, and certificates recognising having passed a course.	Cardinality comes from linking element	
	ext:asQualifications/@classCode="QUAL"		1..1	
	ext:asQualifications/ext:code		1..1	Qualifications is a text field, so the text list is captured in ext:code/originalText.



## Examples

### Example 12.7. Qualification - Bachelor of Pharmacy

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

### Example 12.8. 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>
```

## 12.4 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). <a href="#">All Languages (required)</a> <a href="#">Common Languages in Australia (extensible)</a>
	ext:languageCommunication/modeCode		0..1	<a href="#">v3 Code System LanguageAbilityMode (preferred)</a>
	ext:languageCommunication/proficiencyLevelCode		0..1	<a href="#">v3 Code System LanguageAbilityProficiency (preferred)</a>
	ext:languageCommunication/preferenceInd		0..1	This CDA schema element is of type Boolean (BL).

## Examples

### Example 12.9. Language Communication - English is preferred

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

### Example 12.10. Language Communication - Pitjantjatjara is preferred

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

### Example 12.11. 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
<b>Identifier</b>	A technical identifier - identifies some entity uniquely and unambiguously.	Cardinality comes from linking element	<a href="#">Element</a>	See: instantiation choices	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 <b>SHOULD NOT</b> be instantiated.  <b>instantiation choices:</b>  If the identifier is for a <a href="#">Patient</a> , <a href="#">Practitioner</a> , <a href="#">PractitionerRole</a> , <a href="#">Organization</a> , <a href="#">RelatedPerson</a> , or <a href="#">Device</a> , then the identifier is expected to be instantiated as ext:asEntityIdentifier/@classCode="IDENT". See < <a href="#">Entity Identifier</a> > for available attributes.  The identifier element may be instantiated as id.
Identifier > <b>use</b>	The purpose of this identifier.	0..1	<a href="#">code</a>	n/a	This logical element has no mapping to CDA.
Identifier > <b>type</b>	A coded type for the identifier that can be used to determine which identifier to use for a specific purpose.	0..1	<a href="#">CodeableConcept</a>	//ext:asEntityIdentifier/ext:code	ext:code is only available if the identifier is instantiated as ext:asEntityIdentifier/@classCode="IDENT". ext:code/originalText or ext:code/@displayName <b>SHALL</b> be included.  <a href="#">Identifier Type Codes (extensible)</a>
Identifier > <b>system</b>	Establishes the namespace for the value - that is, a URL that describes a set values that are unique.	0..1	<a href="#">uri</a>	See: instantiation choices	<b>instantiation choices:</b>  If the identifier is for a <a href="#">Patient</a> , <a href="#">Practitioner</a> , <a href="#">PractitionerRole</a> , <a href="#">Organization</a> , <a href="#">RelatedPerson</a> , or <a href="#">Device</a> , then the identifier system is expected to be instantiated as ext:asEntityIdentifier/ext:id/@root.  The identifier system may be instantiated as id/@root.
Identifier > <b>value</b>	The portion of the identifier typically relevant to the user and which is unique within the context of the system.	0..1	<a href="#">string</a>	See: instantiation choices	<b>instantiation choices:</b>  If the identifier is for a <a href="#">Patient</a> , <a href="#">Practitioner</a> , <a href="#">PractitionerRole</a> , <a href="#">Organization</a> , <a href="#">RelatedPerson</a> , or <a href="#">Device</a> , then identifier value is expected to be instantiated as ext:asEntityIdentifier/ext:id/@extension.  The identifier value may be instantiated as id/@extension.

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

## 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=8003600200002222,
        identifier.system=http://ns.electronichealth.net.au/id/hi/ihi/1.0 -->
        <ext:id assigningAuthorityName="IHI" root="1.2.36.1.2001.1003.0.8003600200002222" />
        <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=Croyden 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>
</inFulfillmentOf>
```

## 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
<b>HumanName</b>	A human's name with the ability to identify parts and usage.	Cardinality comes from linking element	<a href="#">Element</a>	<b>//name</b>	name <b>SHALL</b> have at least text (name with full text representation) or family (name/family) or given (name/given) instantiated.  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.
HumanName > <b>use</b>	Identifies the purpose for this name.	0..1	<a href="#">code</a>	<b>//name/@use</b>	<a href="#">Common Person Name Use (required)</a> <sup>1</sup>
HumanName > <b>text</b>	A full text representation of the name.	0..1	<a href="#">string</a>	<b>//name</b>	
HumanName > <b>family</b>	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	<a href="#">string</a>	<b>//name/family</b>	
HumanName > <b>given</b>	Given name.	0..*	<a href="#">string</a>	<b>//name/given</b>	
HumanName > <b>prefix</b>	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..*	<a href="#">string</a>	<b>//name/prefix</b>	A prefix value can be populated as described in <a href="#">AS 4846 (2014) – Person and provider identification in healthcare [SA2014a]</a> , 4.4.2 Name Title.
HumanName > <b>suffix</b>	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..*	<a href="#">string</a>	<b>//name/suffix</b>	A suffix value can be populated as described in <a href="#">AS 4846 (2014) – Person and provider identification in healthcare [SA2014a]</a> , 4.5.3.2 Name Suffix.
HumanName > <b>period</b>	Indicates the period of time when this name was valid for the named person.	0..1	<a href="#">Period</a>	<b>//name/validTime</b>	

<sup>1</sup>This 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="C">
  <!-- 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
<b>Address</b>	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	<a href="#">Element</a>	//addr	
Address > <b>use</b>	The purpose of this address.	0..1	<a href="#">code</a>	//addr/@use	addr/@use can carry more than one value by a space separated list of codes. <a href="#">Address Use HL7 v3 (required)</a> <sup>1</sup>
Address > <b>type</b>	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	<a href="#">code</a>	//addr/@use	addr/@use can carry more than one value by a space separated list of codes. <a href="#">Address Type HL7 v3 (required)</a> <sup>2</sup>
Address > <b>text</b>	A full text representation of the address.	0..1	<a href="#">string</a>	//addr	The expectation is that this is free text.
Address > <b>line</b>	This component contains the house number, apartment number, street name, street direction, P.O. Box number, delivery hints, and similar address information.	0..*	<a href="#">string</a>	//addr/streetAddressLine	
Address > <b>city</b>	The name of the city, town, village or other community or delivery center.	0..1	<a href="#">string</a>	//addr/city	
Address > <b>district</b>	The name of the administrative area (county).	0..1	<a href="#">string</a>	//addr/county	
Address > <b>state</b>	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	<a href="#">string</a>	//addr/state	
Address > <b>postalCode</b>	A postal code designating a region defined by the postal service.	0..1	<a href="#">string</a>	//addr/postalCode	
Address > <b>country</b>	Country - a nation as commonly understood or generally accepted.	0..1	<a href="#">string</a>	//addr/country	<a href="#">Iso 3166 Part 1: 2 Letter Codes (preferred)</a>
Address > <b>period</b>	Time period when address was/is in use.	0..1	<a href="#">Period</a>	//addr/useablePeriod	

<sup>1</sup>This 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.

