



Shared Medicines List

CDA Implementation Guide

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1 Introduction

1.1 Document purpose and scope

The primary aim of the implementation guide is to take implementers step by step through mapping each element of the Shared Medicines List (SML) model ([Shared Medicines List FHIR Implementation Guide \[DH2019h\]](#)) to a corresponding CDA attribute or element. The resulting CDA document can be used for the electronic exchange of SML information, such as a pharmacist shared medicines list (PSML) document, between healthcare providers.

Whilst this implementation guide is defined to support a generic practitioner-author list as a document, at the time of publication of this implementation guide it is expected that in the near term implementations will be of a pharmacist shared medicines list exchanged with the My Health Record.

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 \(AU Base 1.1\) \[HL7AUF3B1\]](#)) 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, a specification package.

An Agency clinical document 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 (CDA IG) – a statement of constraints and custom extensions on [HL7 Clinical Document Architecture \[HL7CDAR2\]](#)
- FHIR implementation guide (FHIR IG) – a statement of constraints and custom extensions on [FHIR \[HL7FHIR3\]](#)
- 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
- A set of release notes

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 the CDA and, where necessary, custom extensions to the CDA, for the purposes of fulfilling the requirements for Australian implementations of SML.

These descriptions are defined as a set of CDA templates (see [Conformance conventions](#)) presented in CDA mapping tables (see [Mapping presentation and structure](#)). The mapping tables take implementers step by step through mapping each element of the SML model to a corresponding CDA attribute or element.

A logical view of the SML model ([FHIR \[HL7FHIR3\] StructureDefinitions](#)) is presented as a tree structure in a hierarchical table (see [4 Shared Medicines List hierarchy](#)). The SML model is published as a set of [FHIR \[HL7FHIR3\]](#) profiles in [Shared Medicines List FHIR Implementation Guide \[DH2019h\]](#).

The starting point for the CDA templates is the clinical document model template defined in [ClinicalDocument \(Shared Medicines List Authored by Practitioner\)](#), which references the additional templates necessary to assert conformance for 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.

This implementation guide is intended to align 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 CDA 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
Source material errors	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.

Reference	Description
Recording information that a medicine list contains medicine items packed in a dose administration aid	<p>National agreement on the inclusion of a statement or an indicator that a medicines list document includes medicine items packed in a dose administration aid (DAA) is not yet supported. A supporting data model would allow recording information about an individual receiving packed medicines so that consultations with healthcare providers and healthcare can be tailored to suit the individual. This has been raised in HL7 AU github for consideration in the HL7 AU Medications work group, see https://github.com/hl7au/au-fhir-base/issues/320.</p> <p>In the interim, HL7 AU recommends supporting this requirement as a note in the medicines list (List.note). One possible way a sending system may indicate that one or more medicine items are packed, or not packed, by a pharmacy in a dose administration aid is with the text 'Packed medicines: Yes', 'Packed medicines: No', or 'Packed medicines: Unknown'.</p> <p>More information about dose administration aids: https://www.nps.org.au/australian-prescriber/articles/appropriate-use-of-dose-administration-aids#summary.</p>
PBS Medicine Item Codes	The PBS Medicines Item Codes value set, originating from the HL7 AU Base Medication profile, is a placeholder resource. Forthcoming work is expected to result in an authoritative value set published in the National Clinical Terminology Service (NCTS) with the following canonical URL: https://healthterminologies.gov.au/fhir/ValueSet/australian-pbs-item-1 . Implementers are to make use of the value set served via the NCTS when available.
GTIN for Medicines	No expansion is available for this value set using the associated code system published in the HL7 AU Base material. None of the concepts defined by the code system are included in the code system resource. Implementers are expected to have available an expansion that defines what codes are in the value sets to make use of this terminology.
MIMS Terminology	No expansion is available for this value set using the associated code system published in the HL7 AU Base material. None of the concepts defined by the code system are included in the code system resource. Implementers are expected to have available an expansion that defines what codes are in the value sets to make use of this terminology.

Reference	Description
Terminology publication	<p>The following terminology resources are not yet available in NCTS:</p> <ul style="list-style-type: none">• Australian Pharmaceutical Benefits Scheme Schedule Item• Healthcare Identifier Geographic Area• Medicines Review Type• Medicine Item Change from Practitioner Medicine Review• Empty Reason HL7 v3 NullFlavor v2• NameUse (HL7 FHIR) to Common Person Name Use• Medication > medication-brand-name SNOMED CT code• Medication > medication-generic-name SNOMED CT code

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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 \[HL7V3DT\]](#).

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 narratives](#).

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

- [HL7 Clinical Document Architecture \[HL7CDAR2\]](#)
- [HL7 V3 RIM, Data types and Vocabulary \[HL7V3DT\]](#)
- [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 document as the HL7 CDA schema). CDA documents which include extensions will fail to validate against the HL7 CDA schema – this is a known limitation.

A shared medicines list 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 [Conformance requirements](#).

2.3 Conformance conventions

Templates

This implementation guide specifies the CDA templates for implementing the document model that is the subject of this implementation guide, i.e. Shared Medicines List. A CDA template is a set of constraints, and where necessary, custom extensions to [HL7 Clinical Document Architecture \[HL7CDAR2\]](#).

In this implementation guide CDA templates are presented in a CDA mapping table and indicated by the presence of a `templateId`.

Template identifiers (`templateId`) are unique to each CDA template. When valued in an instance, the template identifier signals the imposition of a set of template-defined constraints. The root value of this attribute (e.g. `@root="1.2.36.1.2001.1001.100.1002.226"`) provides a unique identifier for the template in question. The extension value of this attribute (e.g. `@extension="1.0"`) provides the version identifier for the template in question.

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 [HL7 V3 RIM, Data types and Vocabulary \[HL7V3DT\]](#) 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.

For example if a specification of 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

The template context in this implementation guide is that of an open template unless otherwise stated.

Terminology binding

Vocabulary is specified in this implementation guide, in some cases binding an element to a value set or binding an attribute to a single fixed code. For guidance on coding common clinical concepts in CDA documents see [Representing Coding in CDA Documents Implementation Guidance \[NEHT2011bv\]](#).

A value set binding, if present in this specification, will be specified in the "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), e.g. [v3 Code System ParticipationFunction \(required\)](#).

Conformance verbs

Where used in this document, 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 verbs

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

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

Cardinality

The cardinality range specifies the allowable occurrences within a document instance. Cardinality range is specified 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

2.4 Mapping presentation and structure

The content of this implementation guide is a set of CDA templates that are presented as a mapping from the logical view of a set of models (i.e. [FHIR \[HL7FHIR3\]](#) StructureDefinitions) to CDA. These models are published as [FHIR \[HL7FHIR3\]](#) profiles in [Shared Medicines List FHIR Implementation Guide \[DH2019h\]](#).

CDA templates are located within a templates chapter, e.g. [9 Section 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 SML model that template corresponds to, e.g. observation (Summary Statement of Allergy or Intolerance) defines the CDA template of the observation CDA schema element to represent the model for Summary Statement of Allergy or Intolerance.

A CDA mapping table aims to take implementers step by step through mapping each element of the SML 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.

x.x CDA schema element (model / element)

Implementation guidance specific to the usage scenarios expected to be supported by this implementation guide may be present above the mapping table. This content is informative; there may be valid reasons not to follow this guidance, but the full implications must be understood and carefully weighed before choosing a different course.

CDA mapping

Element	Element descrip- tion	Card	Element type	CDA schema element	Constraints and com- ments
CDA conformance level, e.g. CDA Header, CDA Body Level 3 Data Elements					
The logical hierarchical path in the SML model expressed using names of the elements in the SML model. If there is a name in round brackets after the path, this is the label for that element or resource. The text in bold (the last in the path) is the subject for this row. i.e. Parent (Label) > Child e.g. AllergyIntolerance (Summary Statement of Allergy or Intolerance) > patient	The description of the element in the SML model. (See Conformance conventions)	The cardinality of the element in the SML model. The root element of each template will typically express an inherited cardinality from the parent element in a parent template by stating: "Cardinality comes from linking element"	The type of the element (hyper-linked to the definition of the [HL7FHIR3] type) in the SML model. This may be expressed as a type that is further constrained by a model in the convention <type> as <model name>, e.g. Patient as Patient with Mandatory Identifier.	<p>Context: The root context that is applied as a prefix to the CDA schema element paths in the mapping rows below</p> <p>The CDA schema element(s) in the CDA template that correspond to the model element. The syntax for this is similar to XPath:</p> <pre>/name{[index]}n</pre> <p>Where:</p> <ul style="list-style-type: none"> { } indicates optional { }n means a section that may repeat [index] differentiates two similar mappings <p>Example:</p> <p>participant[location] participant[location]/@typeCode="ORG" participant[location]/associatedEntity participant[location]/associatedEntity/@classCode="SDLOC" participant[location]/associatedEntity/code</p> <p>A sequence of names refers to the XML path in the CDA document. The path always starts from the context as defined in the grey header row above each group of mapping rows.</p> <p>The last name is shown in bold to make the path easier to read. The last name may be a reference to an attribute or an element, as defined in the Australian Digital Health Agency CDA schema.</p> <p>An index after the name, such as "participation[location]" implies that there can be two or more templates of a participation CDA schema element or that the CDA schema element name may be repeated in one or more templates. The indexes differentiate which CDA schema element is referenced in the path.</p> <p>It is possible for one model element to map to more than one CDA schema element.</p>	<p>Constraints on the CDA schema element(s).</p> <p>Terminology binding, identified by a hyperlinked value set title followed by the terminology binding strength (hyperlinked to the definition of the binding strength). When applicable, followed by a reference to a footnote that provides a hyperlink to related concept map.</p> <p>e.g. Address Type HL7 v3 (required)¹</p> <p>Additional information about the mapping and/or constraints which are identified by conformance verbs (See Conformance conventions).</p> <p>e.g. See <code> for available attributes.</p>

¹Note: The source terminology binding on address type[\[DH2019h\]](#) and the terminology binding in the representation of the model in this specification are different. Mappings between the set of concepts are defined in [v3 map for AddressType](#) concept map.

3 Conformance

3.1 Conformance requirements

This document describes how the SML model is implemented as a CDA document. Conformance claims are not made against this implementation guide directly; rather, they are made against additional conformance profiles documented elsewhere. Any document that claims conformance to 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** use the mappings as they are stated in this document.
- It **SHALL** use all fixed values specified in the mappings (e.g. @attribute="FIXED_VALUE").
- It **SHALL** be valid against the additional conformance requirements that are established in this document (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 and it **SHALL** be clinically safe for receivers of the document to ignore the non-narrative additions when interpreting the existing content.

A system that *consumes* SML CDA documents may claim conformance if it correctly processes conformant instance documents, including correctly understanding all the information in the header. It may, but is not required to, reject non-conformant documents. Conformant systems that consume SML CDA documents are not required to process any or all of the structured data entries in the CDA document, but they **SHALL** be able to correctly render the document for end-users when appropriate (see [Clinical Document Architecture Release 2](#)).

Conformance profiles of this document **MAY** make additional rules that override this document in regard to:

- Allowing the use of alternative value sets in place of the value sets specified in this document.
- Allowing the use of alternative identifiers in place of the Healthcare Identifiers Service identifiers.
- Making required data elements and section divisions optional.

3.2 CDA narratives

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

It is a [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. 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.
 - 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.
- The narrative contents **SHALL** completely and accurately represent the clinical information encoded in the section. Content **SHALL NOT** be omitted from the narrative.
- 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. The examples provided in sections of this document offer some guidance for narrative block markup and may be easily adapted as boilerplate markup.

4 Shared Medicines List hierarchy

A shared medicines list document is defined as:

A list of medicines authored by a practitioner at a point in time that describes the medicines an individual is taking.
Shared Medicines List FHIR Implementation Guide [DH2019h]

4.1 Hierarchy

The hierarchy below provides a logical view of the Shared Medicines List 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.

Each row contains information about a single element. The top level row contains two occupied cells: Name of the document model, and the Type (hyperlinked to the definition of the type).

Each following row contains three occupied cells: Name of the child element in the model, Cardinality (the lower and upper bounds on how many times this element is allowed to appear in the resource), and the Type (hyperlinked to the definition of the type). Type may be expressed as a type that is further constrained by a referenced model, e.g. Patient as Base Patient.

Name	Cardinality	Type
Composition (Shared Medicines List)		Composition as Shared Medicines List Authored by Practitioner
composition-author-role	1..1	Reference(PractitionerRole as PractitionerRole with Practitioner with Mandatory Identifier)
information-recipient	0..*	Reference(Practitioner as Base Practitioner Patient as Base Patient RelatedPerson as Base RelatedPerson PractitionerRole as Base PractitionerRole Organization as Base Organization)
identifier	0..1	Identifier
status	1..1	code
type	1..1	CodeableConcept
subject	1..1	Reference(Patient as Patient with Mandatory Identifier)
encounter	0..1	Reference(Encounter as Summary of an Encounter for an Event)
date	1..1	dateTime
author	1..1	Reference(Practitioner as Practitioner with Mandatory Identifier)
title	1..1	string
attester (Legal Attester)	1..1	BackboneElement
mode	1..1	code
time	1..1	dateTime
party	1..1	Reference(Practitioner as Practitioner with Mandatory Identifier)
custodian	1..1	Reference(Organization as Organization with Mandatory Identifier)
section (Allergies)	0..1	BackboneElement
title	1..1	string
code	1..1	CodeableConcept
text	1..1	Narrative
entry	0..*	Reference(AllergyIntolerance as Summary Statement of Allergy or Intolerance)
emptyReason	0..1	CodeableConcept
section (Medicines List)	1..*	BackboneElement

Name			Cardinality	Type
		title	1..1	string
		code	1..1	CodeableConcept
		text	1..1	Narrative
		entry	0..1	Reference (List as List of Medicine Items with Change Information Authored by Practitioner Observation as Assertion of No Relevant Finding)
		emptyReason	0..1	CodeableConcept

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4.2 Expanded hierarchy

The hierarchy below provides an expanded logical view of the Shared Medicines List model as a tree structure in a hierarchical table that includes the structure of the first level of referenced models; it is not intended to represent how the data contents are represented in a CDA document.

Each row contains information about a single element. The top level row contains two occupied cells: Name of the document model, and the Type (hyperlinked to the definition of the type).

Each following row contains three occupied cells: Name of the child element in the model, Cardinality (the lower and upper bounds on how many times this element is allowed to appear in the resource), and the Type (hyperlinked to the definition of the type). Type may be expressed as a type that is further constrained by a referenced model, e.g. Patient as Base Patient.

Name		Cardinality	Type
Composition (Shared Medicines List)			Composition as Shared Medicines List Authored by Practitioner
	composition-author-role	1..1	Reference(PractitionerRole as PractitionerRole with Practitioner with Mandatory Identifier)
	identifier	0..*	Identifier
	active	0..1	boolean
	period	0..1	Period
	practitioner	1..1	Reference(Practitioner as Practitioner with Mandatory Identifier)
	organization	0..1	Reference(Organization as Base Organization)
	code	0..*	CodeableConcept
	specialty	0..*	CodeableConcept
	location	0..*	Reference(Location)
	healthcareService	0..*	Reference(HealthcareService)
	telecom	0..*	ContactPoint
	availableTime	0..*	BackboneElement
	daysOfWeek	0..*	code
	allDay	0..1	boolean
	availableStartTime	0..1	time
	availableEndTime	0..1	time
	notAvailable	0..*	BackboneElement
	description	1..1	string
	during	0..1	Period
	availabilityExceptions	0..1	string
	information-recipient	0..*	Reference(Practitioner as Base Practitioner)
	identifier	0..*	Identifier
	active	0..1	boolean
	name	0..*	HumanName
	telecom	0..*	ContactPoint
	address	0..*	Address
	gender	0..1	code
	birthDate	0..1	date
	qualification	0..*	BackboneElement
	identifier	0..*	Identifier
	code	1..1	CodeableConcept
	period	0..1	Period
	issuer	0..1	Reference(Organization as Base Organization)

Name			Cardinality	Type
	communication		0..*	CodeableConcept
	information-recipient		0..*	Reference(Patient as Base Patient)
	birthPlace		0..1	Address
	indigenous-status		0..1	Coding
	closing-the-gap-registration		0..1	boolean
	patient-mothersMaidenName		0..1	string
	identifier		0..*	Identifier
	active		0..1	boolean
	name		0..*	HumanName
	telecom		0..*	ContactPoint
	gender		0..1	code
	birthDate		0..1	date
		date-accuracy-indicator	0..1	Coding
		birthTime	0..1	dateTime
	deceased[x]		0..1	boolean dateTime
		date-accuracy-indicator	0..1	Coding
	address		0..*	Address
	maritalStatus		0..1	CodeableConcept
	multipleBirth[x]		0..1	boolean integer
	contact		0..*	BackboneElement
		relationship	0..*	CodeableConcept
		name	0..1	HumanName
		telecom	0..*	ContactPoint
		address	0..1	Address
		gender	0..1	code
		organization	0..1	Reference(Organization as Base Organization)
		period	0..1	Period
	communication		0..*	BackboneElement
		language	1..1	CodeableConcept
		preferred	0..1	boolean
	generalPractitioner		0..*	Reference(Practitioner as Base Practitioner Organization as Base Organization)
	managingOrganization		0..1	Reference(Organization as Base Organization)
	information-recipient		0..*	Reference(RelatedPerson as Base RelatedPerson)
		identifier	0..*	Identifier
		active	0..1	boolean
		name	0..*	HumanName
		telecom	0..*	ContactPoint
		address	0..*	Address
		gender	0..1	code
		birthDate	0..1	date
	qualification		0..*	BackboneElement
		identifier	0..*	Identifier
		code	1..1	CodeableConcept
		period	0..1	Period
		issuer	0..1	Reference(Organization as Base Organization)
	communication		0..*	CodeableConcept

Name		Cardinality	Type
	information-recipient	0..*	Reference(PractitionerRole as Base PractitionerRole)
	identifier	0..*	Identifier
	active	0..1	boolean
	period	0..1	Period
	practitioner	1..1	Reference(Practitioner as Practitioner with Mandatory Identifier)
	organization	0..1	Reference(Organization as Base Organization)
	code	0..*	CodeableConcept
	specialty	0..*	CodeableConcept
	location	0..*	Reference(Location)
	healthcareService	0..*	Reference(HealthcareService)
	telecom	0..*	ContactPoint
	availableTime	0..*	BackboneElement
	daysOfWeek	0..*	code
	allDay	0..1	boolean
	availableStartTime	0..1	time
	availableEndTime	0..1	time
	notAvailable	0..*	BackboneElement
	description	1..1	string
	during	0..1	Period
	availabilityExceptions	0..1	string
	information-recipient	0..*	Reference(Organization as Base Organization)
	identifier	0..*	Identifier
	active	0..1	boolean
	type	0..*	CodeableConcept
	name	0..1	string
	alias	0..*	string
	telecom	0..*	ContactPoint
	address	0..*	Address
	partOf	0..1	Reference(Organization as Base Organization)
	contact	0..*	BackboneElement
	purpose	0..1	CodeableConcept
	name	0..1	HumanName
	telecom	0..*	ContactPoint
	address	0..1	Address
	identifier	0..1	Identifier
	status	1..1	code
	type	1..1	CodeableConcept
	subject	1..1	Reference(Patient as Patient with Mandatory Identifier)
	birthPlace	0..1	Address
	indigenous-status	0..1	Coding
	closing-the-gap-registration	0..1	boolean
	patient-mothersMaidenName	0..1	string
	identifier	1..*	Identifier
	active	0..1	boolean
	name	0..*	HumanName
	telecom	0..*	ContactPoint

Name			Cardinality	Type
	gender		0..1	code
	birthDate		0..1	date
	date-accuracy-indicator		0..1	Coding
	birthTime		0..1	dateTime
	deceased[x]		0..1	boolean dateTime
	date-accuracy-indicator		0..1	Coding
	address		0..*	Address
	maritalStatus		0..1	CodeableConcept
	multipleBirth[x]		0..1	boolean integer
	contact		0..*	BackboneElement
	relationship		0..*	CodeableConcept
	name		0..1	HumanName
	telecom		0..*	ContactPoint
	address		0..1	Address
	gender		0..1	code
	organization		0..1	Reference(Organization as Base Organization)
	period		0..1	Period
	communication		0..*	BackboneElement
	language		1..1	CodeableConcept
	preferred		0..1	boolean
	generalPractitioner		0..*	Reference(Practitioner as Base Practitioner Organization as Base Organization)
	managingOrganization		0..1	Reference(Organization as Base Organization)
encounter			0..1	Reference(Encounter as Summary of an Encounter for an Event)
	encounter-description		0..1	string
	status		1..1	code
	class		0..1	Coding
	type		0..*	CodeableConcept
	subject		1..1	Reference(Patient as Patient with Mandatory Identifier)
	period		1..1	Period
	reason		0..*	CodeableConcept
date			1..1	dateTime
author			1..1	Reference(Practitioner as Practitioner with Mandatory Identifier)
	identifier		1..*	Identifier
	active		0..1	boolean
	name		0..*	HumanName
	telecom		0..*	ContactPoint
	address		0..*	Address
	gender		0..1	code
	birthDate		0..1	date
	qualification		0..*	BackboneElement
	identifier		0..*	Identifier
	code		1..1	CodeableConcept
	period		0..1	Period
	issuer		0..1	Reference(Organization as Base Organization)
	communication		0..*	CodeableConcept

Name	Cardinality		Type
title	1..1		string
attester (Legal Attester)	1..1		BackboneElement
mode	1..1		code
time	1..1		dateTime
party	1..1		Reference(Practitioner as Practitioner with Mandatory Identifier)
identifier	1..*		Identifier
active	0..1		boolean
name	0..*		HumanName
telecom	0..*		ContactPoint
address	0..*		Address
gender	0..1		code
birthDate	0..1		date
qualification	0..*		BackboneElement
identifier	0..*		Identifier
code	1..1		CodeableConcept
period	0..1		Period
issuer	0..1		Reference(Organization as Base Organization)
communication	0..*		CodeableConcept
custodian	1..1		Reference(Organization as Organization with Mandatory Identifier)
identifier	1..*		Identifier
active	0..1		boolean
type	0..*		CodeableConcept
name	0..1		string
alias	0..*		string
telecom	0..*		ContactPoint
address	0..*		Address
partOf	0..1		Reference(Organization as Base Organization)
contact	0..*		BackboneElement
purpose	0..1		CodeableConcept
name	0..1		HumanName
telecom	0..*		ContactPoint
address	0..1		Address
section (Allergies)	0..1		BackboneElement
title	1..1		string
code	1..1		CodeableConcept
text	1..1		Narrative
entry	0..*		Reference(AllergyIntolerance as Summary Statement of Allergy or Intolerance)
author-related-person	0..1		Reference(RelatedPerson as Base RelatedPerson)
clinicalStatus	0..1		code
verificationStatus	1..1		code
type	0..1		code
code	1..1		CodeableConcept
patient	1..1		Reference(Patient as Patient with Mandatory Identifier)
onset[x]	0..1		dateTime, Age, Period, Range

Name				Cardinality	Type
		recorder		0..1	Reference(Patient as Base Patient Practitioner as Base Practitioner)
		note		0..*	Annotation
		reaction		0..*	BackboneElement
			substance	0..1	CodeableConcept
			manifestation	1..*	CodeableConcept
		emptyReason		0..1	CodeableConcept
	section (Medicines List)			1..*	BackboneElement
		title		1..1	string
		code		1..1	CodeableConcept
		text		1..1	Narrative
		entry		0..1	Reference(List as List of Medicine Items with Change Information Authored by Practitioner)
			author-role	1..1	Reference(PractitionerRole as PractitionerRole with Practitioner with Mandatory Identifier)
			status	1..1	code
			title	0..1	string
			code	1..1	CodeableConcept
			subject	1..1	Reference(Patient as Patient with Mandatory Identifier)
			encounter	0..1	Reference(Encounter as Summary of an Encounter for an Event)
			date	1..1	dateTime
			source	1..1	Reference(Practitioner as Practitioner with Mandatory Identifier)
			note	0..*	Annotation
			entry	1..*	BackboneElement
			change-description	0..1	string
			flag	1..1	CodeableConcept
			item	1..1	Reference(MedicationStatement as Medicine Item Statement)
		entry		0..1	Reference(Observation as Assertion of No Relevant Finding)
			status	1..1	code
			code	1..1	CodeableConcept
			subject	1..1	Reference(Patient as Patient with Mandatory Identifier)
			effective[x]	0..1	dateTime Period
			performer	0..*	Reference(Practitioner as Base Practitioner) Organization as Base Organization) RelatedPerson as Base RelatedPerson) Patient as Base Patient)
			value[x]	1..1	CodeableConcept
		emptyReason		0..1	CodeableConcept