<sup>2</sup>This 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
<b>Address</b>	An Australian address expressed using postal conventions (as opposed to GPS or other location definition formats).	Cardinality comes from linking element	<a href="#">Element</a>	//addr	addr <b>SHALL</b> have text or one or more line (addr/streetAddressLine).
Address > <b>no-fixed-address</b>	No fixed address indicator.	0..1	<a href="#">boolean</a>	n/a	Not mapped directly; if 0..1 is "true", addr <b>SHOULD</b> be "NO FIXED ADDRESS" and addr/@use <b>SHOULD</b> be "PHYS".
Address > <b>use</b>	The purpose of this address.	0..1	<a href="#">code</a>	//addr/@use	addr/@use can carry more than one value by a space separated list of codes. <a href="#">Address Use HL7 v3 (required)</a> <sup>1</sup>
Address > <b>type</b>	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	<a href="#">code</a>	//addr/@use	addr/@use can carry more than one value by a space separated list of codes. <a href="#">Address Type HL7 v3 (required)</a> <sup>2</sup>
Address > <b>text</b>	A full text representation of the address.	0..1	<a href="#">string</a>	//addr	The expectation is that this is free text.
Address > <b>line</b>	This component contains the house number, apartment number, street name, street direction, P.O. Box number, delivery hints, and similar address information.	0..*	<a href="#">string</a>	//addr/streetAddressLine	
Address > <b>city</b>	The name of the city, town, village or other community or delivery center.	0..1	<a href="#">string</a>	//addr/city	
Address > <b>district</b>	The name of the administrative area (county).	0..1	<a href="#">string</a>	//addr/county	
Address > <b>state</b>	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	<a href="#">string</a>	//addr/state	state <b>SHALL</b> be populated with the code e.g. "NT". <a href="#">Australian States and Territories (required)</a>
Address > <b>postalCode</b>	A postal code designating a region defined by the postal service.	0..1	<a href="#">string</a>	//addr/postalCode	The maximum length of postalCode <b>SHALL</b> be 4.

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

<sup>1</sup>This 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.

<sup>2</sup>This 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	<a href="#">Element</a>	//telecom	In CDA, ContactPoint value and system are represented as parts of telecom/@value.  If ContactPoint value is present, ContactPoint system <b>SHALL</b> be present.
ContactPoint > system	Telecommunications form for contact point - what communications system is required to make use of the contact.	0..1	<a href="#">code</a>	//telecom/@value	Makes up part of the attribute: "system: value", e.g. "tel: phone number", "mailto: email address", "http: URL", etc.  <a href="#">HL7 URLScheme (required)</a>
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	<a href="#">string</a>	//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	<a href="#">code</a>	//telecom/@use	<a href="#">HL7 TelecommunicationAddressUse (required)</a> <sup>1</sup>
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	<a href="#">positiveInt</a>	n/a	This logical element has no mapping to CDA.
ContactPoint > period	Time period when the contact point was/is in use.	0..1	<a href="#">Period</a>	//telecom/usablePeriod	

<sup>1</sup>This 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="WP" 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
<b>Dosage</b>	Indicates how the medication is/was taken or should be taken by the patient.	Cardinality comes from linking element	<a href="#">Element</a>	See: instantiation choices	<b>instantiation choices:</b>  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 > <b>sequence</b>	Indicates the order in which the dosage instructions should be applied or interpreted.	0..1	<a href="#">integer</a>	//entryRelationship[dosage] //entryRelationship[dosage]/@typeCode="COMP" //entryRelationship[dosage]/sequenceNumber	sequenceNumber <b>SHALL NOT</b> be instantiated for a single instance of dosage.  The value of sequenceNumber <b>SHALL</b> be an ordinal number starting at "1" and increasing by "1" for each subsequent instance of dosage.
Dosage > <b>text</b>	Free text dosage instructions e.g. SIG.	0..1	<a href="#">string</a>	//text	
Dosage > <b>additionalInstruction</b>	Supplemental instruction - e.g. 'with meals'.	0..*	<a href="#">CodeableConcept</a>	n/a	Not mapped directly for this model; included implicitly in text, or patientInstruction, or timing, or asNeeded.
Dosage > <b>patientInstruction</b>	Instructions in terms that are understood by the patient or consumer.	0..1	<a href="#">string</a>	//text	
Dosage > <b>timing</b>	When medication should be administered.	0..1	<a href="#">Timing</a>	//effectiveTime	Recommended mappings for this logical type to CDA (R2) are available: <a href="#">Timing</a> .

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Dosage > <b>asNeeded[x]</b>	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	<a href="#">boolean</a>   <a href="#">CodeableConcept</a>	//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"	<a href="#">v3 Code System ActCode</a>
				//precondition/criterion/value	value/@xsi:type SHALL be "CD" or "BL".  If value/@xsi:type is "CD" then value/originalText or value/@displayName <b>SHALL</b> be included.  <a href="#">Clinical Finding (preferred)</a>
Dosage > <b>site</b>	Body site to administer to.	0..1	<a href="#">CodeableConcept</a>	//approachSiteCode	approachSiteCode/originalText or approachSiteCode/@displayName <b>SHALL</b> be included.  <a href="#">Body Site (preferred)</a>
Dosage > <b>route</b>	How drug should enter body.	0..1	<a href="#">CodeableConcept</a>	//routeCode	routeCode/originalText or routeCode/@displayName <b>SHALL</b> be included.  <a href="#">Route of Administration (preferred)</a>
Dosage > <b>method</b>	Technique for administering medication.	0..1	<a href="#">CodeableConcept</a>	//ext:methodCode	ext:methodCode/originalText or ext:methodCode/@displayName <b>SHALL</b> be included.  <a href="#">SNOMED CT Administration Method Codes (preferred)</a>
Dosage > <b>dose[x]</b>	Amount of medication per dose.	0..1	<a href="#">Range</a>   <a href="#">SimpleQuantity</a>	//doseQuantity	
Dosage > <b>maxDosePerPeriod</b>	Upper limit on medication per unit of time.	0..1	<a href="#">Ratio</a>	//maxDoseQuantity	
Dosage > <b>maxDosePerAdministration</b>	Upper limit on medication per administration.	0..1	<a href="#">SimpleQuantity</a>	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 > <b>maxDosePerLifetime</b>	Upper limit on medication per lifetime of the patient.	0..1	<a href="#">SimpleQuantity</a>	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 > <b>rate[x]</b>	Amount of medication per unit of time.	0..1	<a href="#">Ratio</a>   <a href="#">Range</a>   <a href="#">SimpleQuantity</a>	//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"/>
        </effectiveTime>
      </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-ae1aa84a4f43" />
    <!-- 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">
      <criteria>
        <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4" />
        <value xsi:type="CD" nullFlavor="NI" />
      </criteria>
    </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	<a href="#">Element</a>	//effectiveTime	
Timing > event	Identifies specific times when the event occurs.	0..*	<a href="#">dateTime</a>	//effectiveTime/@value	
Timing > repeat	A set of rules that describe when the event is scheduled.	0..1	<a href="#">Element</a>	n/a	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.  If duration is present, durationUnit <b>SHALL</b> be present.  If timeOfDay is present, when <b>SHALL NOT</b> be present.  If period is present, periodUnit <b>SHALL</b> be present.  duration <b>SHALL</b> be a non-negative value.  period <b>SHALL</b> be a non-negative value.  If periodMax is present, period <b>SHALL</b> be present.  If offset is present, when <b>SHALL</b> be present.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Timing > repeat > <b>bounds[x]</b>	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	<a href="#">Duration</a>   <a href="#">Range</a>   <a href="#">Period</a>	See: instantiation choices	effectiveTime/@xsi:type <b>SHALL</b> be "IVL_TS".  <b>instantiation choices:</b>  If bounds is a <a href="#">Duration</a> then it <b>SHALL</b> be instantiated as effectiveTime/width.  If bounds is a <a href="#">Range</a> then it is expected to be included in <a href="#">Dosage</a> as text, or additionalInstruction, or patientInstruction as appropriate.  If bounds is a <a href="#">Period</a> then it <b>SHALL</b> be instantiated as effectiveTime/low/@value and effectiveTime/high/@value.
Timing > repeat > <b>count</b>	A total count of the desired number of repetitions.	0..1	<a href="#">integer</a>	//repeatNumber/@value	count <b>SHALL</b> only be instantiated in the repeatNumber element of the <a href="#">Dosage</a> substanceAdministration act where the moodCode is "INT" or "PLAN".
Timing > repeat > <b>countMax</b>	A maximum value for the count of the desired repetitions (e.g. do something 6-8 times).	0..1	<a href="#">integer</a>	//repeatNumber/high/@value	
Timing > repeat > <b>duration</b>	How long this thing happens for when it happens.	0..1	<a href="#">decimal</a>	//effectiveTime/phase/width/@value	effectiveTime/@xsi:type <b>SHOULD</b> be "PVL_TS".
Timing > repeat > <b>durationMax</b>	The upper limit of how long this thing happens for when it happens.	0..1	<a href="#">decimal</a>	n/a	This logical element has no mapping to CDA.
Timing > repeat > <b>durationUnit</b>	The units of time for the duration, in UCUM units.	0..1	<a href="#">code</a>	//effectiveTime/phase/width/@unit	effectiveTime/@xsi:type <b>SHOULD</b> be "PVL_TS".
Timing > repeat > <b>frequency</b>	The number of times to repeat the action within the specified period / period range (i.e. both period and periodMax provided).	0..1	<a href="#">integer</a>	//effectiveTime/frequency //effectiveTime/frequency/numerator	frequency is expressed as the numerator (with an xsi:type of "INT") and period is expressed in CDA as the denominator.  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.  effectiveTime/@xsi:type <b>SHALL</b> be "PVL_TS".
Timing > repeat > <b>frequencyMax</b>	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	<a href="#">integer</a>	//effectiveTime/phase	effectiveTime/@xsi:type <b>SHOULD</b> be "PVL_TS".
Timing > repeat > <b>period</b>	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	<a href="#">decimal</a>	See: instantiation choices	effectiveTime/@xsi:type <b>SHOULD</b> be "PVL_TS".  <b>instantiation choices:</b>  May be represented by effectiveTime/phase or effectiveTime/period.
Timing > repeat > <b>periodMax</b>	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	<a href="#">decimal</a>	See: instantiation choices	effectiveTime/@xsi:type <b>SHOULD</b> be "PVL_TS".  <b>instantiation choices:</b>  May be represented by effectiveTime/phase or effectiveTime/period/high.