5 CDA Header templates

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

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

5.1 ClinicalDocument

CDA mapping

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

CDA schema element	Definition	Card	Constraints and comments
ClinicalDocument/templateId	A templateId signals the imposition of a set of template-defined constraints. The value provides a unique identifier for the templates in question.	1..*	<p>All attributes of the templateId element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.</p> <p>Exactly one template identifier SHALL indicate the constraints defined in this mapping table and have @root="1.2.36.1.2001.1001.102.101.100033" and @extension="1.0".</p> <p>Exactly one template identifier SHALL indicate the constraints defined in the CDA Rendering Specification [NEHT2012s] and have @root="1.2.36.1.2001.1001.100.149" and @extension="1.0".</p> <p>In addition to the template identifiers above, a template identifier is expected for the clinical document model as per ClinicalDocument (Shared Medicines List Authored by Practitioner). Additional template identifiers may be required by other specifications.</p> <p>Systems are not required to recognise any other template identifiers than the clinical document model templateId in order to understand the document as a [type] but these identifiers may influence how the document must be handled.</p>
ClinicalDocument/id	Represents the unique instance identifier of a clinical document.	1..1	<p>All attributes of the id element defined by the Australian Digital Health Agency CDA schema SHALL be allowed with the exception that @nullFlavor SHALL NOT be present.</p> <p>See <id> for available attributes.</p>
ClinicalDocument/code	The code specifying the particular kind of document (e.g. History and Physical, Discharge Summary, Progress Note).	1..1	<p>All attributes of the code element defined by the Australian Digital Health Agency CDA schema SHALL be allowed with the exception that @nullFlavor SHALL NOT be present.</p> <p>See <code> for available attributes.</p>
ClinicalDocument/title	Represents the title of the document.	0..1	
ClinicalDocument/effectiveTime	Signifies the document creation time, when the document first came into being. Where the CDA document is a transform from an original document in some other format, the ClinicalDocument.effectiveTime is the time the original document is created.	1..1	<p>All attributes of the effectiveTime element defined by the Australian Digital Health Agency CDA schema SHALL be allowed with the exception that @nullFlavor SHALL NOT be present.</p> <p>See <time> for available attributes.</p>
ClinicalDocument/confidentialityCode/@nullFlavor="NA"	Codes that identify how sensitive a piece of information is and/or that indicate how the information may be made available or disclosed.	1..1	
ClinicalDocument/languageCode	Specifies the human language of character data (whether they be in contents or attribute values).	0..1	<Language Code> – <DIALECT> The <Language Code> SHALL be "en". The <DIALECT> SHOULD be "AU".
ClinicalDocument/languageCode/@code		1..1	
ClinicalDocument/setId	Represents an identifier that is common across all document revisions.	0..1	<p>All attributes of the setId element defined by the Australian Digital Health Agency CDA schema SHALL be allowed.</p> <p>See <id> for available attributes.</p>
ClinicalDocument/versionNumber	An integer value used to version successive replacement documents.	0..1	
ClinicalDocument/versionNumber/@value		1..1	
ClinicalDocument/ext:completionCode	The lifecycle status of a document.	1..1	<p>All attributes of the completionCode element defined by the Australian Digital Health Agency CDA schema SHALL be allowed with the exception that @nullFlavor SHALL NOT be present.</p> <p>See <code> for available attributes.</p> <p>Australian Healthcare Clinical Document Architecture Document Lifecycle Status (required)</p>

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

5.2 LegalAuthenticator

CDA mapping

CDA schema element	Definition	Card	Constraints and comments
CDA Header Data Elements			Context: /ClinicalDocument/
legalAuthenticator	Represents a participant who has legally authenticated the document.	Cardinality comes from linking element	
legalAuthenticator/templateId	The use of templateId signals the imposition of a set of template-defined constraints.	1..1	
legalAuthenticator/templateId/@root="1.2.36.1.2001.1001.102.101.100012"		1..1	
legalAuthenticator/templateId/@extension="1.0"		1..1	
legalAuthenticator/time/@value	Indicates the time of authentication.	1..1	
legalAuthenticator/signatureCode/@code="S"	Indicates that the signature has been affixed and is on file.	1..1	
legalAuthenticator/assignedEntity	A legalAuthenticator is a person in the role of an assigned entity (AssignedEntity class). An assigned entity is a person assigned to the role by the scoping organization. The entity playing the role is a person (Person class). The entity scoping the role is an organization (Organization class).	1..1	
legalAuthenticator/assignedEntity/code	The specific kind of role.	0..1	See <code> for available attributes.
legalAuthenticator/assignedEntity/id	A unique identifier for the player entity in this role.	1..1	See <id> for available attributes.
legalAuthenticator/assignedEntity/assignedPerson	The entity playing the role (assignedEntity) is a person.	1..1	
legalAuthenticator/assignedEntity/assignedPerson/ext:asEntityIdentifier	The entity identifier of the person.	0..*	See <Entity Identifier> for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier.
legalAuthenticator/assignedEntity/addr	A postal address for the entity (assignedPerson) while in the role (assignedEntity).	0..*	Recommended mappings for the complex data type to CDA (R2): Address.
legalAuthenticator/assignedEntity/telecom	A telecommunication address for the entity (assignedPerson) while in the role (assignedEntity).	0..*	Recommended mappings for the complex data type to CDA (R2): ContactPoint.
legalAuthenticator/assignedEntity/assignedPerson/name	A non-unique textual identifier or moniker for the entity (assignedPerson).	0..*	Recommended mappings for the complex data type to CDA (R2): HumanName.
legalAuthenticator/assignedEntity/representedOrganization	The entity scoping the role (assignedEntity).	0..1	
legalAuthenticator/assignedEntity/representedOrganization/ext:asEntityIdentifier	A unique identifier for the scoping entity (represented organization) in this role (assignedEntity).	0..*	See <Entity Identifier> for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier.
legalAuthenticator/assignedEntity/representedOrganization/name	A non-unique textual identifier or moniker for the entity (representedOrganization).	0..*	

5.3 Administrative Observations

CDA mapping

CDA schema element	Definition	Card	Constraints and comments
Conformance level comes from linking elements	Context: /ClinicalDocument/component/structuredBody/		
component[admin_obs]	The SML document model contains a number of elements for which there are no equivalent elements at that point in the hierarchical structure of the model mapped into CDA. These elements are considered to be "Administrative Observations" about the encounter, the patient or some other participant.	Cardinality comes from linking element	ClinicalDocument SHALL contain at most one Administrative Observation section. The Administrative Observations section SHALL NOT be populated if there are no entries or text to go in it.
component[admin_obs]/section		1..1	
component[admin_obs]/section/templateId		1..1	The use of templateId signals the imposition of a set of template-defined constraints.
component[admin_obs]/section/templateId/@root="1.2.36.1.2001.1001.102.101.100000"		1..1	
component[admin_obs]/section/templateId/@extension="1.0"		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	See <id> for available attributes.
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	
component[admin_obs]/section/code/@codeSystemName		0..1	Optional CDA element. codeSystemName SHOULD be "NCTIS Data Components".
component[admin_obs]/section/code/@displayName		0..1	Optional CDA element. displayName SHOULD be "Administrative Observations".
component[admin_obs]/section/title="Administrative Observations"		0..1	
component[admin_obs]/section/text		0..1	See CDA narratives .

6 Document CDA templates

This chapter contains mapping from the Composition (Shared Medicines List) model to a CDA clinical document class, expressed as a series of CDA templates that describe how the CDA document is composed.

CDA templates are expected to be reused from one document type (or Composition model) to another. Each CDA template is presented under a heading in the format of "CDA schema element" ("model name") where "CDA schema element" is the root element for a CDA template and "model name" is the name of a model that constrains an element in the Shared Medicines List hierarchy.

6.1 ClinicalDocument (Shared Medicines List Authored by Practitioner)

The following are the overarching usage scenarios this template is intended to support:

- A clinical information system (CIS) sends or receives a practitioner authored shared medicines list document with the My Health Record system
- A contracted service provider (CSP) sends or receives a practitioner authored shared medicines list document with the My Health Record system
- A CIS sends or receives a practitioner authored shared medicines list document with another CIS or CSP
- A CSP sends or receives a practitioner authored shared medicines list document with a CIS or another CSP
- A registered portal or registered repository receives a practitioner authored shared medicines list document

An expected usage scenario; further scoping the above overarching scenarios is:

- A practitioner authored shared medicines list document exchanged as a pharmacist shared medicines list (PSML)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
				Context: /	
Composition	A list of medicines authored by a practitioner at a point in time that describes the medicines an individual is taking.	0..*	DomainResource	ClinicalDocument	In CDA the maximum occurrences of ClinicalDocument is 1. Although the model indicates that Composition is 0..*, in a CDA implementation this is limited to 0..1. In addition to the template defined in this mapping table, ClinicalDocument SHALL conform to the template defined in ClinicalDocument .
				ClinicalDocument/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				ClinicalDocument/templateId/@root="1.2.36.1.2001.1001.102.101.100065"	
				ClinicalDocument/templateId/@extension="1.0"	
Composition > composition-author-role	A practitioner role that authored this composition. This is not to be confused with who typed in the information.	1..1	Reference (PractitionerRole as PractitionerRole with Practitioner with Mandatory Identifier)	ClinicalDocument/author	author SHALL conform to the template defined in author (PractitionerRole with Practitioner with Mandatory Identifier) .
Composition > information-recipient	A recipient who should receive a copy of the composition. A recipient is an entity to whom a copy of the composition is directed at the time of authoring of the composition.	0..*	Reference (Practitioner as Base Practitioner Patient as Base Patient RelatedPerson as Base RelatedPerson PractitionerRole as Base PractitionerRole Organization as Base Organization)	ClinicalDocument/informationRecipient	In CDA an information-recipient cannot be instantiated as a Device, this logical type has no mapping to CDA. In CDA an information-recipient (Practitioner) is part of information-recipient (PractitionerRole). informationRecipient SHALL conform to a template defined in informationRecipient (Base Patient) or informationRecipient (Base RelatedPerson) or informationRecipient (Base PractitionerRole) or informationRecipient (Base Organization) .
Composition > identifier	Logical identifier for the composition, assigned when created. This identifier stays constant as the composition is changed over time.	0..1	Identifier	ClinicalDocument/setId	
Composition > status	The workflow/clinical status of this composition. The status is a marker for the clinical standing of the document.	1..1	code	ClinicalDocument/ext:completionCode	Australian Healthcare Clinical Document Architecture Document Lifecycle Status (required)¹
Composition > type	Specifies the particular kind of composition (e.g. History and Physical, Discharge Summary, Progress Note). This usually equates to the purpose of making the composition.	1..1	CodeableConcept	ClinicalDocument/code	
				ClinicalDocument/code/@code="56445-0"	
				ClinicalDocument/code/@codeSystem="2.16.840.1.113883.6.1"	
				ClinicalDocument/code/@codeSystemName	Optional CDA element. codeSystemName SHOULD be "LOINC".
				ClinicalDocument/code/@displayName	Optional CDA element. displayName SHOULD be "Medication summary".

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Composition > subject	Who or what the composition is about. The composition can be about a person, (patient or healthcare practitioner), a device (e.g. a machine) or even a group of subjects (such as a document about a herd of livestock, or a set of patients that share a common exposure).	1..1	Reference(Patient) as Patient with Mandatory Identifier	ClinicalDocument/recordTarget	recordTarget SHALL conform to the template defined in recordTarget (Patient with Mandatory Identifier) .
Composition > encounter	Describes the clinical encounter or type of care this documentation is associated with.	0..1	Reference(Encounter) as Summary of an Encounter for an Event	ClinicalDocument/componentOf[enc]	When sending a PSML, this element is expected to be sent.
				ClinicalDocument/componentOf[enc]/encompassingEncounter	encompassingEncounter SHALL conform to the template defined in encompassingEncounter (Summary of an Encounter for an Event) .
Composition > date	The composition editing time, when the composition was last logically changed by the author.	1..1	dateTime	ClinicalDocument/author/time	
Composition > author	Identifies who is responsible for the information in the composition, not necessarily who typed it in.	1..1	Reference(Practitioner) as Practitioner with Mandatory Identifier	ClinicalDocument/author	In CDA an author (Practitioner) is part of composition-author-role (PractitionerRole). author SHALL conform to the template defined in author (PractitionerRole with Practitioner with Mandatory Identifier) .
Composition > title	Official human-readable label for the composition.	1..1	string	ClinicalDocument/title	
Composition > attester (Legal Attester)	A participant who has attested to the accuracy of the composition/document.	1..1	BackboneElement	ClinicalDocument/legalAuthenticator	legalAuthenticator SHALL conform to the template defined in LegalAuthenticator .
Composition > attester (Legal Attester) > mode	The type of attestation the authenticator offers.	1..1	code	n/a	Not mapped separately, the logical mode of "legal" is implicit in legalAuthenticator.
Composition > attester (Legal Attester) > time	When the composition was attested by the party.	1..1	dateTime	n/a	Not mapped separately, implicit in legalAuthenticator/time/@value.
Composition > attester (Legal Attester) > party	Who attested the composition in the specified way.	1..1	ReferencePractitioner as Practitioner with Mandatory Identifier	n/a	Not mapped separately, implicit in legalAuthenticator/as-signedEntity. The practitioner SHALL have an identifier (legalAuthenticator/as-signedEntity/assignedPerson/ext:asEntityIdentifier).
Composition > custodian	Identifies the organization or group who is responsible for ongoing maintenance of and access to the composition/document information.	1..1	Reference(Organization) as Organization with Mandatory Identifier	ClinicalDocument/custodian	custodian SHALL conform to the template defined in custodian (Organization with Mandatory Identifier) .
Composition > section (Allergies)	Information about allergies or intolerances. Information may include allergies or intolerances that have been identified or reported, or may include statements that a patient is not known to have an allergy or category of allergies.	0..1	BackboneElement	ClinicalDocument/component/structuredBody/component[allergy]	When sending a PSML, this section is expected only if at least one statement of allergy or intolerance can be sent. section SHALL conform to the template defined in section (Allergies) .
				ClinicalDocument/component/structuredBody/component[allergy]/section	

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Composition > section (Medicines List)	Information about medicines. This may include self-prescribed, clinician prescribed and nonprescription medicines, as well as all regular, intermittent and as required medicines pertinent to a patient. Information may also include changes to the therapy, including dose changes, new medicines and ceased medicines.	1..*	BackboneElement	ClinicalDocument/component/structuredBody/ component[meds] ClinicalDocument/component/structuredBody/component[meds]/ section	When sending a PSML, this is expected as either: <ul style="list-style-type: none"> • a History of Medication section (section/code@code="10160-0"), or • a Current Medicines section (section/code@code="101.32009") and, optionally a Ceased Medicines section (section/code@code="101.32027") section SHALL conform to the template defined in section (Medicines List) .

¹Note: The source terminology binding on status in Shared Medicines List [DH2019h] and the terminology binding in the representation of the model in this specification are different. Mappings between the set of concepts are defined in [CompositionStatus \(HL7 FHIR\) to Australian Healthcare Clinical Document Architecture Document Lifecycle Status](#) concept map.

7 Participation CDA templates

This chapter contains mapping from the Individual (e.g. Patient with Mandatory Identifier) and Entity (e.g. Organization with Mandatory Identifier) models to CDA participation classes, expressed as a series of CDA templates that describe how each CDA participation is composed.

CDA templates are expected to be reused from one document type (or Composition model) to another. Each CDA template is presented under a heading in the format of "CDA schema element" ("model name") where "CDA schema element" is the root element for a CDA template and "model name" is the name of a model that constrains an element in the Shared Medicines List hierarchy.

7.1 recordTarget (Patient with Mandatory Identifier)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	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	DomainResource	<code>recordTarget[pat]</code>	
				<code>recordTarget[pat]/templateId</code>	The use of templateId signals the imposition of a set of template-defined constraints.
				<code>recordTarget[pat]/templateId/@root="1.2.36.1.2001.1001.102.101.100004"</code>	
				<code>recordTarget[pat]/templateId/@extension="1.0"</code>	
				<code>recordTarget[pat]/patientRole/id</code>	See <id> for available attributes.
				<code>recordTarget[pat]/patientRole/patient</code>	
Patient > birthPlace	The registered place of birth of the patient. A system may use the address.text if they don't store the birthPlace address in discrete elements.	0..1	Address	<code>recordTarget[pat]/patientRole/patient/birthplace</code>	
				<code>recordTarget[pat]/patientRole/patient/birthplace/place</code>	
				<code>recordTarget[pat]/patientRole/patient/birthplace/place/addr</code>	Recommended mappings for the complex data type to CDA (R2): Address Address as AU Base Address .
Patient > indigenous-status	National Health Data Dictionary (NHDD) based indigenous status for a patient.	0..1	Coding	<code>recordTarget[pat]/patientRole/patient/ethnicGroupCode</code>	When sending to the My Health Record this element is expected to be sent. See <code> for available attributes. Australian Indigenous Status (required)

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
CDA Header Data Elements					
Patient > closing-the-gap-registration	Indication for eligibility for the Closing the Gap program.	0..1	boolean	entry[close_gap] entry[close_gap]/observation entry[close_gap]/observation/@classCode="OBS" entry[close_gap]/observation/@moodCode="EVN" entry[close_gap]/observation/id entry[close_gap]/observation/code entry[close_gap]/observation/code/@code="103.32011" entry[close_gap]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" entry[close_gap]/observation/code/@codeSystemName entry[close_gap]/observation/code/@displayName entry[close_gap]/observation/value	Context: /ClinicalDocument/component/structuredBody/component@admin_obs]/section/ See Administrative Observations . Optional CDA element. See <id> for available attributes. Optional CDA element. codeSystemName SHOULD be "NCTIS Data Components". Optional CDA element. displayName SHOULD be "Closing the Gap Copayment Eligibility Indicator". The value is "true" if eligible for Closing the Gap co-payment. value/@xsi:type SHALL be "BL".
Patient > patient-mothersMaidenName	Mother's maiden (unmarried) name, commonly collected to help verify patient identity.	0..1	string	entry[mothers_name] entry[mothers_name]/observation entry[mothers_name]/observation/@classCode="OBS" entry[mothers_name]/observation/@moodCode="EVN" entry[mothers_name]/observation/id entry[mothers_name]/observation/code entry[mothers_name]/observation/code/@code="103.10245" entry[mothers_name]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" entry[mothers_name]/observation/code/@codeSystemName entry[mothers_name]/observation/code/@displayName entry[mothers_name]/observation/value	Optional CDA element. See <id> for available attributes. Optional CDA element. codeSystemName SHOULD be "NCTIS Data Components". Optional CDA element. displayName SHOULD be "Mother's Original Family Name". value/@xsi:type SHALL be "ST".

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
CDA Header Data Elements		Context: /ClinicalDocument/			
Patient > identifier	An identifier for this patient.	1..*	Identifier	recordTarget[pat]/patientRole/patient/ext:asEntityIdentifier	When sending to the My Health Record an IHII is expected. See Entity Identifier for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
Patient > active	Whether this patient record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Patient > name	A name associated with the individual.	0..*	HumanName	recordTarget[pat]/patientRole/patient/name	Recommended mappings for the complex data type to CDA (R2): HumanName .
Patient > telecom	A contact detail (e.g. a telephone number or an email address) by which the individual may be contacted.	0..*	ContactPoint	recordTarget[pat]/patientRole/telecom	Recommended mappings for the complex data type to CDA (R2): ContactPoint .
Patient > gender	Administrative Gender - the gender that the patient is considered to have for administration and record keeping purposes.	0..1	code	recordTarget[pat]/patientRole/patient/administrativeGenderCode	Required CDA element in the Australian Digital Health Agency CDA schema. Although this element is required, a sending system may send a patient without gender by instantiating administrativeGenderCode/@nullFlavor="NI". No other nullFlavor value SHALL be allowed. See code for available attributes. AdministrativeGender (required)
Patient > birthDate	The date of birth for the individual.	0..1	date	recordTarget[pat]/patientRole/patient/birthTime	See time for available attributes.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
CDA Header Data Elements					
Patient > birthDate > date-accuracy-indicator	General date accuracy indicator coding.	0..1	Coding	entry[dob_acc]	
				entry[dob_acc]/observation	
				entry[dob_acc]/observation/@classCode="OBS"	
				entry[dob_acc]/observation/@moodCode="EVN"	
				entry[dob_acc]/observation/id	Optional CDA element. See <id> for available attributes.
				entry[dob_acc]/observation/code	
				entry[dob_acc]/observation/code/@code="102.16234"	
				entry[dob_acc]/observation/code/@codeSystem="1.2.36.1.2001.1001.101"	
				entry[dob_acc]/observation/code/@codeSystemName	Optional CDA element. codeSystemName SHOULD be "NCTIS Data Components".
				entry[dob_acc]/observation/code/@displayName	Optional CDA element. displayName SHOULD be "Date of Birth Accuracy Indicator".
				entry[dob_acc]/observation/value	value/@xsi:type SHALL be "CS". Date Accuracy Indicator (required)
CDA Header Data Elements					
Patient > birthDate > patient-birthTime	The time of day that the Patient was born. This includes the date to ensure that the timezone information can be communicated effectively.	0..1	dateTime	n/a	Not mapped separately, encompassed in patientRole/patient/birthTime.
Patient > deceased[x]	Indicates if the individual is deceased or not. Deceased date accuracy indicator is optional.	0..1	boolean dateTime	recordTarget[pat]/patientRole/patient/ext:deceasedInd recordTarget[pat]/patientRole/patient/ext:deceasedTime	Only one of patientRole/patient/ext:deceasedInd or patientRole/patient/ext:deceasedTime SHOULD be instantiated.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
CDA Header Data Elements				Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ See Administrative Observations	
Patient > deceased[x] > date-accuracy-indicator	General date accuracy indicator coding.	0..1	Coding	entry[dod_acc]	
				entry[dod_acc]/observation	
				entry[dod_acc]/observation/@classCode="OBS"	
				entry[dod_acc]/observation/@moodCode="EVN"	
				entry[dod_acc]/observation/id	Optional CDA element. See <id> for available attributes.
				entry[dod_acc]/observation/code	
				entry[dod_acc]/observation/code/@code="102.16252"	
				entry[dod_acc]/observation/code/@codeSystem="1.2.36.1.2001.1001.101"	
				entry[dod_acc]/observation/code/@codeSystemName	Optional CDA element. codeSystemName SHOULD be "NCTIS Data Components".
				entry[dod_acc]/observation/code/@displayName	Optional CDA element. displayName SHOULD be "Date of Death Accuracy Indicator".
				entry[dod_acc]/observation/value	value/@xsi:type SHALL be "CS". Date Accuracy Indicator (required)
CDA Header Data Elements				Context: /ClinicalDocument/	
Patient > address	Addresses for the individual.	0..*	Address	recordTarget[pat]/patientRole/addr	When sending to the My Health Record this element is not expected to be sent. Recommended mappings for the complex data type to CDA (R2): Address Address as AU Base Address .
Patient > maritalStatus	This field contains a patient's most recent marital (civil) status.	0..1	CodeableConcept	recordTarget[pat]/patientRole/patient/maritalStatusCode	See <code> for available attributes. Marital Status Codes (extensible)
Patient > multipleBirth[x]	Indicates whether the patient is part of a multiple (bool) or indicates the actual birth order (integer).	0..1	boolean integer	recordTarget[pat]/patientRole/patient/ext:multipleBirthInd	Only one of patientRole/patient/ext:multipleBirthInd or patientRole/patient/ext:multipleBirthOrderNumber SHOULD be instantiated.
Patient > contact	A contact party (e.g. guardian, partner, friend) for the patient.	0..*	BackboneElement	participant[pat_contact]	participant[pat_contact] SHALL conform to the template defined in participant (Patient contact) .
Patient > communication	Languages which may be used to communicate with the patient about his or her health.	0..*	BackboneElement	recordTarget[pat]/patientRole/patient/languageCommunication	

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Patient > communication > language	The ISO-639-1 alpha 2 code in lower case for the language, optionally followed by a hyphen and the ISO-3166-1 alpha 2 code for the region in upper case; e.g. 'en' for English, or 'en-US' for American English versus 'en-EN' for England English.	1..1	CodeableConcept	recordTarget[pat]/patientRole/patient/languageCommunication/ languageCode	This CDA schema element is of type CodedSimpleValue (CS). Common Languages in Australia (extensible)
Patient > communication > preferred	Indicates whether or not the patient prefers this language (over other languages he masters up a certain level).	0..1	boolean	recordTarget[pat]/patientRole/patient/languageCommunication/ preferenceInd	
Patient > generalPractitioner	Patient's nominated care provider.	0..*	Reference(Organization as Base Organization Practitioner as Base Practitioner)	participant	participant SHALL conform to the template defined in participant (generalPractitioner Base Organization) or participant (generalPractitioner Base Practitioner) .
Patient > managingOrganization	Organization that is the custodian of the patient record.	0..1	Reference(Organiza- tion as Base Organiza- tion)	recordTarget[pat]/patientRole/providerOrganization[manag_org]	providerOrganization SHALL conform to the template defined in providerOrganization (Base Organization) .

7.2 participant (Patient contact)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
CDA Header Data Elements				Context: /ClinicalDocument/	
Patient > contact	A contact party (e.g. guardian, partner, friend) for the patient.	Cardinality comes from linking element	BackboneElement	participant[pat_contact]	The patient's contact SHALL have at least: <ul style="list-style-type: none"> name (participant[pat_contact]/associatedEntity/associatedPerson/name), or telecom (participant[pat_contact]/associatedEntity/telecom), or address (participant[pat_contact]/associatedEntity/addr), or organization (participant[pat_contact]/associatedEntity/scopingOrganization)
				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]/templateId/@extension="1.0"	
				participant[pat_contact]/associatedEntity	
				participant[pat_contact]/associatedEntity/@typeCode="CON"	
				participant[pat_contact]/associatedEntity/id	Patient > contact is represented in CDA by a participant.
Patient > contact > relationship	The nature of the relationship between the patient and the contact person.	0..*	CodeableConcept	participant[pat_contact]/associatedEntity/associatedPerson/ext:personalRelationship	See <Personal Relationship> for available attributes. ContactEntityType (extensible)
Patient > contact > name	A name associated with the contact person.	0..1	HumanName	participant[pat_contact]/associatedEntity/associatedPerson/name	Recommended mappings for the complex data type to CDA (R2): HumanName .
Patient > contact > telecom	A contact detail for the person, e.g. a telephone number or an email address.	0..*	ContactPoint	participant[pat_contact]/associatedEntity/telecom	Recommended mappings for the complex data type to CDA (R2): ContactPoint .
Patient > contact > address	Address for the contact person.	0..1	Address	participant[pat_contact]/associatedEntity/addr	Recommended mappings for the complex data type to CDA (R2): Address Address as AU Base Address .
Patient > contact > gender	Administrative Gender - the gender that the contact person is considered to have for administration and record keeping purposes.	0..1	code	participant[pat_contact]/associatedEntity/associatedPerson/ext:administrativeGenderCode	See <code> for available attributes. AdministrativeGender (required)

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Patient > contact > organization	Organization on behalf of which the contact is acting or for which the contact is working.	0..1	Reference(Organization as Base Organization)	participant[pat_contact]/associatedEntity/scopingOrganization	contact > organization template is not currently defined.
				participant[pat_contact]/associatedEntity/scopingOrganization/@classCode="ORG"	
Patient > contact > period	The period during which this contact person or organization is valid to be contacted relating to this patient.	0..1	Period	n/a	This logical element has no mapping to CDA.

7.3 participant (generalPractitioner Base Organization)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	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	DomainResource	participant[gen_prac_org]	The organization SHALL have at least: <ul style="list-style-type: none"> • identifier (participant[gen_prac_org]/associatedEntity/scopingOrganization/ext:asEntityIdentifier), or • name (participant[gen_prac_org]/associatedEntity/scopingOrganization/name)
				participant[gen_prac_org]/@typeCode="PART"	
				participant[gen_prac_org]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				participant[gen_prac_org]/templateId/@root="1.2.36.1.2001.1001.102.101.100036"	
				participant[gen_prac_org]/templateId/@extension="1.0"	
				participant[gen_prac_org]/functionCode/@code="PCP"	
				participant[gen_prac_org]/associatedEntity	
				participant[gen_prac_org]/associatedEntity/@classCode="PROV"	
				participant[gen_prac_org]/associatedEntity/id	Optional CDA element. See <id> for available attributes.
Organization > identifier	Identifier for the organization that is used to identify the organization across multiple disparate systems.	0..*	Identifier	participant[gen_prac_org]/associatedEntity/scopingOrganization/ext:asEntityIdentifier	See <Entity Identifier> for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
Organization > active	Whether the organization's record is still in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Organization > type	The kind(s) of organization that this is.	0..1	CodeableConcept	participant[gen_prac_org]/associatedEntity/code	See <code> for available attributes. OrganizationType (example)
Organization > name	A name associated with the organization.	0..1	string	participant[gen_prac_org]/associatedEntity/scopingOrganization/name	In CDA name and alias are represented by scopingOrganization/name.
Organization > alias	A list of alternate names that the organization is known as, or was known as in the past.	0..*	string	participant[gen_prac_org]/associatedEntity/scopingOrganization/name	In CDA name and alias are represented by scopingOrganization/name.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Organization > telecom	A contact detail for the organization.	0..*	ContactPoint	participant[gen_prac_org]/associatedEntity/ telecom	telecom/@use is Organization Telecom Use HL7 V3 (required) . Recommended mappings for the complex data type to CDA (R2): ContactPoint .
Organization > address	An address for the organization.	0..*	Address	participant[gen_prac_org]/associatedEntity/ addr	addr/@use is Organization Address Use HL7 V3 (required) . Recommended mappings for the complex data type to CDA (R2): Address Address as AU Base Address .
Organization > partOf	The organization of which this organization forms a part.	0..1	Reference(Organization as Base Organization)	participant[gen_prac_org]/associatedEntity/scopingOrganization/ asOrganizationPartOf	wholeOrganization SHALL conform to the template defined in wholeOrganization (Base Organization) .
				participant[gen_prac_org]/associatedEntity/scopingOrganization/asOrganizationPartOf/ wholeOrganization	
CDA Header Data Elements					
Organization > contact	Contact for the organization for a certain purpose.	0..*	BackboneElement	participant[org_contact]	participant[org_contact] SHALL conform to the template defined in participant (Organization contact) .

7.4 participant (generalPractitioner Base Practitioner)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	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	DomainResource	participant[gen_prac_prac]	The practitioner SHALL have at least: <ul style="list-style-type: none"> • identifier (participant[gen_prac_prac]/associatedEntity/associatedPerson/ext:asEntityIdentifier), or • name (participant[gen_prac_prac]/associatedEntity/associatedPerson/name)
				participant[gen_prac_prac]/@typeCode="PART"	
				participant[gen_prac_prac]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				participant[gen_prac_prac]/templateId/@root="1.2.36.1.2001.1001.102.101.100037"	
				participant[gen_prac_prac]/templateId/@extension="1.0"	
				participant[gen_prac_prac]/functionCode/@code="PCP"	
				participant[gen_prac_prac]/associatedEntity	
				participant[gen_prac_org]/associatedEntity/@classCode="PROV"	
				participant[gen_prac_prac]/associatedEntity/id	Optional CDA element. See < id > for available attributes.
Practitioner > identifier	An identifier that applies to this person in this role.	0..*	Identifier	participant[gen_prac_prac]/associatedEntity/associatedPerson/ext:asEntityIdentifier	See < Entity Identifier > for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
Practitioner > active	Whether this practitioner's record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Practitioner > name	The name(s) associated with the practitioner.	0..*	HumanName	participant[gen_prac_prac]/associatedEntity/associatedPerson/name	Recommended mappings for the complex data type to CDA (R2): HumanName .
Practitioner > telecom	A contact detail for the practitioner, e.g. a telephone number or an email address.	0..*	ContactPoint	participant[gen_prac_prac]/associatedEntity/telecom	Recommended mappings for the complex data type to CDA (R2): ContactPoint .

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Practitioner > address	Address(es) of the practitioner that are not role specific (typically home address). Work addresses are not typically entered in this property as they are usually role dependent.	0..*	Address	participant[gen_prac_prac]/associatedEntity/addr	Recommended mappings for the complex data type to CDA (R2): Address Address as AU Base Address .
Practitioner > gender	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	code	participant[gen_prac_prac]/associatedEntity/associatedPerson/ ext:administrativeGenderCode	See code for available attributes. AdministrativeGender (required)
Practitioner > birthDate	The date of birth for the practitioner.	0..1	date	participant[gen_prac_prac]/associatedEntity/associatedPerson/ ext:birthTime	
Practitioner > qualification	Qualifications obtained by training and certification.	0..*	BackboneElement	See: instantiation choices	<p>It is possible that the qualification may be able to be captured as a complex structure or as a text list.</p> <p>instantiation choices:</p> <p>If the qualification or list of qualifications is the result of capturing a text field then this element is expected to be as ext:Qualifications/@classCode="QUAL". See Qualification for available attributes.</p> <p>If more information can be captured than a narrative list then this logical element is expected to be instantiated as ext:coverage2[prac_qual] and SHALL conform to the template defined in ext:coverage (Practitioner qualification).</p>
Practitioner > communication	A language the practitioner is able to use in patient communication.	0..*	CodeableConcept	participant[gen_prac_prac]/associatedEntity/associatedPerson/ ext:languageCommunication	See Language Communication for available attributes.

7.5 author (PractitionerRole with Practitioner with Mandatory Identifier)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Conformance level comes from linking elements				Context: Comes from linking elements	
PractitionerRole	A specific set of Roles/Locations/specialties/services that a practitioner may perform at an organization for a period of time.	Cardinality comes from linking element	DomainResource	author[prac_rol]	
				author[prac_rol]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				author[prac_rol]/templateId/@root="1.2.36.1.2001.1001.102.101.100006"	
				author[prac_rol]/templateId/@extension="1.0"	
				author[prac_rol]/assignedAuthor	The use of templateId signals the imposition of a set of template-defined constraints. See <id> for available attributes.
				author[prac_rol]/assignedAuthor/id	
PractitionerRole > identifier	Business identifiers for practitioner in a role.	0..*	Identifier	author[prac_rol]/assignedAuthor/assignedPerson/ext:asEntityIdentifier	In CDA the identifier for both PractitionerRole and Practitioner for an author participation are expected to be included in assignedPerson/ext:asEntityIdentifier. When sending to the My Health Record an HPI-I is expected. Cardinality of this element SHALL be interpreted as 1..*. See <Entity Identifier> for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
PractitionerRole > active	Whether this practitioner's record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Practitioner > period	The period during which the person is authorized to act as a practitioner in these role(s) for the organization.	0..1	Period	n/a	This logical element has no mapping to CDA.
PractitionerRole > practitioner	Practitioner that is able to provide the defined services for the organization.	1..1	DomainResource	author[prac_rol]/assignedAuthor/assignedPerson	assignedPerson SHALL conform to the template defined in assignedPerson (Practitioner with Mandatory Identifier) .
PractitionerRole > organization	The organization where the Practitioner performs the roles associated.	0..1	Reference(Organization as Base Organization)	author[prac_rol]/assignedAuthor/representedOrganization	representedOrganization SHALL conform to the template defined in representedOrganization (Base Organization) .
PractitionerRole > code	Roles which this practitioner is authorized to perform for the organization.	0..*	code	author[prac_rol]/assignedAuthor/code	A code equivalent to the provider's professional role, e.g. 159011008 Community pharmacist is expected. See <code> for available attributes. Australian and New Zealand Standard Classification of Occupations (preferred) or Practitioner Role (preferred) ¹

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
PractitionerRole > specialty	Specific specialty of the practitioner.	0..*	code	n/a	specialty is not currently mapped.
PractitionerRole > location	The location(s) at which this practitioner provides care.	0..*	Reference(Location)	n/a	location is not currently mapped.
PractitionerRole > healthcareService	The list of healthcare services that this worker provides for this role's Organization/Location(s).	0..*	Reference(Health-careService)	n/a	healthcareService is not currently mapped.
PractitionerRole > telecom	Contact details that are specific to the role/location/service.	0..*	ContactPoint	author[prac_rol]/assignedAuthor/telecom	In CDA the telecom for both PractitionerRole and Practitioner for an author participation are expected to be included in assignedAuthor/telecom. Recommended mappings for the complex data type to CDA (R2): ContactPoint .
PractitionerRole > availableTime	A collection of times that the Service Site is available.	0..*	BackboneElement	n/a	availableTime is not currently mapped.
PractitionerRole > notAvailable	The HealthcareService is not available during this period of time due to the provided reason.	0..*	string	n/a	notAvailable is not currently mapped.
PractitionerRole > availabilityExceptions	A description of site availability exceptions, e.g. public holiday availability. Succinctly describing all possible exceptions to normal site availability as details in the available Times and not available Times.	0..1	CodeableConcept	n/a	availabilityExceptions is not currently mapped.

¹Note: The source representation of this terminology binding on code in PractitionerRole with Practitioner with Mandatory Identifier [DH2019h] 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.

7.6 custodian (Organization with Mandatory Identifier)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	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	DomainResource	custodian[org]	
				custodian[org]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				custodian[org]/templateId/@root="1.2.36.1.2001.1001.102.101.100002"	
				custodian[org]/templateId/@extension="1.0"	
				custodian[org]/assignedCustodian	
				custodian[org]/assignedCustodian/representedCustodianOrganization	
				custodian[org]/assignedCustodian/representedCustodianOrganization/id	See <id> for available attributes.
Organization > identifier	Identifier for the organization that is used to identify the organization across multiple disparate systems.	1..*	Identifier	custodian[org]/assignedCustodian/representedCustodianOrganization/ext:asEntityIdentifier	When sending to the My Health Record an HPI-O is expected. See <Entity Identifier> for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
Organization > active	Whether the organization's record is still in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Organization > type	The kind(s) of organization that this is.	0..1	CodeableConcept	n/a	This logical element has no mapping to CDA.
Organization > name	A name associated with the organization.	0..1	string	custodian[org]/assignedCustodian/representedCustodianOrganization/ name	In CDA name and alias are represented by representedCustodianOrganization/name.
Organization > alias	A list of alternate names that the organization is known as, or was known as in the past.	0..*	string	n/a	This logical element has no mapping to CDA.
Organization > telecom	A contact detail for the organization.	0..*	ContactPoint	custodian[org]/assignedCustodian/representedCustodianOrganization/ telecom	In CDA the maximum occurrences of representedCustodianOrganization/telecom is 1. Although the model indicates that telecom is 0..*, in a CDA implementation this is limited to 0..1. telecom/@use is Organization Telecom Use HL7 V3 (required) . Recommended mappings for the complex data type to CDA (R2): ContactPoint .

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Organization > address	An address for the organization.	0..*	Address	custodian[org]/assignedCustodian/representedCustodianOrganization/addr	addr/@use is Organization Address Use HL7 V3 (required) . In CDA the maximum occurrences of representedCustodianOrganization/addr is 1. Although the model indicates that address is 0..*, in a CDA implementation this is limited to 0..1. Recommended mappings for the complex data type to CDA (R2): Address Address as AU Base Address .
Organization > partOf	The organization of which this organization forms a part.	0..1	Reference(Organization as Base Organization)	n/a	This logical element has no mapping to CDA.
CDA Header Data Elements					Context: /ClinicalDocument/
Organization > contact	Contact for the organization for a certain purpose.	0..*	BackboneElement	participant[org_contact]	participant[org_contact] SHALL conform to the template defined in participant (Organization contact) .

7.7 informationRecipient (Base Patient)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Conformance level comes from linking elements		Context: /ClinicalDocument/			
Patient	Demographics and other administrative information about an individual receiving care or other health-related services.	Cardinality comes from linking element	DomainResource	informationRecipient[pat]	The patient SHALL have at least: <ul style="list-style-type: none"> • name (informationRecipient[pat]/intendedRecipient/informationRecipient/name), or • identifier (informationRecipient[pat]/intendedRecipient/informationRecipient/ext:asEntityIdentifier)
				informationRecipient[pat]/@typeCode	This CDA schema element can be valued as "PRCP" primary information recipient or "TRC" secondary information recipient.
				informationRecipient[pat]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				informationRecipient[pat]/templateId/@root="1.2.36.1.2001.1001.102.101.100022"	
				informationRecipient[pat]/templateId/@extension="1.0"	
				informationRecipient[pat]/intendedRecipient	
				informationRecipient[pat]/intendedRecipient/@classCode="ASSIGNED"	Optional CDA element.
				informationRecipient[pat]/intendedRecipient/id	information-recipient (patient) is represented in CDA by an information recipient with the same id as the patient that is the subject of this document. This SHALL hold the same value as patientRole/id.
				informationRecipient[pat]/intendedRecipient/ext:code	Optional CDA element.
				informationRecipient[pat]/intendedRecipient/ext:code/@code="ONESELF"	
				informationRecipient[pat]/intendedRecipient/ext:code/@codeSystem="2.16.840.1.113883.5.111"	
				informationRecipient[pat]/intendedRecipient/informationRecipient	
Patient > birthPlace	The registered place of birth of the patient. A system may use the address.text if they don't store the birthPlace address in discrete elements.	0..1	Address	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/birthPlace/place/addr.
Patient > indigenous-status	National Health Data Dictionary (NHDD)-based indigenous status for a patient.	0..1	Coding	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ethnicGroupCode.
Patient > closing-the-gap-registration	Indication for eligibility for the Closing the Gap program.	0..1	boolean	n/a	Not mapped directly for this participant; this is implicit in entry[close_gap]/observation/value.

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

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

7.8 informationRecipient (Base PractitionerRole)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Conformance level comes from linking elements					Context: /ClinicalDocument/
PractitionerRole	A specific set of Roles/Locations/specialties/services that a practitioner may perform at an organization for a period of time.	Cardinality comes from linking element	DomainResource	informationRecipient[prac_rol]	The practitioner role SHALL have at least: <ul style="list-style-type: none"> • practitioner role or practitioner identifier (informationRecipient[prac_rol]/intendedRecipient/informationRecipient[prac]/ext:asEntityIdentifier), or • practitioner name (informationRecipient[prac_rol]/intendedRecipient/informationRecipient[prac]/name)
				informationRecipient[prac_rol]/@typeCode	This CDA schema element can be valued as "PRCP" primary information recipient or "TRC" secondary information recipient.
				informationRecipient[prac_rol]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				informationRecipient[prac_rol]/templateId/@root="1.2.36.1.2001.1001.102.101.100078"	
				informationRecipient[prac_rol]/templateId/@extension="1.0"	
				informationRecipient[prac_rol]/intendedRecipient	
				informationRecipient[prac_rol]/intendedRecipient/@classCode="ASSIGNED"	Optional CDA element.
PractitionerRole > identifier	Business identifiers for practitioner in a role.	0..*	Identifier	informationRecipient[prac_rol]/intendedRecipient/informationRecipient/ext:asEntityIdentifier	In CDA the identifier for both PractitionerRole and Practitioner for an informationRecipient participation are expected to be included in intendedRecipient/informationRecipient/ext:asEntityIdentifier.
					See Entity Identifier for available attributes.
Practitioner > period	The period during which the person is authorized to act as a practitioner in these role(s) for the organization.	0..1	Period	n/a	This logical element has no mapping to CDA.
PractitionerRole > practitioner	Practitioner that is able to provide the defined services for the organisation.	0..1	DomainResource	informationRecipient[prac_rol]/intendedRecipient/informationRecipient	informationRecipient SHALL conform to the template defined in informationRecipient (Base Practitioner) .

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
PractitionerRole > organization	The organization where the Practitioner performs the roles associated.	0..1	Reference(Organization as Base Organization)	informationRecipient[prac_rol]/intendedRecipient/receivedOrganization	receivedOrganization SHALL conform to the template defined in receivedOrganization (Base Organization) .
PractitionerRole > code	Roles which this practitioner is authorized to perform for the organization.	0..*	code	informationRecipient[prac_rol]/intendedRecipient/ext:code	See <code> for available attributes. Australian and New Zealand Standard Classification of Occupations (preferred) or Practitioner Role (preferred) ¹
PractitionerRole > specialty	Specific specialty of the practitioner.	0..*	code	n/a	specialty is not currently mapped.
PractitionerRole > location	The location(s) at which this practitioner provides care.	0..*	Reference(Location)	n/a	location is not currently mapped.
PractitionerRole > healthcareService	The list of healthcare services that this worker provides for this role's Organization/Location(s).	0..*	Reference(HealthcareService)	n/a	healthcareService is not currently mapped.
PractitionerRole > telecom	Contact details that are specific to the role/location/service.	0..*	ContactPoint	informationRecipient[prac_rol]/intendedRecipient/telecom	In CDA the telecom for both PractitionerRole and Practitioner for an informationRecipient participation are expected to be included in intendedRecipient/telecom. Recommended mappings for the complex data type to CDA (R2): ContactPoint .
PractitionerRole > availableTime	A collection of times that the Service Site is available.	0..*	BackboneElement	n/a	availableTime is not currently mapped.
PractitionerRole > notAvailable	The HealthcareService is not available during this period of time due to the provided reason.	0..*	string	n/a	notAvailable is not currently mapped.
PractitionerRole > availabilityExceptions	A description of site availability exceptions, e.g. public holiday availability. Succinctly describing all possible exceptions to normal site availability as details in the available Times and not available Times.	0..1	CodeableConcept	n/a	availabilityExceptions is not currently mapped.

¹Note: The source representation of this terminology binding on code in [\[DH2019h\]](#) 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.

7.9 informationRecipient (Base RelatedPerson)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Conformance level comes from linking elements					Context: /ClinicalDocument/
RelatedPerson	Information about a person that is involved in the care for a patient, but who is not the target of healthcare, nor has a formal responsibility in the care process.	Cardinality comes from linking element	DomainResource	informationRecipient[rel_per]	The related person SHALL have at least: <ul style="list-style-type: none"> name (informationRecipient[rel_per]/intendedRecipient/informationRecipient/name), or identifier (informationRecipient[rel_per]/intendedRecipient/informationRecipient/ext:asEntityIdentifier), or relationship (informationRecipient[rel_per]/intendedRecipient/informationRecipient/ext:personalRelationship)
				informationRecipient[rel_per]/@typeCode	This CDA schema element can be valued as "PRCP" primary information recipient or "TRC" secondary information recipient.
				informationRecipient[rel_per]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				informationRecipient[rel_per]/templateId/@root="1.2.36.1.2001.1001.102.101.100021"	
				informationRecipient[rel_per]/templateId/@extension="1.0"	
				informationRecipient[rel_per]/intendedRecipient	
				informationRecipient[rel_per]/intendedRecipient/@classCode="ASSIGNED"	Optional CDA element.
				informationRecipient[rel_per]/intendedRecipient/id	Optional CDA element. See <id> for available attributes.
				informationRecipient[rel_per]/intendedRecipient/informationRecipient	
RelatedPerson > identifier	Identifier for a person within a particular scope.	0..*	Identifier	informationRecipient[rel_per]/intendedRecipient/informationRecipient/ext:asEntityIdentifier	See <Entity Identifier> for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
RelatedPerson > active	Whether this related person record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
RelatedPerson > patient	The patient this person is related to.	1..1	Reference(Patient as Base Patient)	n/a	Not mapped directly for this participant; this is implicit in patientRole.
RelatedPerson > relationship	The nature of the relationship between a patient and the related person.	0..1	string	informationRecipient[rel_per]/intendedRecipient/informationRecipient/ext:personalRelationship	See < Personal Relationship > for available attributes.
RelatedPerson > name	A name associated with the person.	0..*	HumanName	informationRecipient[rel_per]/intendedRecipient/informationRecipient/name	Recommended mappings for the complex data type to CDA (R2): HumanName .
RelatedPerson > telecom	A contact detail for the person, e.g. a telephone number or an email address.	0..*	ContactPoint	informationRecipient[rel_per]/intendedRecipient/telecom	Recommended mappings for the complex data type to CDA (R2): ContactPoint .
RelatedPerson > gender	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	code	informationRecipient[rel_per]/intendedRecipient/informationRecipient/ext:administrativeGenderCode	See < code > for available attributes. AdministrativeGender (required)
RelatedPerson > birthDate	The date on which the related person was born.	0..1	date	informationRecipient[rel_per]/intendedRecipient/informationRecipient/ext:birthTime	See < time > for available attributes.
RelatedPerson > address	Address where the related person can be contacted or visited.	0..*	Address	informationRecipient[rel_per]/intendedRecipient/addr	Recommended mappings for the complex data type to CDA (R2): Address Address as AU Base Address .
RelatedPerson > period	The period of time that this relationship is considered to be valid. If there are no dates defined, then the interval is unknown.	0..1	Period	informationRecipient[rel_per]/intendedRecipient/informationRecipient/ext:personalRelationship[related]/ext:effectiveTime	See < time > for available attributes.

7.10 informationRecipient (Base Organization)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Conformance level comes from linking elements					Context: /ClinicalDocument/
Organization	A formally or informally recognized grouping of people or organizations formed for the purpose of achieving some form of collective action. Includes companies, institutions, corporations, departments, community groups, healthcare practice groups, etc.	Cardinality comes from linking element	DomainResource	informationRecipient[org]/	The organization SHALL have at least: <ul style="list-style-type: none"> • identifier (informationRecipient[org]/ext:asEntityIdentifier), or • name (informationRecipient[org]/name)
				informationRecipient[org]/@typeCode	This CDA schema element can be valued as "PRCP" primary information recipient or "TRC" secondary information recipient.
				informationRecipient[org]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				informationRecipient[org]/templateId/@root="1.2.36.1.2001.1001.102.101.100023"	
				informationRecipient[org]/templateId/@extension="1.0"	
				informationRecipient[org]/intendedRecipient	
				informationRecipient[org]/intendedRecipient/@classCode="ASSIGNED"	Optional CDA element.
				informationRecipient[org]/intendedRecipient/id	Optional CDA element. See < id > for available attributes.
					informationRecipient[org]/intendedRecipient/receivedOrganization
Organization > identifier	Identifier for the organization that is used to identify the organization across multiple disparate systems.	0..*	Identifier	informationRecipient[org]/intendedRecipient/receivedOrganization/ext:asEntityIdentifier	See < Entity Identifier > for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
Organization > active	Whether the organization's record is still in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Organization > type	The kind(s) of organization that this is.	0..1	CodeableConcept	informationRecipient[org]/intendedRecipient/ext:code	See < code > for available attributes. OrganizationType (example)
Organization > name	A name associated with the organization.	0..1	string	informationRecipient[org]/intendedRecipient/receivedOrganization/name	In CDA name and alias are represented by receivedOrganization/name.
Organization > alias	A list of alternate names that the organization is known as, or was known as in the past.	0..*	string	informationRecipient[org]/intendedRecipient/receivedOrganization/name	In CDA name and alias are represented by receivedOrganization/name.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Organization > telecom	A contact detail for the organization.	0..*	ContactPoint	informationRecipient[org]/intendedRecipient/ telecom	telecom/@use is Organization Telecom Use HL7 V3 (required) . Recommended mappings for the complex data type to CDA (R2): ContactPoint .
Organization > address	An address for the organization.	0..*	Address	informationRecipient[org]/intendedRecipient/ addr	addr/@use is Organization Address Use HL7 V3 (required) . Recommended mappings for the complex data type to CDA (R2): Address Address as AU Base Address .
Organization > partOf	The organization of which this organization forms a part.	0..1	Reference(Organization as Base Organization)	informationRecipient[org]/intendedRecipient/receivedOrganization/ asOrganizationPartOf informationRecipient[org]/intendedRecipient/receivedOrganization/asOrganizationPartOf/ wholeOrganization	wholeOrganization SHALL conform to the template defined in wholeOrganization (Base Organization) .
CDA Header Data Elements					Context: /ClinicalDocument/
Organization > contact	Contact for the organization for a certain purpose.	0..*	BackboneElement	participant[org_contact]	participant[org_contact] SHALL conform to the template defined in participant (Organization contact) .