Logical element	Logical element description	Logical card	Logical type	CDA schema element	CDA constraints and comments
Timing > repeat > <b>periodUnit</b>	The units of time for the period in UCUM units.	0..1	<a href="#">code</a>	See: instantiation choices	effectiveTime/@xsi:type <b>SHOULD</b> be "PIVL_TS".  <b>instantiation choices:</b>  May be represented by effectiveTime/phase/@unit or effectiveTime/period/low/@unit or effectiveTime/period/high/@unit.
Timing > repeat > <b>dayOfWeek</b>	If one or more days of week is provided, then the action happens only on the specified day(s).	0..*	<a href="#">code</a>	//effectiveTime/@xsi:type="PIVL_TS"	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.
				//effectiveTime/@alignment="DW"	
				//effectiveTime/phase	
				//effectiveTime/phase/low/@value	
				//effectiveTime/phase/low/@inclusive="true"	
				//effectiveTime/phase/high/@value	
				//effectiveTime/phase/high/@inclusive="false"	
Timing > repeat > <b>timeOfDay</b>	Specified time of day for action to take place.	0..*	<a href="#">time</a>	//effectiveTime/phase	effectiveTime/@xsi:type <b>SHOULD</b> be "PIVL_TS".
				//effectiveTime/phase/low	
				//effectiveTime/phase/low/@value	
Timing > repeat > <b>when</b>	Real world events that the occurrence of the event should be tied to.	0..*	<a href="#">code</a>	//effectiveTime/event	This CDA schema element is of type CodedSimpleValue (CS).  effectiveTime/@xsi:type <b>SHALL</b> be "EIVL_TS".  <a href="#">EventTiming (required)</a>
Timing > repeat > <b>offset</b>	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	<a href="#">unsignedInt</a>	//effectiveTime/offset	effectiveTime/@xsi:type <b>SHALL</b> be "EIVL_TS".
Timing > <b>code</b>	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	<a href="#">CodeableConcept</a>	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_MrR2aPnp6EygO6hpI88B195esjRWZ0agtY/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_MrR2aPnp6EygO6hpI88B195esjRWZ0agtY/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_MrR2aPnp6EygO6hpI88B195esjRWZ0agtY/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_MrR2aPnp6EygO6hpI88B195esjRWZ0agtY/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_MrR2aPnp6EygO6hpI88B195esjRWZ0agtY/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_MrR2aPnp6EygO6hpI88B195esjRWZ0agtY/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_MrR2aPnpX6Eyg06hpI88B195esjRWZ0agtY/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_MrR2aPnpX6Eyg06hpI88B195esjRWZ0agtY/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_MrR2aPnpX6Eyg06hpI88B195esjRWZ0agtY/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_MrR2aPnpX6EygO6hpI88B195esjRWZ0agtY/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_MrR2aPnpX6EygO6hpI88B195esjRWZ0agtY/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_MrR2aPnpX6EygO6hpI88B195esjRWZ0agtY/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="PIVL_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
<b>CodeableConcept</b>	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	<a href="#">Element</a>	<b>//code</b>	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 > <b>coding</b>	A reference to a code defined by a terminology system.	0..*	<a href="#">Coding</a>	See: instantiation choices	<b>instantiation choices:</b>  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 > <b>system</b>	The identification of the code system that defines the meaning of the symbol in the code.	0..1	<a href="#">uri</a>	<b>//code/@codeSystem</b>	codeSystem <b>SHALL</b> be a UUID or an OID.
CodeableConcept > coding > <b>version</b>	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	<a href="#">string</a>	<b>//code/@codeSystemVersion</b>	
CodeableConcept > coding > <b>code</b>	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	<a href="#">code</a>	<b>//code/@code</b>	
CodeableConcept > coding > <b>display</b>	A representation of the meaning of the code in the system, following the rules of the system.	0..1	<a href="#">string</a>	<b>//code/@displayName</b>	
CodeableConcept > coding > <b>userSelected</b>	Indicates that this coding was chosen by a user directly - i.e. off a pick list of available items (codes or displays).	0..1	<a href="#">boolean</a>	n/a	This logical element has no mapping to CDA.
CodeableConcept > <b>text</b>	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	<a href="#">string</a>	<b>//code/originalText</b>	

## 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)
<a href="#">Personal Health Notes - example 1</a>	My Health Record system	Personal Health Notes
<a href="#">Personal Health Notes - example 2</a>	My Health Record system	Personal Health Notes
<a href="#">Personal Health Summary example 1</a>	My Health Record system	Personal Health Summary
<a href="#">Personal Health Summary example 2</a>	My Health Record system	Personal Health Summary
<a href="#">Personal Health Summary example 3</a>	My Health Record system	Personal Health Summary
<a href="#">Personal Health Summary example 4</a>	My Health Record system	Personal Health Summary
<a href="#">Personal Health Summary example 5</a>	My Health Record system	Personal 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 [Personal Health Records FHIR Implementation Guide \[DH2020g\]](#).