7.11 informant (Base Patient)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
CDA Header Data Elements					
Patient	Demographics and other administrative information about an individual receiving care or other health-related services.	Cardinality comes from linking element	DomainResource	Context: Comes from linking element	
				informant[pat]	The patient SHALL have at least: <ul style="list-style-type: none"> • name (informant[pat]/assignedEntity/assignedPerson/name), or • identifier (informant[pat]/assignedEntity/assignedPerson/ext:asEntityIdentifier)
				informant[pat]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				informant[pat]/templateId/@root="1.2.36.1.2001.1001.102.101.100051"	
				informant[pat]/templateId/@extension="1.0"	
				informant[pat]/assignedEntity	
				informant[pat]/assignedEntity/id	This SHALL hold the same value as patientRole/id.
				informant[pat]/assignedEntity/code	Optional CDA element.
				informant[pat]/assignedEntity/code/@code="ONESELF"	
				informant[pat]/assignedEntity/code/@codeSystem="2.16.840.1.113883.5.111"	
				informant[pat]/assignedEntity/assignedPerson	
Patient > birthPlace	The registered place of birth of the patient. A system may use the address.text if they don't store the birthPlace address in discrete elements.	0..1	Address	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/birthplace/place/addr.
Patient > indigenous-status	National Health Data Dictionary (NHDD) based indigenous status for a patient.	0..1	Coding	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ethnicGroupCode.
Patient > closing-the-gap-registration	Indication for eligibility for the Closing the Gap program.	0..1	boolean	n/a	Not mapped directly for this participant; this is implicit in entry[close_gap]/observation/value.
Patient > patient-mothersMaidenName	Mother's maiden (unmarried) name, commonly collected to help verify patient identity.	0..1	string	n/a	Not mapped directly for this participant; this is implicit in entry[mothers_name]/observation/value.
Patient > identifier	An identifier for this patient.	0..*	Identifier	informant[pat]/assignedEntity/assignedPerson/ext:asEntityIdentifier	See <Entity Identifier> for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
Patient > active	Whether this patient record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Patient > name	A name associated with the individual.	0..*	HumanName	informant[pat]/assignedEntity/assignedPerson/ name	Recommended mappings for the complex data type to CDA (R2): HumanName .
Patient > telecom	A contact detail (e.g. a telephone number or an email address) by which the individual may be contacted.	0..*	ContactPoint	informant[pat]/assignedEntity/ telecom	Recommended mappings for the complex data type to CDA (R2): ContactPoint .
Patient > gender	Administrative Gender - the gender that the patient is considered to have for administration and record keeping purposes.	0..1	code	informant[pat]/assignedEntity/assignedPerson/ ext:administrativeGenderCode	See code for available attributes. AdministrativeGender (required)
Patient > birthDate	The date of birth for the individual.	0..1	date	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/birthTime.
Patient > deceased[x]	Indicates if the individual is deceased or not. Deceased date accuracy indicator is optional.	0..1	boolean dateTime	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ext:deceasedTime or patientRole/patient/ext:deceasedInd.
Patient > address	Addresses for the individual.	0..*	Address	informant[pat]/assignedEntity/ addr	When sending to the My Health Record this element is not expected to be sent. Recommended mappings for the complex data type to CDA (R2): Address Address as AU Base Address .
Patient > maritalStatus	This field contains a patient's most recent marital (civil) status.	0..1	CodeableConcept	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/maritalStatusCode.
Patient > multipleBirth[x]	Indicates whether the patient is part of a multiple (bool) or indicates the actual birth order (integer).	0..1	boolean integer	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ext:multipleBirthInd or patientRole/patient/multipleBirthOrderNumber.
Patient > contact	A contact party (e.g. guardian, partner, friend) for the patient.	0..*	BackboneElement	n/a	This logical element has no mapping to CDA.
Patient > communication	Languages which may be used to communicate with the patient about his or her health.	0..*	BackboneElement	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/languageCommunication.
Patient > generalPractitioner	Patient's nominated care provider.	0..*	Reference(Organization as Base Organization Practitioner as Base Practitioner)	n/a	This logical element has no mapping to CDA.
Patient > managingOrganization	Organization that is the custodian of the patient record.	0..1	Reference(Organization as Base Organization)	n/a	This logical element has no mapping to CDA.

7.12 informant (Base RelatedPerson)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Conformance level comes from linking elements		Context: Comes from linking elements			
RelatedPerson	Information about a person that is involved in the care for a patient, but who is not the target of healthcare, nor has a formal responsibility in the care process.	Cardinality comes from linking element	DomainResource	informant[rel_per]	The related person SHALL have at least: <ul style="list-style-type: none"> • name (informant[rel_per]/relatedEntity/relatedPerson/name), or • identifier (informant[rel_per]/relatedEntity/relatedPerson/ext:asEntityIdentifier), or • relationship (informant[rel_per]/relatedEntity/relatedPerson/ext:personalRelationship)
				informant[rel_per]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				informant[rel_per]/templateId/@root="1.2.36.1.2001.1001.102.101.100052"	
				informant[rel_per]/templateId/@extension="1.0"	
				informant[rel_per]/relatedEntity	
				informant[rel_per]/relatedEntity/@classCode="PRS"	
				informant[rel_per]/relatedEntity/code	Optional CDA element.
RelatedPerson > identifier	Identifier for a person within a particular scope.	0..*	Identifier	informant[rel_per]/relatedEntity/relatedPerson/ext:asEntityIdentifier	See Entity Identifier for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
					This logical element has no mapping to CDA.
RelatedPerson > active	Whether this related person record is in active use.	0..1	boolean	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient.
RelatedPerson > patient	The patient this person is related to.	1..1	Reference(Patient as Base Patient)	n/a	See Personal Relationship for available attributes.
RelatedPerson > relationship	The nature of the relationship between a patient and the related person.	0..1	string	informant[rel_per]/relatedEntity/relatedPerson/ext:personalRelationship	Recommended mappings for the complex data type to CDA (R2): HumanName .
RelatedPerson > name	A name associated with the person.	0..*	HumanName	informant[rel_per]/relatedEntity/relatedPerson/name	Recommended mappings for the complex data type to CDA (R2): HumanName .
RelatedPerson > telecom	A contact detail for the person, e.g. a telephone number or an email address.	0..*	ContactPoint	informant[rel_per]/relatedEntity/telecom	

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
RelatedPerson > gender	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	code	informant[rel_per]/relatedEntity/relatedPerson/ext:administrativeGenderCode	See <code> for available attributes. AdministrativeGender (required)
RelatedPerson > birthDate	The date on which the related person was born.	0..1	date	informant[rel_per]/relatedEntity/relatedPerson/ext:birthTime	See <time> for available attributes.
RelatedPerson > address	Address where the related person can be contacted or visited.	0..*	Address	informant[rel_per]/relatedEntity/addr	Recommended mappings for the complex data type to CDA (R2): Address Address as AU Base Address .
RelatedPerson > period	The period of time that this relationship is considered to be valid. If there are no dates defined, then the interval is unknown.	0..1	Period	informant[rel_per]/relatedEntity/relatedPerson/ext:personalRelationship[related]/ext:effectiveTime	See <time> for available attributes.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Practitioner > gender	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	code	informant[prac]/assignedEntity/assignedPerson/ ext:administrativeGenderCode	See code for available attributes. AdministrativeGender (required)
Practitioner > birthDate	The date of birth for the practitioner.	0..1	date	informant[prac]/assignedEntity/assignedPerson/ ext:birthTime	See time for available attributes.
Practitioner > qualification	Qualifications obtained by training and certification.	0..*	BackboneElement	See: instantiation choices	<p>It is possible that the qualification may be able to be captured as a complex structure or as a text list.</p> <p>instantiation choices:</p> <p>If the qualification or list of qualifications is the result of capturing a text field then this element is expected to be as ext:Qualifications/@classCode="QUAL". See Qualification for available attributes.</p> <p>If more information can be captured than a narrative list then this logical element is expected to be instantiated as ext:coverage2[prac_qual] and SHALL conform to the template defined in ext:coverage (Practitioner qualification).</p>
Practitioner > communication	A language the practitioner is able to use in patient communication.	0..*	CodeableConcept	informant[prac]/assignedEntity/assignedPerson/ ext:languageCommunication	See Language Communication for available attributes.

7.14 author (Base Patient)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	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	DomainResource	author[pat]	The patient SHALL have at least: <ul style="list-style-type: none"> • name (author[pat]/assignedAuthor/assignedPerson/name), or • identifier (author[pat]/assignedAuthor/assignedPerson/ext:asEntityIdentifier)
				author[pat]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				author[pat]/templateId/@root="1.2.36.1.2001.1001.102.101.100084"	
				author[pat]/templateId/@extension="1.0"	
				author[pat]/assignedAuthor/id	
				author[pat]/assignedAuthor/code	
				author[pat]/assignedAuthor/code/@code="ONESELF"	
				author[pat]/assignedAuthor/code/@codeSystem="2.16.840.1.113883.5.111"	
				author[pat]/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	Address	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/birthPlace/place/addr.
Patient > indigenous-status	National Health Data Dictionary (NHDD) based indigenous status for a patient.	0..1	Coding	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ethnicGroupCode.
Patient > closing-the-gap-registration	Indication for eligibility for the Closing the Gap program.	0..1	boolean	n/a	Not mapped directly for this participant; this is implicit in entry[close_gap]/observation/value.
Patient > patient-mothersMaiden-Name	Mother's maiden (unmarried) name, commonly collected to help verify patient identity.	0..1	string	n/a	Not mapped directly for this participant; this is implicit in entry[mothers_name]/observation/value.
Patient > identifier	An identifier for this patient.	0..*	Identifier	author[pat]/assignedAuthor/assignedPerson/ext:asEntityIdentifier	The value of one identifier SHALL be an Australian IHI. See < Entity Identifier > for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
Patient > active	Whether this patient record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Patient > name	A name associated with the individual.	0..*	HumanName	author[pat]/assignedAuthor/assignedPerson/ name	Recommended mappings for the complex data type to CDA (R2): HumanName .
Patient > telecom	A contact detail (e.g. a telephone number or an email address) by which the individual may be contacted.	0..*	ContactPoint	author[pat]/assignedAuthor/ telecom	Recommended mappings for the complex data type to CDA (R2): ContactPoint .
Patient > gender	Administrative Gender - the gender that the patient is considered to have for administration and record keeping purposes.	0..1	code	author[pat]/assignedAuthor/assignedPerson/ ext:administrativeGenderCode	See code for available attributes. AdministrativeGender (required)
Patient > birthDate	The date of birth for the individual.	0..1	date	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/birthTime.
Patient > deceased[x]	Indicates if the individual is deceased or not. Deceased date accuracy indicator is optional.	0..1	boolean dateTime	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ext:deceasedTime or patientRole/patient/ext:deceasedInd.
Patient > address	Addresses for the individual.	0..*	Address	author[pat]/assignedAuthor/ addr	When sending to the My Health Record this element is not expected to be sent. Recommended mappings for the complex data type to CDA (R2): Address .
Patient > maritalStatus	This field contains a patient's most recent marital (civil) status.	0..1	CodeableConcept	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/maritalStatusCode.
Patient > multipleBirth[x]	Indicates whether the patient is part of a multiple (bool) or indicates the actual birth order (integer).	0..1	boolean integer	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/ext:multipleBirthInd or patientRole/patient/multipleBirthOrderNumber.
Patient > contact	A contact party (e.g. guardian, partner, friend) for the patient.	0..*	BackboneElement	n/a	This logical element has no mapping to CDA.
Patient > communication	Languages which may be used to communicate with the patient about his or her health.	0..*	BackboneElement	n/a	Not mapped directly for this participant; this is implicit in patientRole/patient/languageCommunication.
Patient > generalPractitioner	Patient's nominated care provider.	0..*	Reference(Organization as Base Organization Practitioner as Base Practitioner))	n/a	This logical element has no mapping to CDA.
Patient > managingOrganization	Organization that is the custodian of the patient record.	0..1	Reference(Organization as Base Organization))	n/a	This logical element has no mapping to CDA.

7.15 author (Base PractitionerRole)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Conformance level comes from linking elements					Context: Comes from linking elements
PractitionerRole	A specific set of Roles/Locations/specialties/services that a practitioner may perform at an organization for a period of time.	Cardinality comes from linking element	DomainResource	author[prac_rol]	The practitioner role SHALL have at least: <ul style="list-style-type: none"> • practitioner role or practitioner identifier (author[prac_rol]/assignedAuthor/assignedPerson[prac]/ext:asEntityIdentifier), or • practitioner name (author[prac_rol]/assignedAuthor/assignedPerson[prac]/name)
				author[prac_rol]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				author[prac_rol]/templateId/@root="1.2.36.1.2001.1001.102.101.100085"	
				author[prac_rol]/templateId/@extension="1.0"	
				author[prac_rol]/assignedAuthor	The use of templateId signals the imposition of a set of template-defined constraints.
				author[prac_rol]/assignedAuthor/id	
PractitionerRole > identifier	Business identifiers for practitioner in a role.	0..*	Identifier	author[prac_rol]/assignedAuthor/assignedPerson/ext:asEntityIdentifier	In CDA the identifier for both PractitionerRole and Practitioner for an author participation are expected to be included in assignedPerson/ext:asEntityIdentifier. When sending to the My Health Record an HPI-I is expected. See Entity Identifier for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
PractitionerRole > active	Whether this practitioner's record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Practitioner > period	The period during which the person is authorized to act as a practitioner in these role(s) for the organization.	0..1	Period	n/a	This logical element has no mapping to CDA.
PractitionerRole > practitioner	Practitioner that is able to provide the defined services for the organization.	0..1	DomainResource	author[prac_rol]/assignedAuthor/assignedPerson	assignedPerson SHALL conform to the template defined in assignedPerson (Base Practitioner) .
PractitionerRole > organization	The organization where the Practitioner performs the roles associated.	0..1	Reference(Organization as Base Organization)	author[prac_rol]/assignedAuthor/representedOrganization	representedOrganization SHALL conform to the template defined in representedOrganization (Base Organization) .

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
PractitionerRole > code	Roles which this practitioner is authorized to perform for the organization.	0..*	code	author[prac_rol]/assignedAuthor/code	A code equivalent to the provider's professional role, e.g. 159011008 Community pharmacist is expected. See < code > for available attributes. Australian and New Zealand Standard Classification of Occupations (preferred) or Practitioner Role (preferred) ¹
PractitionerRole > specialty	Specific specialty of the practitioner.	0..*	code	n/a	specialty is not currently mapped.
PractitionerRole > location	The location(s) at which this practitioner provides care.	0..*	Reference(Location)	n/a	location is not currently mapped.
PractitionerRole > healthcareService	The list of healthcare services that this worker provides for this role's Organization/Location(s).	0..*	Reference(Health-careService)	n/a	healthcareService is not currently mapped.
PractitionerRole > telecom	Contact details that are specific to the role/location/service.	0..*	ContactPoint	author[prac_rol]/assignedAuthor/telecom	In CDA the telecom for both PractitionerRole and Practitioner for an author participation are expected to be included in assignedAuthor/telecom. Recommended mappings for the complex data type to CDA (R2): ContactPoint .
PractitionerRole > availableTime	A collection of times that the Service Site is available.	0..*	BackboneElement	n/a	availableTime is not currently mapped.
PractitionerRole > notAvailable	The HealthcareService is not available during this period of time due to the provided reason.	0..*	string	n/a	notAvailable is not currently mapped.
PractitionerRole > availabilityExceptions	A description of site availability exceptions, e.g. public holiday availability. Succinctly describing all possible exceptions to normal site availability as details in the available Times and not available Times.	0..1	CodeableConcept	n/a	availabilityExceptions is not currently mapped.

¹Note: The source representation of this terminology binding on code in PractitionerRole with Practitioner with Mandatory Identifier [DH2019h] 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.

7.16 author (Base RelatedPerson)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Conformance level comes from linking elements					Context: Comes from linking elements
RelatedPerson	Information about a person that is involved in the care for a patient, but who is not the target of healthcare, nor has a formal responsibility in the care process.	Cardinality comes from linking elements	DomainResource	author[rel_per]	The related person SHALL have at least: <ul style="list-style-type: none"> • name (author[rel_per]/assignedAuthor/assignedPerson/name), or • identifier (author[rel_per]/assignedAuthor/assignedPerson/ext:asEntityIdentifier), or • relationship (author[rel_per]/assignedAuthor/assignedPerson/ext:personalRelationship)
				author[rel_per]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				author[rel_per]/templateId/@root="1.2.36.1.2001.1001.102.101.100083"	
				author[rel_per]/templateId/@extension="1.0"	
				author[rel_per]/assignedAuthor	
				author[rel_per]/assignedAuthor/id	Optional CDA element. See < id > for available attributes.
				author[rel_per]/assignedAuthor/code	
				author[rel_per]/assignedAuthor/code/@code="AGNT"	
				author[rel_per]/assignedAuthor/code/@codeSystem="2.16.840.1.113883.5.110"	
				author[rel_per]/assignedAuthor/assignedPerson	
RelatedPerson > identifier	Identifier for a person within a particular scope.	0..*	Identifier	author[rel_per]/assignedAuthor/assignedPerson/ext:asEntityIdentifier	When sending to the My Health Record an IHI-I is expected. See < Entity Identifier > for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
RelatedPerson > active	Whether this related person record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
RelatedPerson > patient	The patient this person is related to.	1..1	Reference(Patient as Base Patient)	n/a	Not mapped directly for this participant; this is implicit in patientRole.
RelatedPerson > relationship	The nature of the relationship between a patient and the related person.	0..1	CodeableConcept	author[rel_per]/assignedAuthor/assignedPerson/ext:personalRelationship	See < Personal Relationship > for available attributes.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
RelatedPerson > name	A name associated with the person.	0..*	HumanName	author[rel_per]/assignedAuthor/assignedPerson/name	Recommended mappings for the complex data type to CDA (R2): HumanName .
RelatedPerson > telecom	A contact detail for the person, e.g. a telephone number or an email address.	0..*	ContactPoint	author[rel_per]/assignedAuthor/telecom	Recommended mappings for the complex data type to CDA (R2): ContactPoint .
RelatedPerson > gender	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	code	author[rel_per]/assignedAuthor/assignedPerson/ext:administrativeGenderCode	See <code> for available attributes. AdministrativeGender (required)
RelatedPerson > birthDate	The date on which the related person was born.	0..1	date	author[rel_per]/assignedAuthor/assignedPerson/ext:birthTime	See <time> for available attributes.
RelatedPerson > address	Address where the related person can be contacted or visited.	0..*	Address	author[rel_per]/assignedAuthor/addr	Recommended mappings for the complex data type to CDA (R2): Address .
RelatedPerson > period	The period of time that this relationship is considered to be valid. If there are no dates defined, then the interval is unknown.	0..1	Period	author[rel_per]/assignedAuthor/assignedPerson/ext:personalRelationship[related]/ext:effectiveTime	See <time> for available attributes.

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

8 Entity CDA templates

This chapter contains mapping from the Individual (e.g. Patient with Mandatory Identifier) and Entity (e.g. Organization with Mandatory Identifier) models to CDA entity classes, expressed as a series of CDA templates that describe how each CDA entity is composed.

CDA templates are expected to be reused from one document type (or Composition model) to another. Each CDA template is presented under a heading in the format of "CDA schema element" ("model name") where "CDA schema element" is the root element for a CDA template and "model name" is the name of a model that constrains an element in the Shared Medicines List hierarchy.

8.1 providerOrganization (Base Organization)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	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	DomainResource	providerOrganization[manag_org]	The organization SHALL have at least: <ul style="list-style-type: none">• identifier (providerOrganization[manag_org]/ext:asEntityIdentifier), or• name (providerOrganization[manag_org]/name)
				providerOrganization[manag_org]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				providerOrganization[manag_org]/templateId/@root= "1.2.36.1.2001.1001.102.101.100034"	
				providerOrganization[manag_org]/templateId/@extension="1.0"	
				providerOrganization[manag_org]/id	Optional CDA element. See <id> for available attributes.
Organization > identifier	Identifier for the organization that is used to identify the organization across multiple disparate systems.	0..*	Identifier	providerOrganization[manag_org]/ext:asEntityIdentifier	See <Entity Identifier> for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
Organization > active	Whether the organization's record is still in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Organization > type	The kind(s) of organization that this is.	0..1	CodeableConcept	providerOrganization[manag_org]/standardIndustryClassCode	See <code> for available attributes. OrganizationType (example)

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

8.2 participant (Organization contact)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
CDA Header Data Elements				Context: /ClinicalDocument/	
Organization > contact	Contact for the organization for a certain purpose.	Cardinality comes from linking element	BackboneElement	participant[org_contact]	
				participant[org_contact]/@typeCode="IND"	
				participant[org_contact]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				participant[org_contact]/templateId/@root="1.2.36.1.2001.1001.102.101.100035"	
				participant[org_contact]/templateId/@extension="1.0"	
				participant[org_contact]/associatedEntity	
				participant[org_contact]/associatedEntity/@classCode="CON"	
				participant[org_contact]/associatedEntity/scopingOrganization	
				participant[org_contact]/associatedEntity/scopingOrganization/@classCode="ORG"	Optional CDA element.
				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 SHALL hold the same value as the organization this is a contact for (the value in this id element SHALL be present in a separate participation).
Organization > contact > purpose	Indicates a purpose for which the contact can be reached.	0..1	CodeableConcept	participant[org_contact]/associatedEntity/code	See code for available attributes. ContactEntityType (extensible)
Organization > contact > name	A name associated with the contact.	0..1	HumanName	participant[org_contact]/associatedEntity/associatedPerson	
				participant[org_contact]/associatedEntity/associatedPerson/name	Recommended mappings for the complex data type to CDA (R2): HumanName .
Organization > contact > telecom	A contact detail (e.g. a telephone number or an email address) by which the party may be contacted.	0..*	ContactPoint	participant[org_contact]/associatedEntity/telecom	telecom/@use is Organization Telecom Use HL7 V3 (required) . Recommended mappings for the complex data type to CDA (R2): ContactPoint .
Organization > contact > address	Visiting or postal addresses for the contact.	0..1	Address	participant[org_contact]/associatedEntity/addr	Recommended mappings for the complex data type to CDA (R2): Address Address as AU Base Address .

8.3 representedOrganization (Base Organization)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	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	DomainResource	representedOrganization	The organization SHALL have at least: <ul style="list-style-type: none"> • name (<code>representedOrganization/name</code>), or • identifier (<code>representedOrganization/ext:asEntityIdentifier</code>)
				representedOrganization/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				<code>representedOrganization/templateId/@root="1.2.36.1.2001.1001.102.101.100039"</code>	
				<code>representedOrganization/templateId/@extension="1.0"</code>	
				representedOrganization/id	Optional CDA element. See < id > for available attributes.
Organization > identifier	Identifier for the organization that is used to identify the organization across multiple disparate systems.	0..*	Identifier	<code>representedOrganization/ext:asEntityIdentifier</code>	See < Entity Identifier > for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
Organization > active	Whether the organization's record is still in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Organization > type	The kind(s) of organization that this is.	0..1	CodeableConcept	<code>representedOrganization/standardIndustryClassCode</code>	See < code > for available attributes. OrganizationType (example)
Organization > name	A name associated with the organization.	0..1	string	<code>representedOrganization/name</code>	In CDA name and alias are represented by <code>representedOrganization/name</code> .
Organization > alias	A list of alternate names that the organization is known as, or was known as in the past.	0..*	string	<code>representedOrganization/name</code>	In CDA name and alias are represented by <code>representedOrganization/name</code> .
Organization > telecom	A contact detail for the organization.	0..*	ContactPoint	<code>representedOrganization/telecom</code>	telecom/@use is Organization Telecom Use HL7 V3 (required) . Recommended mappings for the complex data type to CDA (R2): ContactPoint .
Organization > address	An address for the organization.	0..*	Address	<code>representedOrganization/addr</code>	addr/@use is Organization Address Use HL7 V3 (required) . Recommended mappings for the complex data type to CDA (R2): Address Address as AU Base Address .

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Organization > partOf	The organization of which this organization forms a part.	0..1	Reference(Organization as Organization Base)	representedOrganization/asOrganizationPartOf	wholeOrganization SHALL conform to the template defined in wholeOrganization (Base Organization) .
				representedOrganization/asOrganizationPartOf/wholeOrganization	
CDA Header Data Elements				Context: /ClinicalDocument/	
Organization > contact	Contact for the organization for a certain purpose.	0..*	BackboneElement	participant[org_contact]	participant[org_contact] SHALL conform to the template defined in participant (Organization contact) .

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

8.5 manufacturerOrganization (Base Organization)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	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	DomainResource	manufacturerOrganization	The organization SHALL have at least: <ul style="list-style-type: none"> • name (manufacturerOrganization/name), or • identifier (manufacturerOrganization/ext:asEntityIdentifier)
				manufacturerOrganization/templatelid	The use of templatelid signals the imposition of a set of template-defined constraints.
				manufacturerOrganization/templatelid/@root="1.2.36.1.2001.1001.102.101.100071"	
				manufacturerOrganization/templatelid/@extension="1.0"	
				manufacturerOrganization/id	Optional CDA element. See < id > for available attributes.
Organization > identifier	Identifier for the organization that is used to identify the organization across multiple disparate systems.	0..*	Identifier	manufacturerOrganization/ext:asEntityIdentifier	See < Entity Identifier > for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
Organization > type	The kind(s) of organization that this is.	0..1	CodeableConcept	manufacturerOrganization/standardIndustryClassCode	See < code > for available attributes. OrganizationType (example)
Organization > name	A name associated with the organization.	0..1	string	manufacturerOrganization/name	In CDA name and alias are represented by manufacturerOrganization/name.
Organization > alias	A list of alternate names that the organization is known as, or was known as in the past.	0..*	string	manufacturerOrganization/name	In CDA name and alias are represented by manufacturerOrganization/name.
Organization > telecom	A contact detail for the organization.	0..*	ContactPoint	manufacturerOrganization/telecom	telecom/@use is Organization Telecom Use HL7 V3 (required) . Recommended mappings for the complex data type to CDA (R2): ContactPoint .
Organization > address	An address for the organization.	0..*	Address	manufacturerOrganization/addr	addr/@use is Organization Address Use HL7 V3 (required) . Recommended mappings for the complex data type to CDA (R2): Address Address as AU Base Address .

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Organization > partOf	The organization of which this organization forms a part.	0..1	Reference(Organization as Organization Base)	manufacturerOrganization/asOrganizationPartOf	wholeOrganization SHALL conform to the template defined in wholeOrganization (Base Organization) .
				manufacturerOrganization/asOrganizationPartOf/wholeOrganization	
CDA Header Data Elements				Context: /ClinicalDocument/	
Organization > contact	Contact for the organization for a certain purpose.	0..*	BackboneElement	participant[org_contact]	participant[org_contact] SHALL conform to the template defined in participant (Organization contact) .

8.6 assignedPerson (Practitioner with Mandatory Identifier)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	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	DomainResource	assignedPerson[prac]	
				assignedPerson[prac]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				assignedPerson[prac]/templateId/@root="1.2.36.1.2001.1001.102.101.100040"	
				assignedPerson[prac]/templateId/@extension="1.0"	
Practitioner > identifier	An identifier that applies to this person in this role.	1..*	Identifier	assignedPerson[prac]/ext:asEntityIdentifier	When sending to the My Health Record an HPI-I is expected. See <Entity Identifier> for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
Practitioner > active	Whether this practitioner's record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Practitioner > name	The name(s) associated with the practitioner.	0..*	HumanName	assignedPerson[prac]/name	Recommended mappings for the complex data type to CDA (R2): HumanName .
Practitioner > telecom	A contact detail for the practitioner, e.g. a telephone number or an email address.	0..*	ContactPoint	telecom	Recommended mappings for the complex data type to CDA (R2): ContactPoint .
Practitioner > address	Address(es) of the practitioner that are not role specific (typically home address). Work addresses are not typically entered in this property as they are usually role dependent.	0..*	Address	addr	Recommended mappings for the complex data type to CDA (R2): Address Address as AU Base Address .
Practitioner > gender	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	code	assignedPerson[prac]/ext:administrativeGenderCode	See <code> for available attributes. AdministrativeGender (required)
Practitioner > birthDate	The date of birth for the practitioner.	0..1	date	assignedPerson[prac]/ext:birthTime	See <time> for available attributes.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Practitioner > qualification	Qualifications obtained by training and certification.	0..*	BackboneElement	See: instantiation choices	<p>It is possible that the qualification may be able to be captured as a complex structure or as a text list.</p> <p>instantiation choices:</p> <p>If the qualification or list of qualifications is the result of capturing a text field then this element is expected to be as assignedPerson[prac]/ext:Qualifications/@classCode="QUAL". See Qualification for available attributes.</p> <p>If more information can be captured than a narrative list then this logical element is expected to be instantiated as ext:coverage2[prac_qual] and SHALL conform to the template defined in ext:coverage (Practitioner qualification).</p>
Practitioner > communication	A language the practitioner is able to use in patient communication.	0..*	CodeableConcept	assignedPerson[prac]/ext:languageCommunication	See Language Communication for available attributes.

8.7 assignedPerson (Base Practitioner)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	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	DomainResource	assignedPerson[prac]	
				assignedPerson[prac]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				assignedPerson[prac]/templateId/@root="1.2.36.1.2001.1001.102.101.100086"	
				assignedPerson[prac]/templateId/@extension="1.0"	
Practitioner > identifier	An identifier that applies to this person in this role.	0..*	Identifier	assignedPerson[prac]/ext:asEntityIdentifier	See Entity Identifier for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
Practitioner > active	Whether this practitioner's record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Practitioner > name	The name(s) associated with the practitioner.	0..*	HumanName	assignedPerson[prac]/name	Recommended mappings for the complex data type to CDA (R2): HumanName .
Practitioner > telecom	A contact detail for the practitioner, e.g. a telephone number or an email address.	0..*	ContactPoint	telecom	Recommended mappings for the complex data type to CDA (R2): ContactPoint .
Practitioner > address	Address(es) of the practitioner that are not role specific (typically home address). Work addresses are not typically entered in this property as they are usually role dependent.	0..*	Address	addr	Recommended mappings for the complex data type to CDA (R2): Address Address as AU Base Address .
Practitioner > gender	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	code	assignedPerson[prac]/ext:administrativeGenderCode	See code for available attributes. AdministrativeGender (required)
Practitioner > birthDate	The date of birth for the practitioner.	0..1	date	assignedPerson[prac]/ext:birthTime	See time for available attributes.
Practitioner > qualification	Qualifications obtained by training and certification.	0..*	BackboneElement	See: instantiation choices	<p>It is possible that the qualification may be able to be captured as a complex structure or as a text list.</p> <p>instantiation choices:</p> <p>If the qualification or list of qualifications is the result of capturing a text field then this element is expected to be as assignedPerson[prac]/ext:Qualifications/@classCode="QUAL". See Qualification for available attributes.</p> <p>If more information can be captured than a narrative list then this logical element is expected to be instantiated as ext:coverage2[prac_qual] and SHALL conform to the template defined in ext:coverage (Practitioner qualification).</p>

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Practitioner > communication	A language the practitioner is able to use in patient communication.	0..*	CodeableConcept	assignedPerson[prac]/ext:languageCommunication	See Language Communication for available attributes.

8.8 informationRecipient (Base Practitioner)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	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	DomainResource	informationRecipient[prac]	The practitioner SHALL have at least: <ul style="list-style-type: none"> • identifier (informationRecipient[prac]/ext:asEntityIdentifier), or • name (informationRecipient[prac]/name)
				informationRecipient[prac]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				informationRecipient[prac]/templateId/@root="1.2.36.1.2001.1001.102.101.100005"	
				informationRecipient[prac]/templateId/@extension="1.0"	
				informationRecipient[prac]/id	Optional CDA element. See < id > for available attributes.
Practitioner > identifier	An identifier that applies to this person in this role.	0..*	Identifier	informationRecipient[prac]/ext:asEntityIdentifier	See < Entity Identifier > for available attributes. Recommended mappings for the complex data type to CDA (R2): Identifier .
Practitioner > active	Whether this practitioner's record is in active use.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Practitioner > name	The name(s) associated with the practitioner.	0..*	HumanName	informationRecipient[prac]/name	Recommended mappings for the complex data type to CDA (R2): HumanName .
Practitioner > telecom	A contact detail for the practitioner, e.g. a telephone number or an email address.	0..*	ContactPoint	telecom	Recommended mappings for the complex data type to CDA (R2): ContactPoint .
Practitioner > address	Address(es) of the practitioner that are not role specific (typically home address). Work addresses are not typically entered in this property as they are usually role dependent.	0..*	Address	addr	Recommended mappings for the complex data type to CDA (R2): Address Address as AU Base Address .
Practitioner > gender	Administrative Gender - the gender that the person is considered to have for administration and record keeping purposes.	0..1	code	informationRecipient[prac]/ext:administrativeGenderCode	See < code > for available attributes. AdministrativeGender (required)
Practitioner > birthDate	The date of birth for the practitioner.	0..1	date	informationRecipient[prac]/ext:birthTime	See < time > for available attributes.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Practitioner > qualification	Qualifications obtained by training and certification.	0..*	BackboneElement	See: instantiation choices	<p>It is possible that the qualification may be able to be captured as a complex structure or as a text list.</p> <p>instantiation choices:</p> <p>If the qualification or list of qualifications is the result of capturing a text field then this element is expected to be as <code>informationRecipient[prac]/ext:Qualifications/@classCode="QUAL"</code>. See <Qualification> for available attributes.</p> <p>If more information can be captured than a narrative list then this logical element is expected to be instantiated as <code>ext:coverage2[prac_qual]</code> and SHALL conform to the template defined in ext:coverage (Practitioner qualification).</p>
Practitioner > communication	A language the practitioner is able to use in patient communication.	0..*	CodeableConcept	<code>informationRecipient[prac]/ext:languageCommunication</code>	See <Language Communication> for available attributes.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Organization > partOf	The organization of which this organization forms a part.	0..1	Reference(Organization as Organization Base)	wholeOrganization/asOrganizationPartOf	wholeOrganization/asOrganizationPartOf/wholeOrganization SHALL conform to the template defined in wholeOrganization (Base Organization) .
				wholeOrganization/asOrganizationPartOf/wholeOrganization	
CDA Header Data Elements				Context: /ClinicalDocument/	
Organization > contact	Contact for the organization for a certain purpose.	0..*	BackboneElement	participant[org_contact]	participant[org_contact] SHALL conform to the template defined in participant (Organization contact) .

9 Section CDA templates

This chapter contains mapping from the section (e.g. Medicines List) models to CDA section classes, expressed as a series of CDA templates that describe how each CDA section is composed.

CDA templates are expected to be reused from one document type (or Composition model) to another. Each CDA template is presented under a heading in the format of "CDA schema element" ("model name") where "CDA schema element" is the root element for a CDA template and "model name" is the name of a model that constrains an element in the Shared Medicines List hierarchy.

9.1 section (Allergies)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
CDA Body Level 3 Data Elements		Context: Comes from linking elements			
section	Information about allergies or intolerances. Information may include allergies or intolerances that have been identified or reported, or may include statements that a patient is not known to have an allergy or category of allergies.	Cardinality comes from linking element	BackboneElement	section[ai]	This section SHALL contain at least one entry (entry) or an emptyReason (@nullFlavor) but SHALL NOT contain both.
				section[ai]/ templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				section[ai]/templateId/@root="1.2.36.1.2001.1001.102.101.100069"	
				section[ai]/templateId/@extension="1.0"	
section > title	The label for this particular section. This will be part of the rendered content for the document, and is often used to build a table of contents.	1..1	string	section[ai]/title	
section > code	A code identifying the kind of content contained within the section. This must be consistent with the section title.	1..1	CodeableConcept	section[ai]/code	
				section[ai]/code/@code="48765-2"	
				section[ai]/code/@codeSystem="2.16.840.1.113883.6.1"	
				section[ai]/code/@codeSystemName	Optional CDA element. codeSystemName SHOULD be "LOINC".
				section[ai]/code/@displayName	Optional CDA element. displayName SHOULD be "Allergies &or adverse reactions".

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
section > text	A human-readable narrative that contains the attested content of the section, used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it 'clinically safe' for a human to just read the narrative.	1..1	narrative	section[ai]/text	See CDA narratives .
section > entry	A reference to the actual resource from which the narrative in the section is derived.	0..*	Reference(AllergyIntolerance) as Summary Statement of Allergy or Intolerance	section[ai]/entry[adv] section[ai]/entry[adv]/observation	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 SHALL conform to the template defined in observation (Summary Statement of Allergy or Intolerance) .
section > emptyReason	If the section is empty, why the list is empty. An empty section typically has some text explaining the empty reason.	0..1	CodeableConcept	section[ai]/@nullFlavor	Empty Reason HL7 v3 NullFlavor (required)¹ The nullFlavor attribute is used to represent the reason a section is empty of clinical content.

¹Note: The source terminology binding on emptyReason in Allergies [DH2019h] and the terminology binding in the representation of the model in this specification are different. Mappings between the set of concepts are defined in [Non-Clinical Empty Reason \(HL7 FHIR\) to Empty Reason HL7 v3 NullFlavor](#) concept map.

9.2 section (Medicines List)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
CDA Body Level 3 Data Elements				Comes from linking elements	
section	Information about medicines. This may include self-prescribed, clinician prescribed and nonprescription medicines, as well as all regular, intermittent and as required medicines pertinent to a patient. Information may also include changes to the therapy, including dose changes, new medicines and ceased medicines.	1..1	BackboneElement	section	This section SHALL contain an entry (entry) or an emptyReason (@nullFlavor) but SHALL NOT contain both. A Ceased Medicines section (code@code="101.32009") SHALL NOT have an assertion of no relevant finding entry (entry/observation/code/@code="ASSERTION").
				section[med]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				section[med]/templateId/@root="1.2.36.1.2001.1001.102.101.100077"	
				section[med]/templateId/@extension="1.0"	
section > title	The label for this particular section. This will be part of the rendered content for the document, and is often used to build a table of contents.	1..1	string	section[med]/title	
section > code	A code identifying the kind of content contained within the section. This must be consistent with the section title.	1..1	CodeableConcept	section[med]/code	See code for available attributes. History Of Medication Use List Type (required)
section > text	A human-readable narrative that contains the attested content of the section, used to represent the content of the resource to a human. The narrative need not encode all the structured data, but is required to contain sufficient detail to make it 'clinically safe' for a human to just read the narrative.	1..1	narrative	section[med]/text	See CDA narratives .
section > entry	A reference to the actual resource from which the narrative in the section is derived.	0..1	Reference (List as List of Medicine Items with Change Information Authored by Practitioner Observation as Assertion of No Relevant Finding)	section[med]/entry[meds]	instantiation choices:
				See: instantiation choices	If entry is a List then it SHALL be instantiated as section/entry[meds]/act. act SHALL conform to the template defined in act (List of Medicine Items with Change Information Authored by Practitioner) ; that act SHALL have the same code as this section. If entry is an Observation then it SHALL be instantiated as section/entry[meds]/observation. observation SHALL conform to the template defined in observation (Assertion of No Relevant Finding) and SHALL assert that there are no known current medications (observation/value/@code="1234391000168107").

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
section > emptyReason	If the section is empty, why the list is empty. An empty section typically has some text explaining the empty reason.	0..1	CodeableConcept	section[med]/@nullFlavor	<p>Empty Reason HL7 v3 NullFlavor (required)¹</p> <p>The nullFlavor attribute is used to represent the reason a section is empty of clinical content.</p>

¹Note: The source terminology binding on emptyReason in Medicines List [\[DH2019h\]](#) and the terminology binding in the representation of the model in this specification are different. Mappings between the set of concepts are defined in [Non-Clinical Empty Reason \(HL7 FHIR\) to Empty Reason HL7 v3 NullFlavor](#) concept map.

10 Act CDA templates

This chapter contains mapping from the Composition (Shared Medicines List) model and entry (e.g. Summary Statement of Allergy or Intolerance) models to CDA act classes, expressed as a series of CDA templates that describe how each CDA act is composed.

CDA templates are expected to be reused from one document type (or Composition model) to another. Each CDA template is presented under a heading in the format of "CDA schema element" ("model name") where "CDA schema element" is the root element for a CDA template and "model name" is the name of a model that constrains an element in the Shared Medicines List hierarchy.

10.1 encompassingEncounter (Summary of an Encounter for an Event)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
CDA Header Data Elements		Context: /ClinicalDocument/			
Encounter	An interaction between a patient and healthcare provider(s) for the purpose of providing healthcare service(s) or assessing the health status of a patient.	Cardinality comes from linking element	DomainResource	encompassingEncounter[event]	
				encompassingEncounter[event]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				encompassingEncounter[event]/templateId/@root= "1.2.36.1.2001.1001.102.101.100064"	
				encompassingEncounter[event]/templateId/@extension="1.0"	
				encompassingEncounter[event]/id	See <id> for available attributes. This SHALL hold the same value as encounter[event]/id.
Encounter > encounter-description	Description, overview or summary of a clinical event and its reasons.	0..1	string	n/a	Not mapped directly for this model; this is implicit in encounter[event]/text.
Encounter > status	planned arrived triaged in-progress onleave finished cancelled +.	1..1	code	n/a	Not mapped directly for this model; this is implicit in encounter[event]/statusCode.
Encounter > class	inpatient outpatient ambulatory emergency +.	0..1	code	encompassingEncounter[event]/code	See <code> for available attributes. ActEncounterCode (required) This SHALL hold the same value as encounter[event]/code.
Encounter > type	Specific type of encounter (e.g. e-mail consultation, surgical day-care, skilled nursing, rehabilitation).	0..*	CodeableConcept	n/a	This logical element has no mapping to CDA.
Encounter > subject	The patient or group present at the encounter.	0..1	Reference(Patient) as Patient with Mandatory Identifier	n/a	Not mapped directly for this model; this is implicit in patientRole.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Encounter > period	The start and end time of the encounter.	1..1	Period	encompassingEncounter[event]/effectiveTime	See < time > for available attributes. This SHALL hold the same value as encounter[event]/effectiveTime.
Encounter > reason	Reason the encounter takes place, expressed as a code. For admissions, this can be used for a coded admission diagnosis.	0..*	CodeableConcept	n/a	Not mapped directly for this model; this is implicit in encounter[event]/entryRelationship[reason]/observation/value.

10.2 encounter (Summary of an Encounter for an Event)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Conformance level comes from linking elements				Context: Comes from linking elements	
Encounter	An interaction between a patient and healthcare provider(s) for the purpose of providing healthcare service(s) or assessing the health status of a patient.	Cardinality comes from linking element	DomainResource	encounter[event]	This encounter provides further information from the same encounter that is captured in encompassingEncounter.
				encounter[event]/@classCode="ENC"	
				encounter[event]/@moodCode="EVN"	
				encounter[event]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				encounter[event]/templateId/@root="1.2.36.1.2001.1001.102.101.100062"	
				encounter[event]/templateId/@extension="1.0"	
				encounter[event]/id	This element will hold the same value as encompassingEncounter/id. See <id> for available attributes.
Encounter > encounter-description	Description, overview or summary of a clinical event and its reasons.	0..1	string	encounter[event]/text	
Encounter > status	planned arrived triaged in-progress onleave finished cancelled +.	1..1	code	encounter[event]/statusCode	This CDA schema element is of type CodedSimpleValue (CS). Encounter Act Status HL7 V3 (required)¹ statusCode/@code SHOULD be "completed".
Encounter > class	inpatient outpatient ambulatory emergency +.	0..1	CodeableConcept	encounter[event]/code	This element will hold the same value as encompassingEncounter/code. See <code> for available attributes. ActEncounterCode (required)

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Encounter > type	Specific type of encounter (e.g. e-mail consultation, surgical day-care, skilled nursing, rehabilitation).	0..*	code	encounter[event]/entryRelationship[type] encounter[event]/entryRelationship[type]/@typeCode="COMP" encounter[event]/entryRelationship[type]/observation encounter[event]/entryRelationship[type]/observation/@classCode="OBS" encounter[event]/entryRelationship[type]/observation/@moodCode="EVN" encounter[event]/entryRelationship[type]/observation/code encounter[event]/entryRelationship[type]/observation/code/@code="103.17018" encounter[event]/entryRelationship[type]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" encounter[event]/entryRelationship[type]/observation/code/@codeSystemName encounter[event]/entryRelationship[type]/observation/code/@displayName encounter[event]/entryRelationship[type]/observation/value	Optional CDA element. codeSystemName SHOULD be "NCTIS Data Components". displayName SHOULD be "Category". See <code> for available attributes. value/@xsi:type SHALL be "CD". Encounter Type (preferred) When sending a PSML, preferred terminology binding is: Medicines Review Type (preferred)
Encounter > subject	The patient or group present at the encounter.	0..1	Reference(Patient as Patient with Mandatory Identifier)	n/a	Not mapped directly for this model; this is implicit in patientRole.
Encounter > period	The start and end time of the encounter.	1..1	Period	encounter[event]/effectiveTime	This element will hold the same value as encompassingEncounter/effectiveTime. See <time> for available attributes.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Encounter > reason	Reason the encounter takes place, expressed as a code. For admissions, this can be used for a coded admission diagnosis.	0..*	CodeableConcept	encounter[event]/entryRelationship[reason] encounter[event]/entryRelationship[reason]/@typeCode="RSON" encounter[event]/entryRelationship[reason]/observation encounter[event]/entryRelationship[reason]/observation/@classCode="OBS" encounter[event]/entryRelationship[reason]/observation/@moodCode="EVN" encounter[event]/entryRelationship[reason]/observation/code encounter[event]/entryRelationship[reason]/observation/code/@code="103.10141" encounter[event]/entryRelationship[reason]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" encounter[event]/entryRelationship[reason]/observation/code/@displayName encounter[event]/entryRelationship[reason]/observation/code/@codeSystemName encounter[event]/entryRelationship[reason]/observation/statusCode/@code="completed" encounter[event]/entryRelationship[reason]/observation/value	Optional CDA element. displayName SHOULD be "Clinical Indication". codeSystemName SHOULD be "NCTIS Data Components". See <code> for available attributes. value/@xsi:type SHALL be "CD". Encounter Reason Codes (preferred)

¹Note: The source terminology binding on status in Summary of an Encounter for an Event [\[DH2019h\]](#) and the terminology binding in the representation of the model in this specification are different. Mappings between the set of concepts are defined in [EncounterStatus \(HL7 FHIR\) to Encounter Act Status HL7 v3](#) concept map.

10.3 observation (Summary Statement of Allergy or Intolerance)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Conformance level comes from linking elements					
AllergyIntolerance	Risk of harmful or undesirable, physiological response which is unique to an individual and associated with exposure to a substance.	Cardinality comes from linking element	DomainResource	<p>Context: Comes from linking elements</p> <p>observation[allergy]</p> <p>observation[allergy]/@classCode="OBS"</p> <p>observation[allergy]/@moodCode="EVN"</p> <p>observation[allergy]/templateId</p> <p>observation[allergy]/templateId/@root="1.2.36.1.2001.1001.102.101.100014"</p> <p>observation[allergy]/templateId/@extension="1.0"</p> <p>observation[allergy]/code</p>	<p>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[allergy]/value), and optionally in substance (participant[agent]/participantRole/playingEntity/code).</p> <p>An AllergyIntolerance SHALL have a maximum of one instance of recorder or author recorder-related-person (author).</p> <p>All instances of an observation[allergy]/author SHALL conform to one of the templates defined in: author (Base RelatedPerson) or author (Base Patient) or author (Base PractitionerRole).</p> <p>clinicalStatus (entryRelationship[clin_status]/observation) SHALL be instantiated if verificationStatus (entryRelationship[ver_status]/observation/value/@code) is not "entered-in-error".</p> <p>The use of templateId signals the imposition of a set of template-defined constraints.</p> <p>This CDA schema element is expected to be populated with AllergyIntolerance type.</p> <p>Where type is unavailable, a default code is provided and SHALL be instantiated as code@code="102.15517", code@displayName="Adverse Reaction", code@codeSystem="1.2.36.1.2001.1001.101".</p>
AllergyIntolerance > author-related-person	Reference to related person that recorded the record and takes responsibility for its content.	0..1	Reference(RelatedPerson as Base RelatedPerson)	observation[allergy]/author	<p>If this element is not instantiated the data is considered to be included via induction in ClinicalDocument/author.</p> <p>author SHALL conform to the template defined in author (Base RelatedPerson).</p>

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
AllergyIntolerance > clinical-Status	The clinical status of the allergy or intolerance.	0..1	code	observation[allergy]/entryRelationship[clin_status] observation[allergy]/entryRelationship[clin_status]/@typeCode="COMP" observation[allergy]/entryRelationship[clin_status]/observation observation[allergy]/entryRelationship[clin_status]/observation/@classCode="OBS" observation[allergy]/entryRelationship[clin_status]/observation/@moodCode="EVN" observation[allergy]/entryRelationship[clin_status]/observation/code observation[allergy]/entryRelationship[clin_status]/observation/code/@code="103.32013" observation[allergy]/entryRelationship[clin_status]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" observation[allergy]/entryRelationship[clin_status]/observation/code/@codeSystemName observation[allergy]/entryRelationship[clin_status]/observation/code/@displayName observation[allergy]/entryRelationship[clin_status]/observation/value	Optional CDA element. codeSystemName SHOULD be "NCTIS Data Components". displayName SHOULD be "Clinical Status". See code for available attributes. value/@xsi:type SHALL be "CD". value/@value SHOULD be "active". AllergyIntolerance Clinical Status (required)

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
AllergyIntolerance > verification-Status	Assertion about certainty associated with the propensity, or potential risk, of a reaction to the identified substance (including pharmaceutical product).	1..1	code	observation[allergy]/entryRelationship[ver_status] observation[allergy]/entryRelationship[ver_status]/@typeCode="COMP" observation[allergy]/entryRelationship[ver_status]/observation observation[allergy]/entryRelationship[ver_status]/observation/@classCode="OBS" observation[allergy]/entryRelationship[ver_status]/observation/@moodCode="EVN" observation[allergy]/entryRelationship[ver_status]/observation/code observation[allergy]/entryRelationship[ver_status]/observation/code/@code="103.32012" observation[allergy]/entryRelationship[ver_status]/observation/code/@codeSystem="1.2.36.1.2001.101.101" observation[allergy]/entryRelationship[ver_status]/observation/code/@codeSystemName observation[allergy]/entryRelationship[ver_status]/observation/code/@displayName observation[allergy]/entryRelationship[ver_status]/observation/value	Optional CDA element. codeSystemName SHOULD be "NCTIS Data Components". displayName SHOULD be "Verification Status". See <code>for available attributes. value/@xsi:type SHALL be "CD". value/@value SHOULD be "unconfirmed" or "confirmed". AllergyIntolerance Verification Status (required) </code>
AllergyIntolerance > type	Identification of the underlying physiological mechanism for the reaction risk.	0..1	code	observation[allergy]/code	See <code>for available attributes. AllergyIntoleranceType (required) </code>
AllergyIntolerance > code	Code for an allergy or intolerance statement (either a positive or a negated/excluded statement). This may be a code for a substance or pharmaceutical product that is considered to be responsible for the adverse reaction risk (e.g., 'Latex'), an allergy or intolerance condition (e.g., 'Latex allergy'), or a negated/excluded code for a specific substance or class (e.g., 'No latex allergy') or a general or categorical negated statement (e.g., 'No known allergy', 'No known drug allergies').	1..1	CodeableConcept	observation[allergy]/value	See <code>for available attributes. value/@xsi:type SHALL be "CD". Indicator of Hypersensitivity or Intolerance to Substance (preferred)¹ </code>
AllergyIntolerance > patient	The patient who has the allergy or intolerance.	1..1	Reference(Patient as Patient with Mandatory Identifier)	n/a	Not mapped directly for this model; this is implicit in patientRole.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
AllergyIntolerance > onset[x]	Estimated or actual date, date-time, or age when allergy or intolerance was identified.	0..1	dateTime Age Period Range	See: instantiation choices	<p>See time for available attributes.</p> <p>instantiation choices:</p> <p>If onset[x] is a dateTime then it SHALL be instantiated as observation[allergy]/effectiveTime/low/@value.</p> <p>If onset[x] is an Age then it SHALL be instantiated as observation[allergy]/entryRelationship[onset]/observation/value. value/@ xsi:type SHALL be "PQ". The code for observation[allergy]/entryRelationship[onset]/observation/code SHALL be code/@code="445518008" and code/@codeSystem="2.16.840.1.113883.6.96".</p> <p>If onset[x] is a Period then it SHALL be instantiated as observation[allergy]/effectiveTime/low/@value.</p> <p>If onset[x] is a Range then it SHALL be instantiated as observation[allergy]/effectiveTime/low/@value.</p>
AllergyIntolerance > recorder	Individual who recorded the record and takes responsibility for its content.	0..1	Reference(Patient) as Base Patient Practitioner as Base Practitioner	observation[allergy]/author	<p>If this element is not instantiated the data is considered to be included via induction in ClinicalDocument/author.</p> <p>In CDA an author (Practitioner) is part of an author (PractitionerRole).</p> <p>author SHALL conform to one of the templates defined in: author (Base Patient) or author (Base PractitionerRole).</p>

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
AllergyIntolerance > note	Additional narrative about the propensity for the Adverse Reaction, not captured in other fields.	0..*	Annotation	observation[allergy]/entryRelationship[note] observation[allergy]/entryRelationship[note]/@typeCode="COMP" observation[allergy]/entryRelationship[note]/act observation[allergy]/entryRelationship[note]/act/@classCode="ACT" observation[allergy]/entryRelationship[note]/act/@moodCode="EVN" observation[allergy]/entryRelationship[note]/act/code observation[allergy]/entryRelationship[note]/act/code/@code="103.16044" observation[allergy]/entryRelationship[note]/act/code/@codeSystem="1.2.36.1.2001.1001.101 observation[allergy]/entryRelationship[note]/act/code/@displayName observation[allergy]/entryRelationship[note]/act/code/@codeSystemName observation[allergy]/entryRelationship[note]/act/author observation[allergy]/entryRelationship[note]/act/effectiveTime observation[allergy]/entryRelationship[note]/act/text	Optional CDA element. displayName SHOULD be "Additional Comments". codeSystemName SHOULD be "NCTIS Data Components". If this element is not instantiated the data is considered to be included via induction in ClinicalDocument/author. See <time> for available attributes. If this element is not instantiated the data is considered to be included via induction in ClinicalDocument/author. text/@xsi:type SHALL be "ST".