# B.1 Personal Health Notes - example 1

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

## Example B.1. Personal Health Notes - 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 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0" xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
xmlns="urn:hl7-org:v3">
  <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" />
  <!-- Personal Health Notes document model templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100017" extension="1.0" />
  <!-- CDA Rendering Specification templateId -->
  <templateId root="1.2.36.1.2001.1001.100.149" extension="1.0" />
  <id root="2.25.134045617645909421812767683577428735500" />
  <!-- Composition type -->
  <code code="100.16681" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Personal Health Notes" />
  <!-- Composition title -->
  <title>Personal Health Notes</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 (My Health Record Patient) -->
  <recordTarget typeCode="RCT">
    <!-- recordTarget (My Health Record Patient) -->
    <templateId root="1.2.36.1.2001.1001.102.101.100091" extension="1.0" />
    <patientRole classCode="PAT">
      <id root="ac0cbaae-f63c-4472-a0ee-268ff8f1f661" />
      <patient classCode="PSN" determinerCode="INSTANCE">
        <!-- 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 -->
        <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>
    </patientRole>
  </recordTarget>
  <!-- Composition author -->
  <author typeCode="AUT">
    <!-- author (My Health Record Patient) templateId -->
    <templateId root="1.2.36.1.2001.1001.102.101.100029" extension="1.0" />
    <!-- Composition date -->
    <time value="20170621090015+1000" />
    <assignedAuthor classCode="ASSIGNED">
      <id root="ac0cbaae-f63c-4472-a0ee-268ff8f1f661" />
      <code code="ONESELF" codeSystem="2.16.840.1.113883.5.111" />
      <assignedPerson classCode="PSN" determinerCode="INSTANCE">
        <!-- 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>
      </assignedPerson>
    </assignedAuthor>
  </author>
  <!-- Composition custodian -->
  <custodian typeCode="CST">
    <!-- custodian (Organization with mandatory identifier) templateId -->
    <templateId root="1.2.36.1.2001.1001.102.101.100002" extension="1.0" />
    <assignedCustodian classCode="ASSIGNED">
      <representedCustodianOrganization classCode="ORG" determinerCode="INSTANCE">
        <id root="84408f3d-5ec5-46bb-9619-1984a0736e33" />
        <!-- Organization identifier -->
        <ext:asEntityIdentifier classCode="IDENT">
          <ext:id root="1.2.36.1.2001.1007.1.8003640001000036" assigningAuthorityName="PAI-0" />
          <ext:assigningGeographicArea classCode="PLC">
            <ext:name>National Identifier</ext:name>
          </ext:assigningGeographicArea>
        </ext:asEntityIdentifier>
      </representedCustodianOrganization>
    </assignedCustodian>
  </custodian>
</ClinicalDocument>
```

```
</ext:assigningGeographicArea>
</ext:asEntityIdentifier>
</representedCustodianOrganization>
</assignedCustodian>
</custodian>
<component typeCode="COMP">
  <structuredBody classCode="DOCBODY" moodCode="EVN">
    <!-- Composition section (Notes)-->
    <component typeCode="COMP">
      <section classCode="DOCSECT" moodCode="EVN">
        <!-- section (Notes) templateId-->
        <templateId root="1.2.36.1.2001.1001.102.101.100010" extension="1.0" />
        <id root="60a9ef00-32b3-40d4-b5f4-1fdee463752a" />
        <!-- section code -->
        <code code="102.15513" codeSystem="1.2.36.1.2001.1001.101" displayName="Notes"/>
        <!-- section title -->
        <title>My Health Notes</title>
        <!-- section text -->
        <text mediaType="text/x-hl7-text+xml">
          <paragraph>My Diabetes</paragraph>
          <paragraph>I saw my doctor today and he said my last test results were getting better, but he was still not happy with my diet.
            I should go back to that nice dietician Kate again.</paragraph>
        </text>
      </section>
    </component>
  </structuredBody>
</component>
</ClinicalDocument>
```

## B.2 Personal Health Notes - example 2

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

### Example B.2. Personal Health Notes - 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 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0" xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
  xmlns="urn:hl7-org:v3">
  <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" section />
  <!-- Personal Health Notes document model templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100017" section />
  <!-- CDA Rendering Specification templateId -->
  <templateId root="1.2.36.1.2001.1001.100.149" section />
  <id root="2.25.134045617645909421812767683577428735500"/>
  <!-- Composition type -->
  <code code="100.16681" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Personal Health Notes"/>
  <!-- Composition title -->
  <title>Personal Health Notes</title>
  <effectiveTime value="20180621090015+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>
    <!-- recordTarget (My Health Record Patient) templateId -->
    <templateId root="1.2.36.1.2001.1001.102.101.100091" section />
    <patientRole>
      <id root="ac0cbaae-f63c-4472-a0ee-268ff8f1f661"/>
      <patient>
        <!-- Patient name -->
        <name>
          <given>Sammy</given>
          <family>GoodPatient</family>
        </name>
        <!-- Patient gender -->
        <administrativeGenderCode code="female" codeSystem="2.16.840.1.113883.4.642.1.2" codeSystemName="AdministrativeGender"
          displayName="Female"/>
        <!-- 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 author -->
  <author>
    <!-- author (RelatedPerson with Mandatory IHI) templateId -->
    <templateId root="1.2.36.1.2001.1001.102.101.100030" section />
    <!-- Composition date -->
    <time value="20180621090015+1000"/>
    <assignedAuthor>
      <id root="5f7349ba-69ef-4c50-8794-3df2bfd3156c"/>
      <code code="AGNT" codeSystem="2.16.840.1.113883.5.110"/>
      <assignedPerson>
        <!-- RelatedPerson 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>
        <!-- RelatedPerson relationship -->
        <ext:personalRelationship classCode="PRS">
          <ext:code code="SIGOTHR" codeSystem="2.16.840.1.113883.5.111"
            codeSystemName="v3 Code System RoleCode" displayName="significant other" />
          <ext:asPersonalRelationship>
            <id root="ac0cbaae-f63c-4472-a0ee-268ff8f1f661"/>
            <administrativeGenderCode nullFlavor="NA" />
          </ext:asPersonalRelationship>
        </ext:personalRelationship>
      </assignedPerson>
    </assignedAuthor>
  </author>
  <!-- Composition custodian -->
  <custodian>
    <!-- custodian (Organization with mandatory identifier) templateId -->
    <templateId root="1.2.36.1.2001.1001.102.101.100002" section />
```

```
<assignedCustodian>
  <representedCustodianOrganization>
    <id root="987d6a7e-6264-43b0-8666-a14e1dbff91"/>
    <!-- Organization identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
      <ext:id root="1.2.36.1.2001.1007.1.8003640001000036" assigningAuthorityName="PAI-O"/>
      <ext:assigningGeographicArea classCode="PLC">
        <ext:name>National Identifier</ext:name>
      </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>
  </representedCustodianOrganization>
</assignedCustodian>
</custodian>

<component>
  <structuredBody>
    <!-- Composition section (Notes)-->
    <component>
      <section>
        <!-- section (Notes) templateId-->
        <templateId root="1.2.36.1.2001.1001.102.101.100010" section />
        <!-- section code -->
        <code code="102.15513" codeSystem="1.2.36.1.2001.1001.101" displayName="Notes"/>
        <!-- section title -->
        <title>My Health Notes</title>
        <!-- section text -->
        <text mediaType="text/x-hl7-text+xml">
          <paragraph>Exercise note</paragraph>
          <paragraph>Have been for a 20 min run every morning since last Friday.</paragraph>
        </text>
      </section>
    </component>
  </structuredBody>
</component>
</ClinicalDocument>
```

## B.3 Personal Health Summary example 1

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

### Example B.3. Personal 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 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0" xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
xmlns="urn:hl7-org:v3">
  <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" />
  <!-- Personal Health Notes document model templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100018" extension="1.0" />
  <!-- CDA Rendering Specification templateId -->
  <templateId root="1.2.36.1.2001.1001.100.149" extension="1.0" />
  <id root="2.25.134045617645909421812767683577428735500" />
  <!-- Composition type -->
  <code code="100.16685" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Personal Health Summary" />
  <!-- Composition title -->
  <title>Personal 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 (My Health Record Patient) -->
  <recordTarget typeCode="RCT">
    <templateId root="1.2.36.1.2001.1001.102.101.100091" extension="1.0" />
    <patientRole classCode="PAT">
      <id root="ac0cbaae-f63c-4472-a0ee-268ff8f1f661" />
      <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 -->
        <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>
    </patientRole>
  </recordTarget>
  <!-- Composition author (My Health Record Patient) -->
  <author typeCode="AUT">
    <templateId root="1.2.36.1.2001.1001.102.101.100TBD" extension="1.0" />
    <!-- Composition date -->
    <time value="20170621090015+1000" />
    <assignedAuthor>
      <id root="ac0cbaae-f63c-4472-a0ee-268ff8f1f661" />
      <code code="ONESELF" codeSystem="2.16.840.1.113883.5.111" />
      <assignedPerson>
        <!-- Patient name -->
        <name use="C">
          <given>Adam</given>
          <given qualifier="IN">A.</given>
          <family>Everyman</family>
        </name>
        <!-- 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>
      </assignedPerson>
    </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="987d6a7e-6264-43b0-8666-a14eld1bfff91" />
      </representedCustodianOrganization>
    </assignedCustodian>
  </custodian>
</ClinicalDocument>
```