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
AllergyIntolerance > reaction	Details about each adverse reaction event linked to exposure to the identified substance.	0..*	BackboneElement	observation[allergy]/entryRelationship[react] observation[allergy]/entryRelationship[react]@typeCode="COMP" observation[allergy]/entryRelationship[react]/observation observation[allergy]/entryRelationship[react]/observation/@classCode="OBS" observation[allergy]/entryRelationship[react]/observation/@moodCode="EVN" observation[allergy]/entryRelationship[react]/observation/code observation[allergy]/entryRelationship[react]/observation/code/@code="102.16474" observation[allergy]/entryRelationship[react]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" observation[allergy]/entryRelationship[react]/observation/code/@codeSystemName observation[allergy]/entryRelationship[react]/observation/code/@displayName	Optional CDA element. codeSystemName SHOULD be "NCTIS Data Components". displayName SHOULD be "Reaction Event".
AllergyIntolerance > reaction > substance	Identification of the specific substance (or pharmaceutical product) considered to be responsible for the Adverse Reaction event. Note: the substance for a specific reaction may be different from the substance identified as the cause of the risk, but it must be consistent with it. For instance, it may be a more specific substance (e.g. a brand medication) or a composite product that includes the identified substance. It must be clinically safe to only process the 'code' and ignore the 'reaction.substance'.	0..1	CodeableConcept	observation[allergy]/entryRelationship[react]/observation/participant[agent] observation[allergy]/entryRelationship[react]/observation/participant[agent]@typeCode="CAGNT" observation[allergy]/entryRelationship[react]/observation/participant[agent]/participantRole observation[allergy]/entryRelationship[react]/observation/participant[agent]/participantRole/playingEntity observation[allergy]/entryRelationship[react]/observation/participant[agent]/participantRole/playingEntity/code	See <code> for available attributes. Adverse Reaction Agent (preferred) ²
AllergyIntolerance > reaction > manifestation	Clinical symptoms and/or signs that are observed or associated with the adverse reaction event.	1..*	CodeableConcept	observation[allergy]/entryRelationship[react]/observation/entryRelationship[mfst] observation[allergy]/entryRelationship[react]/observation/entryRelationship[mfst]@typeCode="MFST" observation[allergy]/entryRelationship[react]/observation/entryRelationship[mfst]@inversionInd="true" observation[allergy]/entryRelationship[react]/observation/entryRelationship[mfst]/observation observation[allergy]/entryRelationship[react]/observation/entryRelationship[mfst]/observation/@classCode="OBS" observation[allergy]/entryRelationship[react]/observation/entryRelationship[mfst]/observation/@moodCode="EVN" observation[allergy]/entryRelationship[react]/observation/entryRelationship[mfst]/observation/code	See <code> for available attributes. Clinical Finding (preferred) ³

¹Note: The source representation of the terminology binding on code in Summary Statement of Allergy or Intolerance [DH2019h] is as an optional slice on the [coding](#) part of the code element. In the representation of the model presented in this specification it is normalised as a preferred binding.

²Note: The source representation of the terminology binding on substance in Summary Statement of Allergy or Intolerance [DH2019h] is as an optional slice on the [coding](#) part of the substance element. In the representation of the model presented in this specification it is normalised as a preferred binding.

³Note: The source representation of the terminology binding on manifestation in Summary Statement of Allergy or Intolerance [DH2019h] is as an optional slice on the [coding](#) part of the manifestation element. In the representation of the model presented in this specification it is normalised as a preferred binding.

10.4 act (List of Medicine Items with Change Information Authored by Practitioner)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Conformance level comes from linking elements				Context: Comes from linking elements	
List	A list of medicines authored by a practitioner at a point in time that describes the medicines an individual is taking.	1..1	DomainResource	act[med_lst]	When sending a Ceased Medicines List (code@code="101.32027"), entry items (entryRelationship[item]/substanceAdministration) are only expected to be ceased medicine items. When sending a Current Medicines List (code@code="101.32009"), entry items (entryRelationship[item]/substanceAdministration) are only expected to be new or existing medicine items and no ceased medicine items. When sending a PSML, and the List is a History of Medication (code@code="10160-0"), at least one entry item (entryRelationship[item]/substanceAdministration) is expected to be sent with at least one new or existing medicine item. A List SHALL have a maximum of one source (author).
				act[med_lst]/@classCode="ACT"	
				act[med_lst]/@moodCode="EVN"	
				act[med_lst]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				act[med_lst]/templateId/@root="1.2.36.1.2001.1001.102.101.100067"	
				act[med_lst]/templateId/@extension="1.0"	
List > author-role	Identifies the practitioner role responsible for the information in the resource (aka author), not necessarily who typed it in.	1..1	Reference(PractitionerRole as Base PractitionerRole)	act[med_lst]/author	This element will hold the same value as ClinicalDocument/author. author role SHALL conform to the template defined in author (PractitionerRole with Practitioner with Mandatory Identifier) .
List > status	Indicates the current state of this list.	1..1	code	act[med_lst]/statusCode	
				act[med_lst]/statusCode/@code="active"	The logical status of "current" is mapped to "active" in CDA.
List > title	A label for the list assigned by the author.	0..1	string	n/a	This logical element has no mapping to CDA. In CDA this is supported in either the narrative or the title of the applicable section.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
List > code	A code identifying the kind of content contained within the section. This must be consistent with the section title.	1..1	CodeableConcept	act[med_lst]/code	See <code> for available attributes. History Of Medication Use List Type (required)
List > subject	The common subject (or patient) of the resources that are in the list, if there is one.	1..1	Reference(Patient as Patient with Mandatory Identifier)	n/a	Not mapped directly for this model; this is implicit in patientRole.
List > encounter	The encounter that is the context in which this list was created.	0..1	Reference(Encounter as Summary of an Encounter for an Event)	act[med_lst]/entryRelationship[enc]	encounter SHALL conform to the template defined in encounter (Summary of an Encounter for an Event) .
				act[med_lst]/entryRelationship[enc]/@typeCode="COMP"	
				act[med_lst]/entryRelationship[enc]/encounter	
List > date	The date that the list was prepared.	1..1	dateTime	act[med_lst]/effectiveTime	See <time> for available attributes. This element will hold the same value as ClinicalDocument/author/time.
List > source	The entity responsible for deciding what the contents of the list were. Where the list was created by a human, this is the same as the author of the list.	1..1	Reference(Practitioner as Practitioner with Mandatory Identifier)	act[med_lst]/author	This element will hold the same value as ClinicalDocument/author. In CDA an author (Practitioner) is part of an author (PractitionerRole). author SHALL conform to the template defined in author (PractitionerRole with Practitioner with Mandatory Identifier) .

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
List > note	Comments that apply to the overall list.	0..*	Annotation	act[med_lst]/entryRelationship[note]	
				act[med_lst]/entryRelationship[note]/@typeCode="COMP"	
				act[med_lst]/entryRelationship[note]/act	
				act[med_lst]/entryRelationship[note]/act/@classCode="INFRM"	
				act[med_lst]/entryRelationship[note]/act/@moodCode="EVN"	
				act[med_lst]/entryRelationship[note]/act/code	
				act[med_lst]/entryRelationship[note]/act/code/@code="103.16044"	
				act[med_lst]/entryRelationship[note]/act/code/@codeSystem="1.2.36.1.2001.1001.101"	
				act[med_lst]/entryRelationship[note]/act/code/@displayName	Optional CDA element. displayName SHOULD be "Additional Comments".
				act[med_lst]/entryRelationship[note]/act/code/@codeSystemName	Optional CDA element. codeSystemName SHOULD be "NCTIS Data Components".
List > entry	List of medicine type entries	1..*	BackboneElement	act[med_lst]/entryRelationship[item]	
				act[med_lst]/entryRelationship[item]/@typeCode="COMP"	
List > entry > change-description	Description of a change including the reason for change.	0..1	string	//entryRelationship[flag]/observation/text	This element will provide the narrative to accompany the flag and may include reasons for stopping or introducing a medicine item, or describe the narrative of the change itself e.g. dose, form, route, frequency.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
List > entry > flag	The flag allows the system constructing the list to indicate the role and significance of the item in the list.	1..1	CodeableConcept	//entryRelationship[flag] //entryRelationship[flag]/@typeCode="SUBJ" //entryRelationship[flag]/@inversionInd="true" //entryRelationship[flag]/observation //entryRelationship[flag]/observation/@classCode="OBS" //entryRelationship[flag]/observation/@moodCode="EVN" //entryRelationship[flag]/observation/code //entryRelationship[flag]/observation/code/@code="288533004" //entryRelationship[flag]/observation/code/@codeSystem="2.16.840.1.113883.6.96" //entryRelationship[flag]/observation/code/@displayName //entryRelationship[flag]/observation/code/@codeSystemName //entryRelationship[flag]/observation/value	See <code> for available attributes. A flag (entryRelationship[flag]) SHALL be instantiated as a direct child of item (entryRelationship[item]). For example act[med_lst]/entryRelationship[item]/substanceAdministration/entryRelationship[flag].
List > entry > item	A reference to the actual resource from which data was derived.	1..1	Reference(MedicineItemStatement as Medicine Item Statement)	act[med_lst]/entryRelationship[item] act[med_lst]/entryRelationship[item]/substanceAdministration	substanceAdministration SHALL conform to the template defined in substanceAdministration (Medicine Item Statement).

10.5 substanceAdministration (Medicine Item Statement)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
	Conformance level comes from linking elements				
MedicationStatement	A record of a medication that is being consumed by a patient. A MedicationStatement may indicate that the patient may be taking the medication now, or has taken the medication in the past or will be taking the medication in the future. The source of this information can be the patient, significant other (such as a family member or spouse), or a clinician. A common scenario where this information is captured is during the history taking process during a patient visit or stay. The medication information may come from sources such as the patient's memory, from a prescription bottle, or from a list of medications the patient, clinician or other party maintains. The primary difference between a medication statement and a medication administration is that the medication administration has complete administration information and is based on actual administration information from the person who administered the medication. A medication statement is often, if not always, less specific. There is no required date/time when the medication was administered, in fact we only know that a source has reported the patient is taking this medication, where details such as time, quantity, or rate or even medication product may be incomplete or missing or less precise. As stated earlier, the medication statement information may come from the patient's memory, from a prescription bottle or from a list of medications the patient, clinician or other party maintains. Medication administration is more formal and is not missing detailed information.	Cardinality comes from linking element	DomainResource	substanceAdministration[med_stat]	All instances of a MedicationStatement informationSource (informant) SHALL conform to one of the templates defined in: informant (Base RelatedPerson) or informant (Base Patient) or informant (Base Practitioner) .
				substanceAdministration[med_stat]/@classCode="SBADM"	
				substanceAdministration[med_stat]/@moodCode	When sending a PSML, this is expected to be "EVN". SHALL NOT be "RQO". HL7 v3 Value Set ActMood (required)
				substanceAdministration[med_stat]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				substanceAdministration[med_stat]/templateId/@root="1.2.36.1.2001.1001.102.101.100066"	
				substanceAdministration[med_stat]/templateId/@extension="1.0"	
MedicationStatement > identifier	External identifier - FHIR will generate its own internal identifiers (probably URLs) which do not need to be explicitly managed by the resource. The identifier here is one that would be used by another non-FHIR system - for example an automated medication pump would provide a record each time it operated; an administration while the patient was off the ward might be made with a different system and entered after the event. Particularly important if these records have to be updated.	0..*	Identifier	substanceAdministration[med_stat]/id	See <id> for available attributes.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
MedicationStatement > context	The encounter or episode of care that establishes the context for this MedicationStatement.	0..1	Reference(Encounter as Summary of an Encounter for an Event)	substanceAdministration[med_stat]/entryRelationship[context]	
				substanceAdministration[med_stat]/entryRelationship[context]/@typeCode="COMP"	
				substanceAdministration[med_stat]/entryRelationship[context]/@inversionInd="true"	
				substanceAdministration[med_stat]/entryRelationship[context]/encounter	encounter SHALL conform to the template defined in encounter (Summary of an Encounter for an Event) .
MedicationStatement > status	A code representing the patient or other source's judgment about the state of the medication used that this statement is about. Generally this will be active or completed.	1..1	code	substanceAdministration[med_stat]/statusCode	This CDA schema element is of type CodedSimpleValue (CS). Medication Act Status HL7 v3 (required) ¹
MedicationStatement > category	Indicates where type of medication statement and where the medication is expected to be consumed or administered.	0..1	CodeableConcept	substanceAdministration[med_stat]/entryRelationship[category]	
				substanceAdministration[med_stat]/entryRelationship[category]/@typeCode="COMP"	
				substanceAdministration[med_stat]/entryRelationship[category]/observation	
				substanceAdministration[med_stat]/entryRelationship[category]/observation/@classCode="OBS"	
				substanceAdministration[med_stat]/entryRelationship[category]/observation/@moodCode="EVN"	
				substanceAdministration[med_stat]/entryRelationship[category]/observation/code	
				substanceAdministration[med_stat]/entryRelationship[category]/observation/code/@code="276339004"	
				substanceAdministration[med_stat]/entryRelationship[category]/observation/code/@codeSystem="2.16.840.1.113883.6.96"	
				substanceAdministration[med_stat]/entryRelationship[category]/observation/code/@codeSystemName	Optional CDA element. codeSystemName SHOULD be "SNOMED CT".
				substanceAdministration[med_stat]/entryRelationship[category]/observation/code/@displayName	Optional CDA element. displayName SHOULD be "Environment".
MedicationStatement > medication[x]	Identifies the medication being administered. This is either a link to a resource representing the details of the medication or a simple attribute carrying a code that identifies the medication from a known list of medications.	1..1	Reference(Medication as Base Medication)	substanceAdministration[med_stat]/consumable	manufacturedProduct SHALL conform to the template defined in manufacturedProduct (Base Medication) .
				substanceAdministration[med_stat]/consumable/manufacturedProduct	
MedicationStatement > effective[x]	The interval of time during which it is being asserted that the patient was taking the medication (or was not taking, when the wasNotGiven element is true).	0..1	dateTime Period	substanceAdministration[med_stat]/effectiveTime	See <time> for available attributes.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
MedicationStatement > dateAsserted	The date when the medication statement was asserted by the information source.	0..1	dateTime	See: instantiation choices	<p>See <time> for available attributes.</p> <p>instantiation choices:</p> <p>Date asserted SHALL be instantiated as informant/as-signedEntity/time when the asserter is a Practitioner.</p> <p>Date asserted SHALL be instantiated as informant/relatedEntity/time when the asserter is a Related Person or Patient.</p>
MedicationStatement > informationSource	The person or organization that provided the information about the taking of this medication. Note: Use derivedFrom when a MedicationStatement is derived from other resources, e.g Claim or MedicationRequest.	0..1	Reference(Related-Person) as Base RelatedPerson Patient as Base Patient Practitioner as Base Practitioner)	substanceAdministration[med_stat]/informant	<p>If this element is not instantiated the data is considered to be included via induction in patientRole.</p> <p>informant SHALL conform to one of the templates defined in: informant (Base RelatedPerson) or informant (Base Patient) or informant (Base Practitioner).</p>
MedicationStatement > subject	The person, animal or group who is/was taking the medication.	1..1	Reference(Patient) as Patient with Mandatory Identifier)	n/a	Not mapped directly for this model; this is implicit in patientRole.
MedicationStatement > taken	Indicator of the certainty of whether the medication was taken by the patient.	1..1	code	See: instantiation choices	<p>This logical element may have a value of y n unk na as per MedicationStatementTaken (required)</p> <p>instantiation choices:</p> <p>When the logical assertion is "y", there is no direct mapping into CDA as this is implicit in the instantiation of the substanceAdministration class.</p> <p>When the logical assertion is "n", this SHALL be instantiated as substanceAdministration/@negationInd="true" unless status is "new" or "suspended" in which case this is implicit in the statusCode; a negationInd SHALL NOT be present where substanceAdministration/statusCode/@code is "new" or "suspended".</p> <p>When the logical assertion is "unk" or "na", this SHALL be instantiated as substanceAdministration/@nullFlavor="UNK" or substanceAdministration/@nullFlavor="NA" respectively.</p>

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
MedicationStatement > reason-NotTaken	A code indicating why the medication was not taken.	0..*	CodeableConcept	substanceAdministration[med_stat]/entryRelationship[not_taken] substanceAdministration[med_stat]/entryRelationship[not_taken]/@typeCode= "COMP" substanceAdministration[med_stat]/entryRelationship[not_taken]/observation substanceAdministration[med_stat]/entryRelationship[not_taken]/observation/@classCode="OBS" substanceAdministration[med_stat]/entryRelationship[not_taken]/observation/@moodCode="EVN" substanceAdministration[med_stat]/entryRelationship[not_taken]/observation/code substanceAdministration[med_stat]/entryRelationship[not_taken]/observation/code/@code="103.32024" substanceAdministration[med_stat]/entryRelationship[not_taken]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" substanceAdministration[med_stat]/entryRelationship[not_taken]/observation/code/@displayName substanceAdministration[med_stat]/entryRelationship[not_taken]/observation/code/@codeSystemName substanceAdministration[med_stat]/entryRelationship[not_taken]/observation/statusCode/@code="completed" substanceAdministration[med_stat]/entryRelationship[not_taken]/observation/value	SHALL only be present if if the logical value of taken is "n" (substanceAdministration/@negationInd="true"). Optional CDA element. displayName SHOULD be "Reason for Status". Optional CDA element. codeSystemName SHOULD be "NCTIS Data Components". See <code> for available attributes. value/@xsi:type SHALL be "CD". Medication Reason Not Taken (preferred)

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
MedicationStatement > reason-Code	A reason for why the medication is being/was taken.	0..*	CodeableConcept	substanceAdministration[med_stat]/entryRelationship[reason] substanceAdministration[med_stat]/entryRelationship[reason]/@typeCode="RSON" substanceAdministration[med_stat]/entryRelationship[reason]/observation substanceAdministration[med_stat]/entryRelationship[reason]/observation/@classCode="OBS" substanceAdministration[med_stat]/entryRelationship[reason]/observation/@moodCode="EVN" substanceAdministration[med_stat]/entryRelationship[reason]/observation/code substanceAdministration[med_stat]/entryRelationship[reason]/observation/code/@code="103.10141" substanceAdministration[med_stat]/entryRelationship[reason]/observation/code/@codeSystem="1.2.36.1.2001.1001.101" substanceAdministration[med_stat]/entryRelationship[reason]/observation/code/@displayName substanceAdministration[med_stat]/entryRelationship[reason]/observation/code/@codeSystemName substanceAdministration[med_stat]/entryRelationship[reason]/observation/value	Optional CDA element. displayName SHOULD be "Clinical Indication". codeSystemName SHOULD be "NCTIS Data Components". See <code> for available attributes. value/@xsi:type SHALL be "CD". Medication Reason Taken (preferred) ³

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
MedicationStatement > note	Provides extra information about the medication statement that is not conveyed by the other attributes.	0..*	Annotation	substanceAdministration[med_stat]/entryRelationship[note] substanceAdministration[med_stat]/entryRelationship[note]/@typeCode="COMP" substanceAdministration[med_stat]/entryRelationship[note]/act substanceAdministration[med_stat]/entryRelationship[note]/act/@classCode="ACT" substanceAdministration[med_stat]/entryRelationship[note]/act/@moodCode="EVN" substanceAdministration[med_stat]/entryRelationship[note]/act/code substanceAdministration[med_stat]/entryRelationship[note]/act/code/@code="103.16044" substanceAdministration[med_stat]/entryRelationship[note]/act/code/@codeSystem="1.2.36.1.2001.1001.101" substanceAdministration[med_stat]/entryRelationship[note]/act/code/@displayName substanceAdministration[med_stat]/entryRelationship[note]/act/code/@codeSystemName substanceAdministration[med_stat]/entryRelationship[note]/act/author substanceAdministration[med_stat]/entryRelationship[note]/act/effectiveTime substanceAdministration[med_stat]/entryRelationship[note]/act/text	Optional CDA element. displayName SHOULD be "Additional Comments". codeSystemName SHOULD be "NCTIS Data Components". If this element is not instantiated the data is considered to be included via induction in ClinicalDocument/author. See <code><time></code> for available attributes. If this element is not instantiated the data is considered to be included via induction in ClinicalDocument/author. text/@xsi:type SHALL be "ST".
MedicationStatement > dosage	Indicates how the medication is/was or should be taken by the patient.	1..*	Reference(Dosage as AU Base Dosage)	substanceAdministration[med_stat]/text	dosage SHALL at least include text or patient instructions Recommended mappings for the complex data type to CDA (R2): Dosage as AU Base Dosage .

¹Note: The source terminology binding on status in Medicine Item Statement [DH2019h] and the terminology binding in the representation of the model in this specification are different. Mappings between the set of concepts are defined in [MedicationStatementStatus \(HL7 FHIR\) to Medication Act Status HL7 v3](#) concept map.

²Note: The source representation of the terminology binding on medication[x] in Medicine Item Statement [DH2019h] is as optional slices on the `coding` part of the medication[x] element. In the representation of the model presented in this specification it is normalised as example bindings.

³Note: The source representation of the terminology binding on reasonCode in Medicine Item Statement [DH2019h] is as an optional slice on the `coding` part of the reasonCode element. In the representation of the model presented in this specification it is normalised as a preferred binding.

10.6 manufacturedProduct (Base Medication)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Conformance level comes from linking elements				Context: Comes from linking elements	
Medication	Medication content use in an Australian context. Includes concepts that are specific to Australian usage.	Cardinality comes from linking element	DomainResource	manufacturedProduct[med]	
				manufacturedProduct[med]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				manufacturedProduct[med]/templateId/@root="1.2.36.1.2001.1001.102.101.100068"	
				manufacturedProduct[med]/templateId/@extension="1.0"	
Medication > medication-brand-name	The brand medication text name for an associated medication, this may be supplied if a coded brand name is not available.	0..1	string	//entryRelationship[brand]	A medication-brand-name (entryRelationship[brand]) SHALL be instantiated as a direct child of item (entryRelationship[item]).
				//entryRelationship[brand]/@typeCode="COMP"	For example act[med_1st]/entryRelationship[item]/substanceAdministration/entryRelationship[brand].
				//entryRelationship[brand]/act	Where brand name is known it is expected to form part of the originalText of the code (manufacturedMaterial/code/@originalText), and optionally be in medication-brand-name (entryRelationship[brand]/act/text).
				//entryRelationship[brand]/act/@classCode="ACT"	
				//entryRelationship[brand]/act/@moodCode="EVN"	
				//entryRelationship[brand]/act/code	
				//entryRelationship[brand]/act/code/@code="TBD"	
				//entryRelationship[brand]/act/code/@codeSystem="2.16.840.1.113883.6.96"	
				//entryRelationship[brand]/act/code/@codeSystemName	Optional CDA element. codeSystemName SHOULD be "SNOMED CT".
				//entryRelationship[brand]/act/code/@displayName	Optional CDA element. displayName SHOULD be "Brand Name".
				//entryRelationship[brand]/act/text	text/@xsi:type SHALL be "ST".