```

    <!-- Organization identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
      <ext:id root="1.2.36.1.2001.1007.1.8003640001000036" assigningAuthorityName="PAI-O" />
      <ext:assigningGeographicArea classCode="PLC">
        <ext:name>National Identifier</ext:name>
      </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>
  </representedCustodianOrganization>
</assignedCustodian>
</custodian>

<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">
          <table>
            <caption>MEDICINES</caption>
            <thead>
              <tr>
                <th>Medicine</th>
                <th>Dosage</th>
                <th>Reason for Medicine</th>
                <th>Notes</th>
              </tr>
            </thead>
            <tbody>
              <tr ID="M1">
                <td ID="M1M">Lasix tablet</td>
                <td ID="M1D">1 tablet daily</td>
                <td ID="M1R">Fluid retention</td>
                <td ID="M1N">Prescribed by GP</td>
              </tr>
              <tr ID="M2">
                <td ID="M2M">Ventolin</td>
                <td ID="M2D">Used when necessary</td>
                <td ID="M2R">Asthma</td>
                <td ID="M2N">Asthma is worse in springtime</td>
              </tr>
              <tr ID="M3">
                <td ID="M3M">St John's Wort</td>
                <td ID="M3D">Directions on bottle</td>
                <td ID="M3N">Depression</td>
                <td></td>
              </tr>
            </tbody>
          </table>
        </text>
        <!-- section entry -->
        <entry typeCode="DRIV">
          <!-- MedicationStatement; taken=y-->
          <substanceAdministration classCode="SBADM" moodCode="EVN">
            <!--substanceAdministration (Summary Statement of Known Medication)-->
            <templateId root="1.2.36.1.2001.1001.102.101.100015" extension="1.0" />
            <id root="4255b903-6f90-41b8-a71c-8ac0ee1ebdc3" />
            <text>
              <reference value="M1"/>
            </text>
            <!-- MedicationStatement status -->
            <statusCode code="active"/>
            <!-- MedicationStatement medication -->
            <consumable>
              <manufacturedProduct>
                <manufacturedMaterial>
                  <code>
                    <originalText><reference value="M1M"/></originalText>
                  </code>
                </manufacturedMaterial>
              </manufacturedProduct>
            </consumable>
            <!-- MedicationStatement reasonCode -->
            <entryRelationship typeCode="RSON">
              <observation classCode="OBS" moodCode="EVN">
                <code code="103.10141" codeSystem="1.2.36.1.2001.1001.101" displayName="Clinical Indication" />
                <value xsi:type="CD">
                  <originalText>
                    <reference value="M1R"/>
                  </originalText>
                </value>
              </observation>
            </entryRelationship>
            <!-- MedicationStatement note -->
            <entryRelationship typeCode="COMP">
              <act classCode="INFRM" moodCode="EVN">
                <code code="103.16044" codeSystem="1.2.36.1.2001.1001.101" displayName="Additional Comments" />
                <text><reference value="M1N"/></text>
              </act>
            </entryRelationship>
          </substanceAdministration>
        </entry>
      <!-- section entry -->
    </component>
  </structuredBody>
</component>

```

```

<entry typeCode="DRIV">
  <!-- MedicationStatement; taken=y-->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!--substanceAdministration (Summary Statement of Known Medication)-->
    <templateId root="1.2.36.1.2001.1001.102.101.100015" extension="1.0" />
    <id root="4255b903-6f90-41b8-a71c-8ac0ee1ebdc3" />
    <text>
      <reference value="M2"/>
    </text>
    <!-- MedicationStatement status -->
    <statusCode code="active"/>
    <!-- MedicationStatement medication -->
    <consumable>
      <manufacturedProduct>
        <manufacturedMaterial>
          <code>
            <originalText><reference value="M2M"/></originalText>
          </code>
        </manufacturedMaterial>
      </manufacturedProduct>
    </consumable>
    <!-- MedicationStatement reasonCode -->
    <entryRelationship typeCode="RSON">
      <observation classCode="OBS" moodCode="EVN">
        <code code="103.10141" codeSystem="1.2.36.1.2001.1001.101" displayName="Clinical Indication" />
        <value xsi:type="CD">
          <originalText>
            <reference value="M2R"/>
          </originalText>
        </value>
      </observation>
    </entryRelationship>
  </substanceAdministration>
</entry>
<!-- section entry -->
<entry typeCode="DRIV">
  <!-- MedicationStatement; taken=y-->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!--substanceAdministration (Summary Statement of Known Medication)-->
    <templateId root="1.2.36.1.2001.1001.102.101.100015" extension="1.0" />
    <id root="4255b903-6f90-41b8-a71c-8ac0ee1ebdc3" />
    <text>
      <reference value="M3"/>
    </text>
    <!-- MedicationStatement status -->
    <statusCode code="active"/>
    <!-- MedicationStatement medication -->
    <consumable>
      <manufacturedProduct>
        <manufacturedMaterial>
          <code>
            <originalText><reference value="M3M"/></originalText>
          </code>
        </manufacturedMaterial>
      </manufacturedProduct>
    </consumable>
    <!-- MedicationStatement reasonCode -->
    <entryRelationship typeCode="RSON">
      <observation classCode="OBS" moodCode="EVN">
        <code code="103.10141" codeSystem="1.2.36.1.2001.1001.101" displayName="Clinical Indication" />
        <value xsi:type="CD">
          <originalText>
            <reference value="M3R"/>
          </originalText>
        </value>
      </observation>
    </entryRelationship>
    <!-- MedicationStatement note -->
    <entryRelationship typeCode="COMP">
      <act classCode="INFRM" moodCode="EVN">
        <code code="103.16044" codeSystem="1.2.36.1.2001.1001.101" displayName="Additional Comments" />
        <text><reference value="M3N"/></text>
      </act>
    </entryRelationship>
  </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" />
      <!-- section code -->
      <code codes="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">
  <!-- AllergyIntolerance -->
  <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"/>
    <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>
  </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 entry -->
<entry typeCode="DRIV">
  <!-- AllergyIntolerance -->
  <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"/>
    <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 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>

```

```
</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>

</structuredBody>
</component>
</ClinicalDocument>
```

## B.4 Personal Health Summary example 2

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

### Example B.4. Personal 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 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0" xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
xmlns="urn:hl7-org:v3">
  <typeId extension="POCD_HD000040" root="2.16.840.1.113883.1.3"/>
  <!-- ClinicalDocument templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100033" extension="1.0"/>
  <!-- Personal Health Notes document model templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100018" extension="1.0"/>
  <!-- CDA Rendering Specification templateId -->
  <templateId root="1.2.36.1.2001.1001.100.149" extension="1.0"/>
  <id root="2b458c49-6d04-4baf-825e-51e8e48b3957"/>
  <!-- Composition type -->
  <code code="100.16685" codeSystem="1.2.36.1.2001.1001.101"
    codeSystemName="NCTIS Data Components" displayName="Personal Health Summary"/>
  <!-- Composition title -->
  <title>Personal Health Summary</title>
  <effectiveTime value="20180921090015+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 (My Health Record Patient) -->
  <recordTarget typeCode="RCT">
    <templateId root="1.2.36.1.2001.1001.102.101.100091" extension="1.0"/>
    <patientRole classCode="PAT">
      <id root="b5376b24-fcaf-4f10-aeec-ab6bd9343445"/>
      <patient>
        <!-- Patient name -->
        <name>
          <given>Mac</given>
          <family>PRIEST</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>
        <ext:asEntityIdentifier classCode="IDENT">
          <!-- Identifier.assigner=Croyden 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>
    </patientRole>
  </recordTarget>
  <!-- Composition author -->
  <author>
    <!-- author (RelatedPerson with Mandatory IHI) -->
    <templateId root="1.2.36.1.2001.1001.102.101.100030" extension="1.0"/>
    <!-- Composition date -->
    <time value="20180921090015+1000"/>
    <assignedAuthor>
      <id root="b5376b24-fcaf-4f10-aeec-ab6bd9343445"/>
      <code code="AGNT" codeSystem="2.16.840.1.113883.5.110"/>
      <assignedPerson>
        <!-- RelatedPerson name -->
        <name>Terry Sampelr</name>
        <!-- RelatedPerson identifier -->
        <ext:asEntityIdentifier classCode="IDENT">
          <ext:id root="1.2.36.1.2001.1003.0.8003608000024083"
            assigningAuthorityName="IHI"/>
          <ext:assigningGeographicArea classCode="PLC">
            <ext:name>National Identifier</ext:name>
          </ext:assigningGeographicArea>
        </ext:asEntityIdentifier>
        <!-- RelatedPerson relationship -->
        <ext:personalRelationship>
          <ext:code code="GRFTH" codeSystem="2.16.840.1.113883.5.111"/>
        </ext:personalRelationship>
      </assignedPerson>
    </assignedAuthor>
  </author>
</ClinicalDocument>
```

```
<ext:asPersonalRelationship>
  <id root="b5376b24-fcaf-4f10-aeec-ab6bd9343445"/>
  <administrativeGenderCode nullFlavor="NA"/>
</ext:asPersonalRelationship>
</ext:personalRelationship>
</assignedPerson>
</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="98b4668d-ff4f-4aee-be90-bd84f634540b"/>
      <!-- Organization identifier -->
      <ext:asEntityIdentifier classCode="IDENT">
        <ext:id root="1.2.36.1.2001.1007.1.8003640001000036"
          assigningAuthorityName="PAI-O"/>
        <ext:assigningGeographicArea classCode="PLC">
          <ext:name>National Identifier</ext:name>
        </ext:assigningGeographicArea>
      </ext:asEntityIdentifier>
    </representedCustodianOrganization>
  </assignedCustodian>
</custodian>
<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">
          <list ID="MEDT">
            <item><content ID="MEDC">St. John's wort</content></item>
            <item><content ID="MEDD">As directed by packaging</content></item>
          </list>
        </text>
        <!-- section entry -->
        <entry typeCode="DRIV">
          <!-- MedicationStatement; taken-y-->
          <substanceAdministration classCode="SBADM" moodCode="EVN">
            <!-- substanceAdministration (Summary Statement of Known Medication)-->
            <templateId root="1.2.36.1.2001.1001.102.101.100015" extension="1.0"/>
            <id root="4255b903-6f90-41b8-a71c-8ac0ee1ebdc3"/>
            <text>
              <reference value="MEDT"/>
            </text>
            <!-- MedicationStatement status -->
            <statusCode code="active"/>
            <!-- MedicationStatement medication -->
            <consumable>
              <manufacturedProduct>
                <manufacturedMaterial>
                  <code>
                    <originalText><reference value="MEDC"/></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"/>
        <!-- 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">Allergy to eggs.</content>
        </text>
        <!--section entry -->
        <entry>
          <!--AllergyIntolerance-->
          <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"/>
            <code code="102.15517" codeSystem="1.2.36.1.2001.1001.101" displayName="Adverse Reaction" />
            <!--AllergyIntolerance code-->
            <value xsi:type="CD">
              <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>
</structuredBody>
</component>
</ClinicalDocument>
```

DRAFT

## B.5 Personal Health Summary example 3

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

### Example B.5. Personal 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 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0" xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
xmlns="urn:hl7-org:v3">
  <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"/>
  <!-- Personal Health Notes document model templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100018" extension="1.0"/>
  <!-- CDA Rendering Specification templateId -->
  <templateId root="1.2.36.1.2001.1001.100.149" extension="1.0"/>
  <id root="4e0857a3-21e9-4792-8708-89f5d8c1413f"/>
  <!-- Composition type -->
  <code code="100.16685" codeSystem="1.2.36.1.2001.1001.101"
    codeSystemName="NCTIS Data Components" displayName="Personal Health Summary"/>
  <!-- Composition title -->
  <title>Personal Health Summary</title>
  <effectiveTime value="20181201090015+1000"/>
  <confidentialityCode nullFlavor="NA"/>
  <languageCode code="en-AU"/>
  <setId root="83ef4ef6-d99e-43a6-9a97-3be53b734815"/>
  <versionNumber value="1"/>
  <!-- Composition status -->
  <ext:completionCode codes="I" codeSystem="1.2.36.1.2001.1001.101.104.20104"
    codeSystemName="NCTIS Document Status Values" displayName="Interim"/>
  <!-- Composition subject (My Health Record Patient) -->
  <recordTarget typeCode="RCT">
    <templateId root="1.2.36.1.2001.1001.102.101.100091" extension="1.0"/>
    <patientRole classCode="PAT">
      <id root="389f272d-8aeb-4e4a-9fde-650270996482"/>
      <patient>
        <!-- Patient name -->
        <name>
          <prefix>Mr.</prefix>
          <given>Lenny</given>
          <family>MATTERSON</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 codes="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 author (RelatedPerson with Mandatory IHI) -->
  <author typeCode="AUT">
    <templateId root="1.2.36.1.2001.1001.102.101.100030" extension="1.0"/>
    <!-- Composition date -->
    <time value="20181201090015+1000"/>
    <assignedAuthor>
      <id root="389f272d-8aeb-4e4a-9fde-650270996482"/>
      <code code="AGNT" codeSystem="2.16.840.1.113883.5.110">
        <originalText>Authorised representative</originalText>
      </code>
      <assignedPerson>
        <!-- RelatedPerson name -->
        <name>Bob Thavaprasagnam</name>
        <!-- RelatedPerson identifier -->
        <ext:asEntityIdentifier classCode="IDENT">
          <ext:id root="1.2.36.1.2001.1003.0.8003608000024083"
            assigningAuthorityName="IHI"/>
          <ext:assigningGeographicArea classCode="PLC">
            <ext:name>National Identifier</ext:name>
          </ext:assigningGeographicArea>
        </ext:asEntityIdentifier>
        <!-- RelatedPerson relationship -->
        <ext:personalRelationship>
          <ext:code code="394619001" codeSystem="2.16.840.1.113883.6.96"/>
          <ext:asPersonalRelationship>
            <id root="389f272d-8aeb-4e4a-9fde-650270996482"/>
            <administrativeGenderCode nullFlavor="NA"/>
          </ext:asPersonalRelationship>
        </ext:personalRelationship>
      </assignedPerson>
    </author>
  </composition>
</ClinicalDocument>
```