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Medication > medication-generic-name	The generic medication text name for an associated medication, this may not be the same as the subject medication (prescribed, dispensed or stated) but may be used to provide an additional or equivalent drug name that is a generic medication concept.	0..1	string	//entryRelationship[generic]	A medication-generic-name (entryRelationship[generic]) SHALL be instantiated as a direct child of item (entryRelationship[item]). For example act[med_lst]/entryRelationship[item]/substanceAdministration/entryRelationship[generic].
				//entryRelationship[generic]/@typeCode="COMP"	
				//entryRelationship[generic]/act	
				//entryRelationship[generic]/act/@classCode="ACT"	
				//entryRelationship[generic]/act/@moodCode="EVN"	
				//entryRelationship[generic]/act/code	
				//entryRelationship[generic]/act/code/@code="TBD"	
				//entryRelationship[generic]/act/code/@codeSystem="2.16.840.1.113883.6.96"	
				//entryRelationship[generic]/act/code/@codeSystemName	Optional CDA element. codeSystemName SHOULD be "SNOMED CT".
				//entryRelationship[generic]/act/code/@displayName	Optional CDA element. displayName SHOULD be "Generic Name".
				//entryRelationship[generic]/act/text	text/@xsi:type SHALL be "ST".
Medication > code	Australian coding slices are typical medicine/product concept codes.	1..1	CodeableConcept	manufacturedProduct[med]/ manufacturedMaterial	When sending a PSML, PBS Item codes are expected to be sent as one or more translations of the AMT code.
				manufacturedProduct[med]/manufacturedMaterial/@determinerCode="KIND"	See <code> for available attributes.
				manufacturedProduct[med]/manufacturedMaterial/code	Australian Medication (preferred) ¹ Australian Pharmaceutical Benefits Scheme Schedule Item (example) ² MIMS Terminology (example) ³ GTIN for Medicines (example) ⁴ Recommended mappings for the complex data type to CDA (R2): CodeableConcept as a Medicine Item Code
Medication > status	A code to indicate if the medication is in active use.	0..1	code	n/a	Not mapped directly for this model; implicit in the status of the referencing act e.g. substanceAdministration[med_stat]/statusCode.
Medication > manufacturer	Set to true if the medication can be obtained without an order from a prescriber.	0..1	Reference(Organization as Base Organization)	manufacturedProduct[med]/ manufacturerOrganization	manufacturerOrganization SHALL conform to the template defined in manufacturerOrganization (Base Organization) .

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Medication > form	Describes the form of the item. Powder; tablets; capsule.	0..1	CodeableConcept	manufacturedProduct[med]/manufacturedMaterial/ext:formCode	See < code > for available attributes. Medication Form (preferred) ⁵
Medication > ingredient	Identifies a particular constituent of interest in the product. Can be coded with AMT.	0..*	BackboneElement	manufacturedProduct[med]/manufacturedMaterial/ext:asIngredient	See < Ingredient > for available attributes.
Medication > ingredient > item[x]	The actual ingredient - either a substance (simple ingredient) or another medication.	1..1	CodeableConcept Reference/Substance as Base Substance Medication as Base Medication	manufacturedProduct[med]/manufacturedMaterial/ext:asIngredient/ext:ingredientManufacturedMaterial manufacturedProduct[med]/manufacturedMaterial/ext:asIngredient/ext:ingredientManufacturedMaterial/ext:code	In CDA, item[x] is represented with ext:code regardless of the logical type. If item[x] is a CodeableConcept , then AMT Medicinal Product (preferred) ⁶ If item[x] is a Substance , then Substance (preferred) ; see < Ingredient > for guidance on including additional available attributes. If item[x] is a Medication , then AMT Medicinal Product (preferred) ; see < Ingredient > for guidance on including additional available attributes.
Medication > ingredient > isActive	Indication of whether this ingredient affects the therapeutic action of the drug.	0..1	boolean	n/a	This logical element has no mapping to CDA.
Medication > ingredient > amount	Specifies how many (or how much) of the items there are in this Medication. For example, 250 mg per tablet. This is expressed as a ratio where the numerator is 250mg and the denominator is 1 tablet.	0..1	SimpleQuantity	manufacturedProduct[med]/manufacturedMaterial/ext:asIngredient/ext:quantity	
Medication > package	Information that only applies to packages (not products).	0..1	BackboneElement	n/a	This logical element has no mapping to CDA.
Medication > package > batch	Information about a group of medication produced or packaged from one production run.	0..1	BackboneElement	n/a	This model restricts the maximum occurrences of batch to 1; the batch is implicit in the mapping of the child elements.
Medication > package > batch > lotNumber	The assigned lot number of a batch of the specified product.	0..1	string	manufacturedProduct[med]/manufacturedMaterial/lotNumberText	
Medication > package > batch > expirationDate	When this specific batch of product will expire.	0..1	dateTime	manufacturedProduct[med]/manufacturedMaterial/ext:expirationTime	See < time > for available attributes.

¹Note: The source representation of the terminology binding on medication[x] in Base Medication [\[DH2019h\]](#) is as optional slices on the [coding](#) part of the medication[x] element. In the representation of the model presented in this specification it is normalised as preferred bindings.

²Note: The source representation of the terminology binding on medication[x] in Base Medication [\[DH2019h\]](#) is as optional slices on the [coding](#) part of the medication[x] element. In the representation of the model presented in this specification it is normalised as example bindings.

³Note: The source representation of the terminology binding on medication[x] in Base Medication [\[DH2019h\]](#) is as optional slices on the [coding](#) part of the medication[x] element. In the representation of the model presented in this specification it is normalised as example bindings.

⁴Note: The source representation of the terminology binding on medication[x] in Base Medication [\[DH2019h\]](#) is as optional slices on the [coding](#) part of the medication[x] element. In the representation of the model presented in this specification it is normalised as example bindings.

⁵Note: The source representation of the terminology binding on form in Base Medication [\[DH2019h\]](#) is as an optional slice on the [coding](#) part of the form element. In the representation of the model presented in this specification it is normalised as a preferred binding.

⁶Note: The source representation of the terminology binding on item[x] in Base Medication [\[DH2019h\]](#) is as an optional slice on the [coding](#) part of the item[x] element. In the representation of the model presented in this specification it is normalised as a preferred binding.

10.7 observation (Assertion of No Relevant Finding)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Conformance level comes from linking elements				Context: Context: Comes from linking elements	
Observation	Statement of clinical judgement that there are no items of specific interest after a reasonable investigation.	Cardinality comes from linking element	DomainResource	observation[no_find]	An Observation SHALL have a maximum of one performer (author or participant/@typeCode="AUT").
				observation[no_find]/@classCode="OBS"	All instances of a recorder (author or participant/@typeCode="AUT") SHALL conform to one of the templates defined in: conform to one of the templates defined in: author (Base PractitionerRole) or participant (author Base Organization) or author (Base RelatedPerson) or author (Base Patient) .
				observation[no_find]/@moodCode="EVN"	
				observation[no_find]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				observation[no_find]/templateId/@root="1.2.36.1.2001.1001.102.101.100032"	
				observation[no_find]/templateId/@extension="1.0"	

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Observation > status	The status of the result value.	1..1	code	observation[no_find]/entryRelationship[status]	
				observation[no_find]/entryRelationship[status]/@typeCode="COMP"	
				observation[no_find]/entryRelationship[status]/observation	
				observation[no_find]/entryRelationship[status]/observation/@classCode="OBS"	
				observation[no_find]/entryRelationship[status]/observation/@moodCode="EVN"	
				observation[no_find]/entryRelationship[status]/observation/code	
				observation[no_find]/entryRelationship[status]/observation/code/@code="103.32010"	
				observation[no_find]/entryRelationship[status]/observation/code/@codeSystem="1.2.36.1.2001.1001.101"	
				observation[no_find]/entryRelationship[status]/observation/code/@codeSystemName	Optional CDA element. codeSystemName SHOULD be "NCTIS Data Components".
				observation[no_find]/entryRelationship[status]/observation/code/@displayName	Optional CDA element. displayName SHOULD be "Observation Result Status".
Observation > code	Describes what was observed. Sometimes this is called the observation 'name'.	1..1	CodeableConcept	observation[no_find]/code	See code for available attributes.
				observation[no_find]/code/@code="ASSERTION"	
				observation[no_find]/code/@codeSystem="2.16.840.1.113883.5.4"	
				observation[no_find]/code/@codeSystemName	Optional CDA element. See code for available attributes. codeSystemName SHOULD be "v3 Code System ActCode".
				observation[no_find]/code/@displayName	Optional CDA element. displayName SHOULD be "Assertion".
Observation > subject	The patient, or group of patients, location, or device whose characteristics (direct or indirect) are described by the observation and into whose record the observation is placed.	1..1	Reference(Patient) as Patient with Mandatory Identifier	n/a	Not mapped directly for this model; this is implicit in patientRole.

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Observation > effective[x]	The time or time-period the observed value is asserted as being true. For biological subjects - e.g. human patients - this is usually called the 'physiologically relevant time'. This is usually either the time of the procedure or of specimen collection, but very often the source of the date/time is not known, only the date/time itself.	0..1	dateTime Period	observation[no_find]/effectiveTime	See <time> for available attributes.
Observation > performer	Who was responsible for asserting the observed value as 'true'.	0..*	Reference(Practitioner as Organization as Base Organization RelatedPerson as Base RelatedPerson Patient as Base Patient)	See: instantiation choices	<p>If this element is not instantiated the data is considered to be included via induction in ClinicalDocument/author.</p> <p>instantiation choices:</p> <p>If performer is an Organization then it SHALL be instantiated as participant. participant SHALL conform to the template defined in participant (author Base Organization).</p> <p>In CDA an author (Practitioner) is part of an author (PractitionerRole).</p> <p>If performer is a Practitioner or RelatedPerson or Patient then it SHALL be instantiated as author. author SHALL conform to one of the templates defined in: author (Base PractitionerRole) or author (Base RelatedPerson) or author (Base Patient).</p>
Observation > value[x]	The information determined as a result of making the observation, if the information has a simple value.	1..1	CodeableConcept	observation[no_find]/value	<p>When sending a PSML, this is expected to be 1234391000168107 No known current medications .</p> <p>value/@xsi:type SHALL be "CD".</p> <p>value/@nullFlavor SHALL NOT be instantiated.</p> <p>Assertion Of Absence value set (required)</p>

10.8 ext:coverage (Practitioner qualification)

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
CDA Header Data Elements					Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ See Administrative Observations .
Practitioner > qualification	Qualifications obtained by training and certification.	Cardinality comes from linking element	BackboneElement	ext:coverage2[prac_qual]	
				ext:coverage2[prac_qual]/@typeCode="COVBY"	
				ext:coverage2[prac_qual]/templateId	The use of templateId signals the imposition of a set of template-defined constraints.
				ext:coverage2[prac_qual]/templateId/@root="1.2.36.1.2001.1001.102.101.100038"	
				ext:coverage2[prac_qual]/templateId/@extension="1.0"	
				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"	Practitioner > qualification is represented in CDA by an entitlement (qualification) held by a participant (practitioner). This SHALL hold the same value as practitioner that this qualification is associated with (the value in this id element SHALL be present in separate participation).
				ext:coverage2[prac_qual]/ext:entitlement/ext:participant[prac]/ext:participantRole/ext:id	
Practitioner > qualification > identifier	An identifier that applies to this person's qualification in this role.	0..*	Identifier	ext:coverage2[prac_qual]/ext:entitlement/ext:id	
Practitioner > qualification > code	Coded representation of the qualification.	1..1	CodeableConcept	ext:coverage2[prac_qual]/ext:entitlement/ext:code	See <code> for available attributes. v2 table 0360, Version 2.7 (example)
Practitioner > qualification > period	Period during which the qualification is valid.	0..1	Period	ext:coverage2[prac_qual]/ext:entitlement/ext:effectiveTime	

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Practitioner > qualification > issuer	Organization that regulates and issues the qualification.	0..1	Reference(Organization as Base Organization)	ext:coverage2[prac_qual]/ext:entitlement/ext:participant[issuer]	<p>ext:participant[issuer]/@typeCode SHALL be "AUT".</p> <p>ext:participant[issuer]/ext:participantRole SHALL be "COMPAR".</p>

11 Common patterns

11.1 code

The <code> element pattern refines the kind of act being recorded. It is of data type CD CWE (Concept Descriptor, Coded With Extensibility). It may have:

- a null attribute (*nullFlavor*)
- *originalText*
- *code* and *codeSystem*
- *qualifier* (CD)
- *translation* (CD)
- any combination of the above.

A *displayName* is highly recommended.

Where used, the *code* attribute **SHALL** contain a code from the relevant vocabulary.

Where used, the *codeSystem* attribute **SHALL** contain the OID for the relevant vocabulary. Values for coding systems can be obtained from the HL7 OID registry accessible from the HL7 home web page at www.hl7.org.

Where used, the *displayName* attribute **SHALL** contain a human-readable description of the code value that is provided by the code system; *displayName* is a case insensitive value except where explicitly stated otherwise by the code system. A preferred interface term for display that is not a member of the description set supplied by the code system **SHALL NOT** be used to populate the *displayName* attribute.

The *codeSystemName* **MAY** be present and, where used, **SHALL** contain a human-readable name for the coding system.

Where used, the *originalText* element **SHALL** be used to carry the full text associated with this code as selected by, typed by or displayed to the author of this statement including the contents of the *qualifier* if present.

Where used, the *qualifier* element **SHALL** carry a code from the same code system as the code; for example if the main concept code is from SNOMED CT the *qualifier* also has to be taken from SNOMED CT as the use of a different code system for a *qualifier* is not allowed. The use of the *qualifier* element is governed by the code system used and cannot be used with code systems that do not provide for qualifiers (e.g. pre-coordinated systems).

Codes can be obtained from a variety of sources. Additional vocabularies are also available from the HL7 Version 3 Vocabulary tables, available to HL7 members through the HL7 web site. In some cases, the vocabularies have been specified; in others, a particular code has been fixed or there is no vocabulary specified. For guidance on coding common clinical concepts in CDA documents see [Representing Coding in CDA Documents Implementation Guidance \[NEHT2011bv\]](#).

Where a code is used from a different code system to that specified, or where the code lies outside the reference set specified, or where a code system or reference set is not specified, the code value **SHALL** be consistent with the meaning of the associated element of the Shared Medicines List model.

If a vocabulary is specified in this implementation guide and no suitable code can be found, the *originalText* element **SHALL** be used to carry the full text as selected by, typed by or displayed to the author of this statement.

If a vocabulary is specified in this implementation guide and it is not possible to use this vocabulary, but an alternate vocabulary is in use, the *originalText* element **SHALL** be used to carry the full text as selected by, typed by or displayed to the author of this statement. The *code* element **SHALL** be used to carry the relevant information from the alternate vocabulary and the alternate vocabulary **SHALL** be registered with HL7 and allocated an appropriate OID.

If an alternate vocabulary is in use and a translation into the specified code system is available, the *originalText* element **SHALL** be used to carry the full text as selected by, typed by or displayed to the author of this statement. The *code* element **SHALL** be used to carry the relevant information from the alternate vocabulary and the alternate vocabulary **SHALL** be registered with HL7 and allocated an appropriate OID. The *translation* element **SHALL** be used to indicate the translation code from the specified vocabulary.

Example 11.1. code

```
<!-- Specified code system in use -->
<code
  code="271807003"
  codeSystem="2.16.840.1.113883.6.96"
  codeSystemName="SNOMED CT"
  codeSystemVersion="20101130"
  displayName="Skin rash" />

<!-- Specified code system in use with a qualifier -->
<code
  code="23986001"
  codeSystem="2.16.840.1.113883.6.96"
  codeSystemName="SNOMED CT"
  displayName="Glaucoma" >
  <originalText>Glaucoma, left</originalText>
  <qualifier>
    <name
      code="272741003"
      codeSystem="2.16.840.1.3883.6.96"
      codeSystemName="SNOMED CT"
      displayName="Laterality" />
    <value
      code="7771000"
      codeSystem="2.16.840.1.113883.6.96"
      codeSystemName="SNOMED CT"
      displayName="Left"
      xsi:type="CD" />
  </qualifier>
</code>
```

```
<!-- Alternate code system in use and a translation into the specified code system is available -->
<code
  code="J45.9"
  codeSystem="2.16.840.1.113883.6.135"
  codeSystemName="icd10am"
  displayName="Asthma, unspecified">
  <originalText>Asthma</originalText>
  <translation
    code="195967001"
    codeSystem="2.16.840.1.113883.6.96"
    codeSystemName="SNOMED CT"
    displayName="Asthma"/>
</code>

<!-- Alternate code system in use and no translation into the specified code system is available -->
<code
  code="J45.9"
  codeSystem="2.16.840.1.113883.6.135"
  codeSystemName="icd10am"
  displayName="Asthma, unspecified">
  <originalText>Asthma</originalText>
</code>

<!-- No suitable code can be found or there is no code system in use -->
<code
  <originalText>Asthma</originalText>
</code>
```

11.2 id

The <id> element pattern is of data type II (Instance Identifier). The II data type may have:

- a null attribute (*nullFlavor*)
- a *root*
- a *root* and an *extension*
- a *root* and an *extension* and an *assigningAuthorityName*
- a *root* and an *assigningAuthorityName*
- a *root* and an *assigningAuthorityName* and a *displayable*
- a *root* and an *extension* and a *displayable*
- a *root* and an *extension* and an *assigningAuthorityName* and a *displayable*
- a *root* and a *displayable*

The root attribute is **REQUIRED** and is a unique identifier that guarantees the global uniqueness of the instance identifier. The root alone **MAY** be the entire instance identifier. The root attribute **SHALL** be a UUID or OID.

The extension attribute **MAY** be present, and is a character string as a unique identifier within the scope of the identifier root.

In the case of business or technical identifier an *assigningAuthorityName* is **RECOMMENDED**.

Identifiers appear in this implementation guide for two different reasons. The first is that the identifier has been identified as relevant to the business process or clinical workflow. These identifiers are documented in mapping tables in the Element column, e.g. Composition > identifier or Medication Statement (Prescription) > identifier, which make clear the meaning of this identifier.

In addition, the implementation makes clear that identifiers may also be found on many other parts of the CDA structure. These identifiers, often referred to as technical identifiers, are allowed to facilitate record matching across multiple versions of related documents, so that the same record can consistently be identified, in spite of variations in the information as the record passes through time or between systems. These identifiers have no meaning in the business specification. If senders provide one of these identifiers, it **SHALL** always be the same identifier in all versions of the record, and it **SHALL** be globally unique per the rules of the II data type.

Example 11.2. id

```
<id root="2.16.840.1.113883.19" extension="123A45" />  
<ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />
```

11.3 time

When a time value is supplied it **SHALL** include hours and minutes.

When a time value is supplied it **MAY** include seconds and fractions of seconds.

When a time value is supplied it **SHALL** include a time zone.

The <time> element pattern is of data type TS (Point in Time) and can also be an interval between two times (IVL_TS), representing a period of time. Both forms can either have a nullFlavor attribute or child components following allowed patterns.

A simple timestamp (point in time) will only contain a value attribute containing the time value, expressed as a series of digits as long as required or as available.

Example 11.3. Simple timestamp

```
<time value="20091030" />
```

This represents "October 30, 2009" to calendar day precision. In cases where the containing element is defined in the CDA schema as "ANY" data type, it is useful to provide an xsi:type attribute, set to the value "TS".

The period of time pattern is defined in terms of one or both of its lowest and highest values. The low and high elements are instances of the timestamp pattern described above. More complex time period concepts can be expressed by combining a high, low, or centre element with a width element.

Example 11.4. Low time

```
<period>
  <low value="20091030" />
</period>
```

This represents "a period after October 30, 2009". In cases where the containing element is defined in the CDA schema as "ANY" data type, it is useful to provide an xsi:type attribute, set to the value "IVL_TS", as in the next example.

Example 11.5. Interval timestamp 1

```
<period xsi:type="IVL_TS">
  <high value="200910301030+1000" />
</period>
```

This represents "a period before 10:30 a.m. UTC+10, October 30, 2009". A discretionary xsi:type attribute has been provided to explicitly cast the pattern to "IVL_TS".

Example 11.6. Interval timestamp 2

```
<period xsi:type="IVL_TS">
  <low value="2007" />
  <high value="2009" />
</period>
```

This represents "the calendar years between 2007 and 2009". The low element **SHALL** precede the high element. As per the previous example, a discretionary xsi:type attribute has been provided to explicitly cast the pattern to "IVL_TS".

Example 11.7. Width time

```
<period>
  <high value="20091017" />
  <width value="2" unit="wk" />
</period>
```

This expresses "two weeks before October 17th, 2009". A low value can be derived from this.

11.4 Entity Identifier

CDA mapping

Element	Definition	Card	CDA schema element	Constraints and comments
CDA Data Elements				
Entity Identifier	A number or code issued for the purpose of identifying a participant within a health-care context.	Cardinality comes from linking element	//ext:asEntityIdentifier	
		1..1	//ext:asEntityIdentifier/@classCode="IDENT"	
		1..1	//ext:asEntityIdentifier/ext:id	
		1..1	//ext:asEntityIdentifier/ext:id/@root	@root SHALL be an OID and SHALL NOT be a UUID. @root SHALL be a globally unique object identifier (i.e. OID) that identifies the combination of geographic area, issuer and type. If no such OID exists, it SHALL be defined before any identifiers can be created.
		0..1	//ext:asEntityIdentifier/ext:id/@extension	If present, @extension SHALL be a unique identifier within the scope of the root that is populated directly from the designation.
		0..1	//ext:asEntityIdentifier/ext:id/@assigningAuthorityName	@assigningAuthorityName SHOULD be used and, if it is used, SHALL be a human-readable 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 SHOULD NOT be used for machine readability purposes.
		0..1	//ext:asEntityIdentifier/ext:code	See <code> for available attributes.
		0..1	//ext:asEntityIdentifier/ext:assigningGeographicArea	
		1..1	//ext:asEntityIdentifier/ext:assigningGeographicArea/@classCode="PLC"	
		0..1	//ext:asEntityIdentifier/ext:assigningGeographicArea/ext:name	If present, ext:name SHALL be 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 SHOULD NOT be used for machine readability purposes. Healthcare Identifier Geographic Area (preferred) This element is expected to be populated with the display, e.g. "National Identifier".

Example 11.8. Entity Identifier

```
<!-- These example fragments are illustrative only. They 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. -->  
  
<!-- person -->  
<x:asEntityIdentifier classCode="IDENT">  
  <x:id root="1.2.36.1.2001.1003.0.8003608833357361" assigningAuthorityName="IHI" />  
  <x:assigningGeographicArea classCode="PLC">  
    <x:name>National Identifier</x:name>  
  </x:assigningGeographicArea>  
</x:asEntityIdentifier>  
  
<x:asEntityIdentifier classCode="IDENT">  
  <x:id root="1.2.36.1.2001.1005.29.8003621566684455" extension="542181" assigningAuthorityName="Croydon GP Centre" />  
  <x:code code="MP" codeSystem="2.16.840.1.113883.12.203" codeSystemName="Identifier Type (HL7)" />  
</x:asEntityIdentifier>  
  
<!-- organisation -->  
<ext:asEntityIdentifier classCode="IDENT">  
  <ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />  
  <ext:assigningGeographicArea classCode="PLC">  
    <ext:name>National Identifier</ext:name>  
  </ext:assigningGeographicArea>  
</ext:asEntityIdentifier>
```

11.5 Personal Relationship

CDA mapping

Element	Definition	Card	CDA schema element	Constraints and comments
CDA Data Elements				
Personal Relationship	The relationship of a participant to a subject of care (patient).	Cardinality comes from linking element	//ext:personalRelationship	This logical data component SHALL NOT be instantiated if the participant is a healthcare provider. If ext:personalRelationship is instantiated the value of Entity Identifier SHALL NOT be a HPI-I.
		0..1	//ext:personalRelationship/@classCode="PRS"	
		0..1	//ext:personalRelationship/ext:id	
		1..1	//ext:personalRelationship/ext:code	See <code> for available attributes. Related Person Relationship Type (extensible)
		0..1	//ext:personalRelationship/ext:statusCode	See <code> for available attributes. v3 Code System RoleStatus (required)
		0..1	//ext:personalRelationship/ext:effectiveTime	See <time> for available attributes.
		1..1	//ext:personalRelationship/ext:asPersonalRelationship	
		0..1	//ext:personalRelationship/ext:asPersonalRelationship/@classCode="PSN"	
		0..1	//ext:personalRelationship/ext:asPersonalRelationship/@determinerCode="INSTANCE"	
		1..1	//ext:personalRelationship/ext:asPersonalRelationship/id	This SHALL hold the same value as patientRole/id.
		1..1	//ext:personalRelationship/ext:asPersonalRelationship/administrativeGenderCode/@nullFlavor="NA"	Included for CDA conformance only.