```
</ext:personalRelationship>
</assignedPerson>
</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="4c1036a4-e94f-4682-8f2b-lcd34713bc11"/>
      <!-- Organization identifier -->
      <ext:asEntityIdentifier classCode="IDENT">
        <ext:id root="1.2.36.20073665175"
          assigningAuthorityName="My Health Notes"/>
        <ext:code code="XX" codeSystem="2.16.840.1.113883.12.203" codeSystemName="Identifier Type (HL7)" />
      </ext:asEntityIdentifier>
    </representedCustodianOrganization>
  </assignedCustodian>
</custodian>
<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 (Assertion of No Relevant Finding)-->
        <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 and/or adverse reactions"/>
        <!-- section title -->
        <title>Allergies and Adverse Reactions</title>
        <!-- section text -->
        <text mediaType="text/x-hl7-text+xml">
          <content ID="ALLERGY">None</content>
        </text>
        <!-- section entry -->
        <entry>
          <!-- AllergyIntolerance -->
          <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"/>
            <code code="102.15517" codeSystem="1.2.36.1.2001.1001.101" displayName="Adverse Reaction" />
            <!--AllergyIntolerance code-->
            <value xsi:type="CD" code="716186003" codeSystem="2.16.840.1.113883.6.96" displayName="No known 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>
</structuredBody>
</component>
</ClinicalDocument>
```



## B.6 Personal Health Summary example 4

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

### Example B.6. Personal Health Summary example 4

<!-- 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 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
  xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance" xmlns="urn:hl7-org:v3">
  <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"/>
  <!-- Personal Health Notes document model templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100018" extension="1.0"/>
  <!-- CDA Rendering Specification templateId -->
  <templateId root="1.2.36.1.2001.1001.100.149" extension="1.0"/>
  <id root="ca0fe89d-2e75-4adf-82c4-da3a7b0f2e36"/>
  <!-- Composition type -->
  <code code="100.16685" codeSystem="1.2.36.1.2001.1001.101"
    codeSystemName="NCTIS Data Components" displayName="Personal Health Summary"/>
  <!-- Composition title -->
  <title>Personal 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 (My Health Record Patient) -->
  <recordTarget typeCode="RCT">
    <templateId root="1.2.36.1.2001.1001.102.101.100091" extension="1.0"/>
    <patientRole classCode="PAT">
      <id root="ac0cbaae-f63c-4472-a0ee-268ff8f1f661"/>
      <patient>
        <!-- Patient name -->
        <name>
          <prefix>Mr.</prefix>
          <given>Lenny</given>
          <family>MATTERSON</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="9" codeSystem="1.2.36.1.2001.1004.200.10012"
          codeSystemName="Australian Indigenous Status"
          displayName="Not stated/inadequately described"/>
        <!-- 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 author (My Health Record Patient) -->
  <author typeCode="AUT">
    <templateId root="1.2.36.1.2001.1001.102.101.100029" extension="1.0"/>
    <!-- Composition date -->
    <time value="20170621090015+1000"/>
    <assignedAuthor>
      <id root="ac0cbaae-f63c-4472-a0ee-268ff8f1f661"/>
      <code code="ONESELF" codeSystem="2.16.840.1.113883.5.111"/>
      <assignedPerson>
        <!-- Patient name -->
        <name>
          <prefix>Mr.</prefix>
          <given>Lenny</given>
          <family>MATTERSON</family>
        </name>
        <!-- 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>
      </assignedPerson>
    </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="987d6a7e-6264-43b0-8666-a14e1d1bfff91"/>
    <!-- Organization identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
      <ext:id root="1.2.36.1.2001.1007.1.8003640001000036"
        assigningAuthorityName="PAI-O"/>
      <ext:assigningGeographicArea classCode="PLC">
        <ext:name>National Identifier</ext:name>
      </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>
  </representedCustodianOrganization>
</assignedCustodian>
</custodian>

<component>
  <structuredBody>
    <!-- Composition section (Medications) -->
    <component>
      <!-- section emptyReason -->
      <section nullFlavor="UNK">
        <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">Unknown</text>
        <!-- section 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 and/or 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">
          <!-- AllergyIntolerance -->
          <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"/>
            <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>
</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>
<!--entry (Summary Statement of Allergy or Intolerance)-->
<entry typeCode="DRIV">
  <!-- AllergyIntolerance -->
  <observation classCode="OBS" moodCode="EVN">
    <templateId root="1.2.36.1.2001.1001.102.101.100014" extension="1.0"/>
    <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>

</structuredBody>
</component>
</ClinicalDocument>
```

DRAFT

## B.7 Personal Health Summary example 5

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

### Example B.7. Personal Health Summary example 5

<!-- 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 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
  xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance" xmlns="urn:hl7-org:v3">
  <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"/>
  <!-- Personal Health Notes document model templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100018" extension="1.0"/>
  <!-- CDA Rendering Specification templateId -->
  <templateId root="1.2.36.1.2001.1001.100.149" extension="1.0"/>
  <id root="7535bf8b-d82b-4d2b-abde-d9db8e25d0de"/>
  <!-- Composition type -->
  <code code="100.16685" codeSystem="1.2.36.1.2001.1001.101"
    codeSystemName="NCTIS Data Components" displayName="Personal Health Summary"/>
  <!-- Composition title -->
  <title>Personal 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 (My Health Record Patient) -->
  <recordTarget typeCode="RCT">
    <templateId root="1.2.36.1.2001.1001.102.101.100091" extension="1.0"/>
    <patientRole classCode="PAT">
      <id root="2079f071-484e-44d6-8983-7fea35f18caf"/>
      <patient>
        <!-- Patient name -->
        <name>
          <family>GoodPatient</family>
          <given>Verily</given>
        </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>
    </patientRole>
  </recordTarget>
  <!-- Composition author (My Health Record Patient) -->
  <author typeCode="AUT">
    <templateId root="1.2.36.1.2001.1001.102.101.100TBD" extension="1.0"/>
    <!-- Composition date -->
    <time value="20170621090015+1000"/>
    <assignedAuthor>
      <id root="2079f071-484e-44d6-8983-7fea35f18caf"/>
      <code code="ONESELF" codeSystem="2.16.840.1.113883.5.111"/>
      <assignedPerson>
        <!-- Patient name -->
        <name>
          <family>GoodPatient</family>
          <given>Verily</given>
        </name>
        <!-- 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>
      </assignedPerson>
    </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="987d6a7e-6264-43b0-8666-a14e1d1bfff91"/>
    <!-- Organization identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
      <ext:id root="1.2.36.1.2001.1007.1.8003640001000036"
        assigningAuthorityName="PAI-O"/>
      <ext:assigningGeographicArea classCode="PLC">
        <ext:name>National Identifier</ext:name>
      </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>
  </representedCustodianOrganization>
</assignedCustodian>
</custodian>

<component>
  <structuredBody>
    <!-- Composition section (Medications) -->
    <component>
      <section>
        <!-- section (Medications) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100011" extension="1.0"/>
        <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></td>
              </tr>
              <tr ID="medication-fluticasonesalmeterol">
                <td>Fluticasone/salmeterol 250/25</td>
                <td>2 bd</td>
                <td></td>
              </tr>
              <tr ID="medication-sodiumchloride">
                <td>Sodium chloride 600mg</td>
                <td>3 m, 3 midi, 2 n</td>
                <td></td>
              </tr>
              <tr ID="medication-megabcomplex">
                <td>Mega B complex</td>
                <td>1 d</td>
                <td></td>
              </tr>
              <tr ID="medication-multivitamin">
                <td>Multivitamin</td>
                <td>1 d</td>
                <td></td>
              </tr>
              <tr ID="medication-bromhexine">
                <td>Bromhexine 0.8mg/ml</td>
                <td>10ml bd</td>
                <td></td>
              </tr>
            </tbody>
          </table>
        </text>
        <!-- section entry -->
        <entry>
          <!-- MedicationStatement; taken=y-->
          <substanceAdministration classCode="SBADM" moodCode="EVN">
            <!--substanceAdministration (Summary Statement of Known Medication)-->
            <templateId root="1.2.36.1.2001.1001.102.101.100015" extension="1.0"/>
            <id root="17645403-3665-4d1d-a4bc-0e866394ca6e"/>
            <!-- 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 Medication)-->
  <templateId root="1.2.36.1.2001.1001.102.101.100015" extension="1.0"/>
  <id root="e3924aaf-5f33-4891-bbaa-cb63bdb0936d"/>
  <!-- MedicationStatement dosage -->
  <text>
    <reference value="medication-fluticasonesalmeterol"/>
  </text>
  <!-- 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 Medication)-->
    <templateId root="1.2.36.1.2001.1001.102.101.100015" extension="1.0"/>
    <id root="a3b95ac7-0dfd-4296-a83a-2adda54d3685"/>
    <!-- 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 Medication)-->
    <templateId root="1.2.36.1.2001.1001.102.101.100015" extension="1.0"/>
    <id root="109b7af2-89f9-445d-b9d0-28c211a9f37f"/>
    <!-- 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 Medication)-->
    <templateId root="1.2.36.1.2001.1001.102.101.100015" extension="1.0"/>
    <id root="94ec52e8-ab6e-4222-b91c-e22ef693899c"/>
    <!-- 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 Medication)-->
    <templateId root="1.2.36.1.2001.1001.102.101.100015" extension="1.0"/>
    <id root="2330366b-10b4-4fbc-9d23-3f794a268fe9"/>
    <!-- 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" extension="1.0"/>
    <id root="985e5ad7-8aba-4542-b48f-72836f7500a7"/>
    <!-- section code -->
    <code code="48765-2" codeSystem="2.16.840.1.113883.6.1"
      displayName="Allergies and/or adverse reactions"/>
    <!-- section title -->
    <title>Allergies and Adverse Reactions</title>
    <!-- section text -->
    <text mediaType="text/x-hl7-text+xml">
      <content ID="ALLERGY">I have no allergies.</content>
    </text>
    <!--section entry-->
    <entry>
      <!--AllergyIntolerance -->
      <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"/>
        <code code="102.15517" codeSystem="1.2.36.1.2001.1001.101" displayName="Adverse Reaction" />
        <!--AllergyIntolerance code-->
        <value xsi:type="CD" code="716186003" codeSystem="2.16.840.1.113883.6.96" displayName="No known 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>
</structuredBody>
</component>
</ClinicalDocument>
```



# 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). At the time of publication of this implementation guide the only end-product clinical specifications supported are Personal Health Notes and Personal Health Summary.

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

Requirement section	Data item	Logical element	CDA schema element	Additional notes
The heading text of the section the requirement is specified in as taken from the requirements specification.	The heading text of the requirement as taken from the requirements 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 "&gt;" notation is used to indicate the hierarchical relationship.</p> <p>For example Patient &gt; communication &gt; 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 <a href="#">XPath like notation</a> and starts as the root element ClinicalDocument e.g.</p> <p>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 templates 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 PHN information requirements

The table below provides mapping from the requirements in *Information Requirements - Consumer Entered Notes [NEHT2011ao]* to the corresponding supported element in the Composition (Personal Health Notes) model and their corresponding CDA schema element(s) in the *ClinicalDocument (Personal Health Notes)* template from the root *ClinicalDocument*.

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

Requirement section	Data item	Logical element	CDA schema element	Additional notes
Individual	Component	Composition > subject Composition > author (Patient)	/ClinicalDocument/recordTarget/ /ClinicalDocument/author/assignedAuthor/	
	Person Name	Patient > name	/ClinicalDocument/recordTarget/patientRole/patient/name /ClinicalDocument/author/assignedAuthor/assignedPerson/name	
	Person Identifier	Patient > identifier	/ClinicalDocument/recordTarget/patientRole/patient/ext:asEntityIdentifier /ClinicalDocument/author/assignedAuthor/assignedPerson/ext:asEntityIdentifier	
Author's Name (Authorised Representative)	Component	Composition > author (RelatedPerson)	/ClinicalDocument/author/assignedAuthor/	
	Author's Name (Authorised Representative)	RelatedPerson > name	/ClinicalDocument/author/assignedAuthor/assignedPerson/name	
Notes	Component	Composition > section (Notes)	/ClinicalDocument/component/structuredBody/component[note]/section/	
	Date Information Entered	Composition > date	/ClinicalDocument/author/time	
	Issue Title	section (Notes) > title	/ClinicalDocument/component/structuredBody/component[note]/section/title	
		section (Notes) > text	/ClinicalDocument/component/structuredBody/component[note]/section/text	
Document Control	Issue Description	section (Notes) > text	/ClinicalDocument/component/structuredBody/component[note]/section/text	
	Component	n/a	n/a	
	DateTime Completed	n/a	/ClinicalDocument/effectiveTime	

## C.2 Mapping from PHS information requirements

The table below provides mapping from the requirements in [Information Requirements - Consumer Entered Health Summary \[NEHT2011ar\]](#) to the corresponding supported element in the Composition (Personal Health Summary) model and their corresponding CDA schema element(s) in the [ClinicalDocument \(Personal Health Summary\)](#) template from the root `ClinicalDocument`.

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

Requirement section	Data item	Logical element	CDA schema element	Additional notes
Individual	Component	Composition > subject Composition > author (Patient)	/ClinicalDocument/recordTarget/ /ClinicalDocument/author/assignedAuthor/	
	Person Name	Patient > name	/ClinicalDocument/recordTarget/patientRole/patient/name /ClinicalDocument/author/assignedAuthor/assignedPerson/name	
	Person Identifier	Patient > identifier	/ClinicalDocument/recordTarget/patientRole/patient/ext:asEntityIdentifier /ClinicalDocument/author/assignedAuthor/assignedPerson/ext:asEntityIdentifier	
	Date of Birth	Patient > birthDate	/ClinicalDocument/recordTarget/patientRole/patient/birthTime	
	Sex	Patient > gender	/ClinicalDocument/recordTarget/patientRole/patient/administrativeGenderCode	
	Address	Patient > address	/ClinicalDocument/recordTarget/patientRole/addr /ClinicalDocument/author/assignedAuthor/addr	
	Communication Details	Patient > telecom	/ClinicalDocument/recordTarget/patientRole/telecom /ClinicalDocument/author/assignedAuthor/telecom	
	Indigenous Status	Patient > indigenous-status	/ClinicalDocument/recordTarget/patientRole/patient/ext:asEntityIdentifier /ClinicalDocument/author/assignedAuthor/assignedPerson/ext:asEntityIdentifier	
Authorised Representative	Component	Composition > author (RelatedPerson)	/ClinicalDocument/author/assignedAuthor/	
	Author's Name (Authorised Representative)	RelatedPerson > name	/ClinicalDocument/author/assignedAuthor/assignedPerson/name	
	Person Identifier	RelatedPerson > identifier	/ClinicalDocument/author/assignedAuthor/assignedPerson/ext:asEntityIdentifier	
	Address	RelatedPerson > address	/ClinicalDocument/author/assignedAuthor/addr	
	Communication Details	RelatedPerson > telecom	/ClinicalDocument/author/assignedAuthor/telecom	

Requirement section	Data item	Logical element	CDA schema element	Additional notes
Allergies and Adverse Reactions	Component	section (Allergies) section (Allergies) > entry section (Allergies) > emptyReason	/ClinicalDocument/component/structuredBody/component[allergy]/section/	
	Agent Description	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	
	Reaction Description	AllergyIntolerance > reaction > manifestation	/ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/observation/entryRelationship[react]/observation/entryRelationship[mfst]/observation/code	
Medicines	Component	section (Medications) section (Medications) > entry section (Medications) > emptyReason	/ClinicalDocument/component/structuredBody/component[meds]/section/	
	Item Description	MedicationStatement > medication[x]	/ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/code  /ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/substanceAdministration/text	
	Dose Information	MedicationStatement > dosage	/ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/substanceAdministration/text	
	Reason for Medicine	MedicationStatement > reasonCode	/ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/substanceAdministration/entryRelationship[reason]/observation/value	
	Additional Comments	MedicationStatement > note	/ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/substanceAdministration/entryRelationship[note]/act/text:ST	
Document Control	Component	n/a	n/a	
	DateTime Input	n/a	/ClinicalDocument/author/time	

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