Example 11.9. Personal Relationship

```
<!-- These example fragments are illustrative only. They 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. -->  
  
<!-- patient -->  
<recordTarget>  
  <patientRole>  
    <!-- patient identifier-->  
    <id extension="100543" root="2.16.840.1.113883.19.1.2.3.4"/>  
  </patientRole>  
</recordTarget>  
  
<!-- author with personal relationship -->  
<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>  
  
<!-- participant performer with personal relationship -->  
<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" />  
        <!--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>
```

11.6 Qualification

CDA mapping

Element	Definition	Card	CDA schema element	Constraints and comments
CDA Data Elements				
Qualification	A list of professional certifications, and certificates recognising having passed a course.	Cardinality comes from linking element	ext:asQualifications	
		1..1	ext:asQualifications/@classCode="QUAL"	
		1..1	ext:asQualifications/ext:code	Qualifications is a text field, so the text list is entered in the originalText of this element.

11.7 Ingredient

CDA mapping

Element	Definition	Card	CDA schema element	Constraints and comments
CDA Data Elements				
Ingredient	An ingredient of the medicine item.	Cardinality comes from linking element	//ext:asIngredient	
		1..1	//ext:asIngredient/@classCode="INGR"	
		0..*	//ext:asIngredient/ext:id	
		0..1	//ext:asIngredient/ext:ingredientManufacturedMaterial	The substance that is the ingredient. This may be another medication.
		1..1	//ext:asIngredient/ext:ingredientManufacturedMaterial/@classCode="MMAT"	
		1..1	//ext:asIngredient/ext:ingredientManufacturedMaterial/@determinerCode="KIND"	
		0..*	//ext:asIngredient/ext:ingredientManufacturedMaterial/ext:id	
		0..1	//ext:asIngredient/ext:ingredientManufacturedMaterial/ext:code	Code for the substance.
		0..1	//ext:asIngredient/ext:ingredientManufacturedMaterial/ext:desc	Name and/or description of the substance.
		0..1	//ext:asIngredient/ext:ingredientManufacturedMaterial/ext:expirationTime	This element is discouraged from use.
		0..1	//ext:asIngredient/ext:ingredientManufacturedMaterial/ext:quantity	This element is discouraged from use as the determinerCode is fixed to "KIND".
		0..1	//ext:asIngredient/ext:quantity	This CDA schema element is of type Ratio Physical Quantity / Physical Quantity (RTO_PQ_PQ). Strength (amount) of the substance as an ingredient in the medicine item, e.g. 2% of the ingredient or 5mg of the ingredient or 10mg of the ingredient per ml or 250 mg per tablet.

Example 11.10. Ingredient

<!-- These example fragments are illustrative only. They 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. -->

```
<!--Medication-->
<consumable>
<manufacturedProduct>
<manufacturedMaterial nullFlavor="NA">
<!--Medication.code-->
<code code="22048011000036105"
codeSystem="2.16.840.1.113883.6.96"
codeSystemName="SNOMED CT"
displayName="amoxicillin 250 mg chewable tablet">
</code>
<!--Medication.ingredient-->
<ext:asIngredient classCode="INGR">
<ext:ingredientManufacturedMaterial classCode="MMAT" determinerCode="KIND">
<!--Medication.ingredient.item[x]-->
<ext:code code="1799011000036105"
codeSystem="2.16.840.1.113883.6.96"
codeSystemName="SNOMED CT"
displayName="amoxicillin"/>
</ext:ingredientManufacturedMaterial>
<!--Medication.ingredient.amount-->
<ext:quantity>
<numerator unit="mg" value="250"/>
<denominator value="1"/>
</ext:quantity>
</ext:asIngredient>
</manufacturedMaterial>
</manufacturedProduct>
</consumable>
```

11.8 Language Communication

CDA mapping

Element	Definition	Card	CDA schema element	Constraints and comments
CDA Data Elements				
Language Communication	The language communication capabilities of an individual.	Cardinality comes from linking element	//ext:languageCommunication	
		1..1	//ext:languageCommunication/languageCode	This CDA schema element is of type CodedSimpleValue (CS). All Languages (required) Common Languages in Australia (extensible)
		0..1	//ext:languageCommunication/modeCode	See <code> for available attributes.
		0..1	//ext:languageCommunication/proficiencyLevelCode	See <code> for available attributes.
		0..1	//ext:languageCommunication/preferenceInd	

Example 11.11. Language Communication

```
<!-- These example fragments are illustrative only. They 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. -->  
  
<!-- Language communication -->  
<ext:languageCommunication>  
  <languageCode code="en"/>  
  <preferenceInd value="true"/>  
</ext:languageCommunication>  
<ext:languageCommunication>  
  <languageCode code="de"/>  
  <preferenceInd value="true"/>  
</ext:languageCommunication>
```

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

This informative appendix provides some guidance on how complex data types referred to in the body of this specification can map to CDA (R2). The mappings provided are a set of preferred mappings and do not represent conformance requirements.

A.1 Identifier

This informative appendix provides some guidance on how the complex data type [Identifier](#), referenced in the body of this specification can map to CDA (R2). The mappings provided are a set of preferred mappings and do not represent conformance requirements.

In addition to examples 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 \[DH2019a\]](#).

CDA mapping

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

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Identifier > assigner	Organization that issued/manages the identifier.	0..1	Reference (Organization)	See: instantiation choices	instantiation choices: If the identifier element is for a Patient, Practitioner, PractitionerRole, Organization, RelatedPerson or Device this is expected to be instantiated as ext:asEntityIdentifier/ext:id/@assigningAuthorityName. The identifier value may be instantiated as id/@assigningAuthorityName.

Example A.1. Identifier

```
<!-- These example fragments are illustrative only. They 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. -->  
  
<!-- subject -->  
<recordTarget>  
  <!-- subject (Patient) -->  
  <patientRole>  
    <patient>  
      <administrativeGenderCode></administrativeGenderCode>  
  
      <!-- 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/ih/1.0 -->  
        <ext:id assigningAuthorityName="IHI" root="1.2.36.1.2001.0.8003600200002222" />  
        <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=Croydon GP Centre,  
        identifier.value=542181,  
        identifier.system=urn:oid:1.2.36.1.2001.1005.29.8003621566684455 -->  
        <ext:id root="1.2.36.1.2001.29.8003621566684455" 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="MO" codeSystem="2.16.840.1.113883.12.203"  
          codeSystemName="Identifier Type (HL7)" displayName="Patient's Medicare number" />  
        <!-- 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>  
  
<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>

<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>

<!--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 HumanName

This informative appendix provides some guidance on how the complex data type [HumanName](#), referenced in the body of this specification can map to CDA (R2). The mappings provided are a set of preferred mappings and do not represent conformance requirements.

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
HumanName	A human's name with the ability to identify parts and usage.	Cardinality comes from linking element	Element	//name	Name SHALL have at least text or family or 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 > use	Identifies the purpose for this name.	0..1	code	//name/@use	Common Person Name Use (required) ¹
HumanName > text	A full text representation of the name.	0..1	string	//name	
HumanName > family	The part of a name that links to the genealogy. In some cultures (e.g. Eritrea) the family name of a son is the first name of his father.	0..1	string	//name/family	
HumanName > given	Given name.	0..*	string	//name/given	
HumanName > prefix	Part of the name that is acquired as a title due to academic, legal, employment or nobility status, etc. and that appears at the start of the name.	0..*	string	//name/prefix	Prefix values can be populated as described in AS 4846 (2014) – Person and provider identification in healthcare [SA2014a] , 4.4.2 Name Title.
HumanName > suffix	Part of the name that is acquired as a title due to academic, legal, employment or nobility status, etc. and that appears at the end of the name.	0..*	string	//name/suffix	Suffix values can be populated as described in AS 4846 (2014) – Person and provider identification in healthcare [SA2014a] , 4.5.3.2 Name Suffix.
HumanName > period	Indicates the period of time when this name was valid for the named person.	0..1	Period	//name/validTime	See <time> for available attributes.

¹Note: The source terminology binding on use in HumanName [\[DH2019h\]](#) and the terminology binding in the representation of the model in this specification are different. Mappings between the set of concepts are defined in [NameUse \(HL7 FHIR\)](#) to [Common Person Name Use](#) concept map.

Example A.2. HumanName

```
<!-- These example fragments are illustrative only. They 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. -->  
  
<!-- HumanName where use=official -->  
<name use="C">  
  <!-- HumanName.given -->  
  <given>Adam</given>  
  <!-- HumanName.given -->  
  <given>A.</given>  
  <!-- HumanName.family -->  
  <family>Everyman</family>  
</name>  
  
<!-- HumanName where use=official -->  
<name use="C">  
  <!-- HumanName.text -->  
  Adam A. Everyman  
</name>  
  
<!-- HumanName where use=usual -->  
<name use="I">  
  <!-- HumanName.given -->  
  <given>Damo</given>  
</name>  
  
<!-- 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>
```

A.3 Address

This informative appendix provides some guidance on how the complex data type [Address](#), referenced in the body of this specification can map to CDA (R2). The mappings provided are a set of preferred mappings and do not represent conformance requirements.

CDA mapping

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

Example A.3. Address

```
<!-- These example fragments are illustrative only. They 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. -->  
  
<!-- 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>  
  
<!-- 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>  
  
<!-- Address where use=old -->  
<addr use="TMP">  
  <!--Address.line-->  
  <streetAddressLine>Rue Lougoraïa 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 Address as AU Base Address

This informative appendix provides some guidance on the constrained form of complex data type [Address](#) as [AU Base Address](#) published by HL7 Australia. The mappings provided are a set of preferred mappings for representing an Australian address and do not represent conformance requirements.

CDA mapping

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

Example A.4. Address

```
<!-- These example fragments are illustrative only. They 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. -->  
  
<!-- 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>  
  
<!-- Australian Address with only text-->  
<addr use="PHYS">  
<!--Address.text-->  
Level 1, 300 George St, Brisbane, QLD 4000  
</addr>  
  
<!-- 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>  
  
<!-- 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](#), referenced in the body of this specification can map to CDA (R2). The mappings provided are a set of preferred mappings and do not represent conformance requirements.

CDA mapping

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
ContactPoint	A human's name with the ability to identify parts and usage.	Cardinality comes from linking element	Element	//telecom	If value is present, system SHALL be present.
ContactPoint > system	Telecommunications form for contact point - what communications system is required to make use of the contact.	0..1	code	//telecom/@value	HL7 URLScheme (required) Makes up part of the attribute: "system:value", e.g. "tel:phone number", "mailto:email address", "http:URL", etc.
ContactPoint > value	The actual contact point details, in a form that is meaningful to the designated communication system (i.e. phone number or email address).	0..1	string	//telecom/@value	Makes up the part of the attribute: "system:value", e.g. "tel:phone number", "mailto:email address", "http:URL", etc.
ContactPoint > use	Identifies the purpose for the contact point.	0..1	code	//telecom/@use	HL7 TelecommunicationAddressUse (required)
ContactPoint > rank	Specifies a preferred order in which to use a set of contacts. Contacts are ranked with lower values coming before higher values.	0..1	positiveInt	n/a	This logical element has no mapping to CDA.
ContactPoint > period	Time period when the contact point was/is in use.	0..1	Period	//telecom/usablePeriod	See < time > for available attributes.

Example A.5. ContactPoint

```
<!-- These example fragments are illustrative only. They 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. -->  
  
<!-- ContactPoint where system=phone, value=+1-(555)555-1212, use=home -->  
<telecom value="tel:+1-(555)555-1212" use="H">  
  <!-- ContactPoint.period -->  
  <useablePeriod xsi:type="IVL_TS">  
    <low value="01012001" />  
    <high value="01012012" />  
  </useablePeriod>  
</telecom>  
  
<!-- ContactPoint where system=phone, value=0712341234, use=home -->  
<telecom use="H" value="tel:0712341234" />  
  
<!-- ContactPoint where system=email, value=sfranklin@mail.com.au, use=work -->  
<telecom use="WP" value="mailto:sfranklin@mail.com.au" />
```

A.6 Dosage as 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. The mappings provided are a set of preferred mappings and do not represent conformance requirements.

CDA mapping

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

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

Example A.6. Dosage

<!-- These example fragments are illustrative only. They 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. -->

```
<entry>
  <!-- MedicationStatement - more than one instance of Dosage -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!-- identifier -->
    <id root="4255b903-6f90-41b8-a71c-8ac0eelebdc3"/>
    <!-- medication.as(medicationCodeableConcept) -->
    <consumable>
      <manufacturedProduct>
        <manufacturedMaterial>
          <code code="6006011000036102"
            codeSystem="1.2.36.1.2001.1004.100"
            displayName="Lasix (frusemide 40 mg) tablet: uncoated, 1 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>
        </effectiveTime>
      </substanceAdministration>
    </entryRelationship>
  </substanceAdministration>
</entry>
```

```
<period value="1" unit="d"/>
</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>

<entry>
  <!-- MedicationStatement - single instance of Dosage -->
  <substanceAdministration classCode="SBADM" moodCode="EVN" >
    <!-- identifier -->
    <id root="ab6d45ff-fd58-4f38-8009-aelaa84a4f43"/>
    <!-- method -->
    <ext:methodCode code="421134003" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Inhale" />
    <!-- route -->
    <routeCode code="ORNEB" codeSystem="2.16.840.1.113883.5.112" codeSystemName="Route Code" displayName="Inhalation, nebulization, oral"/>
    <!-- dose -->
    <doseQuantity value="1" />
    <!-- maxDosePerPeriod -->
    <maxDoseQuantity>
      <numerator value="1" />
      <denominator value="1" unit="h" />
    </maxDoseQuantity>
    <administrationUnitCode code="415215001" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Puff" />
    <!-- medication.as(medicationCodeableConcept) -->
    <consumable>
      <manufacturedProduct>
        <manufacturedMaterial>
          <code code="7113011000036100" codeSystem="1.2.36.1.2001.1004.100"
            displayName="Spiriva (tiotropium (as bromide monohydrate) 18 microgram) inhalation: powder for, 1 capsule">
            <originalText>Spiriva (tiotropium bromide 18mg per inhalation) inhalant</originalText>
          </code>
        </manufacturedMaterial>
      </manufacturedProduct>
    </consumable>
    <!-- asNeededBoolean=true - instantiated as prn with no specified condition -->
    <precondition typeCode="PRCN" >
      <criterion>
        <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4" />
        <value xsi:type="CD" nullFlavor="NI" />
      </criterion>
    </precondition>
  </substanceAdministration>
</entry>
```

A.7 Timing

This informative appendix provides some guidance on how the complex data type [Timing](#), referenced in the body of this specification can map to CDA (R2). The mappings provided are a set of possible mappings and do not represent conformance requirements.

CDA mapping

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

Element	Element description	Card	Element type	CDA schema element	Constraints and comments
Timing > repeat > bounds	Either a duration for the length of the timing schedule, a range of possible length, or outer bounds for start and/or end limits of the timing schedule.	0..1	Duration Range Period	See: instantiation choices	<p>effectiveTime/@xsi:type SHALL be "IVL_TS".</p> <p>instantiation choices:</p> <p>If bounds is a Duration then it is expected to be instantiated as effectiveTime/width.</p> <p>If bounds is a Range then it is expected to be included in Dosage as text, or additionalInstruction, or patientInstruction as appropriate.</p> <p>If bounds is a Period then it is expected to be instantiated as effectiveTime/period.</p>
Timing > repeat > count	A total count of the desired number of repetitions.	0..1	integer	//repeatNumber/@value	count SHALL only be instantiated in the repeatNumber element of the Dosage substanceAdministration act where the moodCode is "INT" or "PLAN".
Timing > repeat > countMax	A maximum value for the count of the desired repetitions (e.g. do something 6-8 times).	0..1	integer	//repeatNumber/high/@value	
Timing > repeat > duration	How long this thing happens for when it happens.	0..1	decimal	//effectiveTime/phase/width/@value	effectiveTime/@xsi:type SHOULD be "PIVL_TS".
Timing > repeat > durationMax	The upper limit of how long this thing happens for when it happens.	0..1	decimal	n/a	This logical element has no mapping to CDA.
Timing > repeat > durationUnit	The units of time for the duration, in UCUM units.	0..1	code	//effectiveTime/phase/width/@unit	effectiveTime/@xsi:type SHOULD be "PIVL_TS".
Timing > repeat > frequency	The number of times to repeat the action within the specified period / period range (i.e. both period and periodMax provided).	0..1	integer	//effectiveTime/ frequency	effectiveTime/@xsi:type SHALL be "PIVL_TS".
				//effectiveTime/frequency/ numerator	frequency is expressed as the numerator (with an xsi:type of "INT") and period is expressed in CDA as the denominator.
Timing > repeat > frequencyMax	If present, indicates that the frequency is a range - so to repeat between [frequency] and [frequencyMax] times within the period or period range.	0..1	integer	//effectiveTime/ phase	effectiveTime/@xsi:type SHOULD be "PIVL_TS".
Timing > repeat > period	Indicates the duration of time over which repetitions are to occur; e.g. to express '3 times per day', 3 would be the frequency and '1 day' would be the period.	0..1	decimal	See: instantiation choices	<p>effectiveTime/@xsi:type SHOULD be "PIVL_TS".</p> <p>instantiation choices:</p> <p>May be represented by effectiveTime/phase or effectiveTime/period.</p>
Timing > repeat > periodMax	If present, indicates that the period is a range from [period] to [periodMax], allowing expressing concepts such as 'do this once every 3-5 days.	0..1	decimal	See: instantiation choices	<p>effectiveTime/@xsi:type SHOULD be "PIVL_TS".</p> <p>instantiation choices:</p> <p>May be represented by effectiveTime/phase or effectiveTime/period/high.</p>

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

Example A.7. Timing

```
<!-- These example fragments are illustrative only. They 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. -->  
  
<!-- 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>  
  
<entry>  
    <!-- MedicationStatement - common timing representations - this is not a meaningful example and is there to show common instantiations  
and their corresponding code -->  
    <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 -->  
        <!-- 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>  
        <!-- 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>  
        <!-- 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>  
        <!-- 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>
<!!--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>
<!!-- 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>
<!!-- qd daily -->
<effectiveTime xsi:type="PIVL_TS" institutionSpecified="true"
  operator="A">
  <!-- frequency=1, period=1, periodUnit=d -->
  <period value="1" unit="d"/>
</effectiveTime>
<!!-- 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>
<!!-- god Every other day -->
<effectiveTime xsi:type="PIVL_TS" institutionSpecified="false"
  operator="A">
  <!-- frequency=1, period=2, periodUnit=d -->
  <period value="2" unit="d"/>
</effectiveTime>
<!!-- 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>
<!!-- q4-6h Every 4 to 6 hours (preferred) -->
<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>
<!!-- q4-6h Every 4 to 6 hours (alternate) -->
<effectiveTime xsi:type="PIVL_TS" institutionSpecified="false"
  operator="A">
  <period xsi:type="PPD_PQ" value="5" unit="h">
    <standardDeviation value="1" unit="h"/>
  </period>
</effectiveTime>
<!!-- gam 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>
<!-- 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>
<!-- 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>
<!-- 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>
<!-- before lunch -->
<effectiveTime xsi:type="EIVL_TS" operator="A">
  <!-- when using code from TimingEvent value set (2.16.840.1.113883.5.139) -->
  <event code="ACD"/>
</effectiveTime>
<!-- 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>
<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>
<consumable>
  <manufacturedProduct>
    <manufacturedMaterial>
      <code nullFlavor="NA"/>
    </manufacturedMaterial>
  </manufacturedProduct>
</consumable>
</substanceAdministration>
</entry>
```

A.8 CodeableConcept as a Medicine Item Code

This informative appendix provides some guidance on how the complex data type [CodeableConcept](#) as a medicine item code (and related elements medication-brand-name and medication-generic-name), referenced in the body of this specification can map to CDA (R2). The mappings provided are a set of preferred mappings and do not represent conformance requirements.

In addition to examples provided in this implementation guide some guidance on representing coding in CDA is provided by [Representing Coding in CDA Documents Implementation Guidance \[NEHT2011bv\]](#).

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/@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)

Example A.8. CodeableConcept as Medicine Item Code

```
<!-- These example fragments are illustrative only. They 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. -->  
  
<!-- 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="TBD" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Brand Name"/>
    <text>Panadol</text>
  </act>
</entryRelationship>
</supply>

<!-- 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>

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

<!-- 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>Valepam</originalText>
        </code>
      </manufacturedMaterial>
    </manufacturedProduct>
  </consumable>
  <!-- medication-brand-name-->
  <entryRelationship typeCode="COMP">
    <act classCode="ACT" moodCode="EVN">
      <code code="TBD" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Brand Name"/>
      <text>Valepam</text>
    </act>
  </entryRelationship>
  <!-- medication-generic-name-->
  <entryRelationship typeCode="COMP">
```

```
<act classCode="ACT" moodCode="EVN">
  <code code="TBD" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Generic Name"/>
  <text>Diazepam</text>
</act>
</entryRelationship>
</substanceAdministration>


<substanceAdministration classCode="SBADM" moodCode="EVN">
  <consumable>
    <manufacturedProduct>
      <manufacturedMaterial>
        <code>
          <originalText>Valpam</originalText>
        </code>
      </manufacturedMaterial>
    </manufacturedProduct>
  </consumable>
  <!-- medication-generic-name-->
  <entryRelationship typeCode="COMP">
    <act classCode="ACT" moodCode="EVN">
      <code code="TBD" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Generic Name"/>
      <text>Valpam</text>
    </act>
  </entryRelationship>
</substanceAdministration>
```


Appendix B. Examples

This informative appendix provides some examples that conform to the conformance requirements specified within this implementation guide.

DRAFT

B.1 Shared Meds List example 1

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

Example B.1. Shared Medicines List example 1

```
<!-- This example is illustrative only. This fragment cannot be treated as clinically valid.  
While every effort has been taken to ensure that the examples are consistent with the message specification, where  
there are conflicts with the written message specification or schema, the specification or schema will take precedence. -->  
  
<ClinicalDocument classCode="DOCLIN" moodCode="EVN" xmlns="urn:hl7-org:v3"  
xmlns:ex="urn:hl7-org/v3-example"  
xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"  
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"  
>  
<typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>  
  <!-- ClinicalDocument templateId -->  
  <templateId root="1.2.36.1.2001.1001.102.101.100033" extension="1.0"/>  
  <!-- ClinicalDocument (Shared Medicines List Authored by Practitioner) templateId-->  
  <templateId root="1.2.36.1.2001.1001.102.101.100065" extension="1.0"/>  
  <!-- CDA Rendering Specification templateId-->  
  <templateId root="1.2.36.1.2001.1001.100.226" extension="1.0"/>  
  <id root="cbc73f0e-90a3-11e9-bc42-526af7764f64"/>  
  <!-- Composition type-->  
  <code code="56445-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"  
    displayName="Medication summary"/>  
  <!-- Composition title-->  
  <title>Pharmacist Shared Medicines List</title>  
  <effectiveTime value="201812111330+1000"/>  
  <confidentialityCode nullFlavor="NA"/>  
  <languageCode code="en-AU"/>  
  <!-- Composition status-->  
  <ext:completionCode code="F" codeSystem="1.2.36.1.2001.1001.101.104.20104"  
    codeSystemName="NCTIS Document Status Values" displayName="Final"/>  
  <!-- Composition subject -->  
<recordTarget typeCode="RCT">  
  <!-- recordTarget (Patient with Mandatory Identifier) templateId-->  
  <templateId root="1.2.36.1.2001.1001.102.101.100004" extension="1.0"/>  
  <patientRole classCode="PAT">  
    <id root="430fa8e6-eaba-4629-bf2f-ac16d7c5e082"/>  
    <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-->  
      <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="1.2.36.1.2001.1003.0.8003608333563104"  
          assigningAuthorityName="IHI"/>  
        <ext:assigningGeographicArea classCode="PLC">  
          <ext:name>National Identifier</ext:name>  
        </ext:assigningGeographicArea>  
      </ext:asEntityIdentifier>  
    </patient>  
  </patientRole>  
</recordTarget>  
  <!-- Composition composition-author-role / Composition author -->  
<author>  
  <!-- author (PractitionerRole with Practitioner with Mandatory Identifier) templateId-->  
  <templateId root="1.2.36.1.2001.1001.102.101.100006" extension="1.0"/>  
  <!-- Composition date -->  
  <time value="201812111330+1000"/>  
  <assignedAuthor>  
    <id root="01f1aee7-a212-4f3d-bb97-b26e7a476559"/>  
    <!-- PractitionerRole code -->  
    <code code="251513" codeSystem="2.16.840.1.113883.13.62"  
      codeSystemName="Australian and New Zealand Standard Classification of Occupations"  
      displayName="Retail Pharmacist"/>  
    <originalText>Pharmacist</originalText>  
  </code>  
  <!--PractitionerRole telecom-->  
  <telecom use="WB" value="mailto:zsin@gmail.com"/>  
  <!-- PractitionerRole practitioner -->  
  <assignedPerson>  
    <!-- assignedPerson (Practitioner with Mandatory Identifier) templateId -->  
    <templateId root="1.2.36.1.2001.1001.102.101.100040" extension="1.0"/>  
    <!-- Practitioner name -->  
    <name>  
      <prefix>Mr.</prefix>  
      <given>Zane</given>  
      <family>Sinclair</family>  
    </name>  
  </assignedPerson>
```

```
</name>
<!-- PractitionerRole identifier / Practitioner identifier -->
<ext:asEntityIdentifier classCode="IDENT">
  <ext:id root="1.2.36.1.2001.1003.0.8003611566708354"
    assigningAuthorityName="HPI-I"/>
  <ext:assigningGeographicArea classCode="PLC">
    <ext:name>National Identifier</ext:name>
  </ext:assigningGeographicArea>
</ext:asEntityIdentifier>
<!--Practitioner qualification-->
<ext:asQualifications classCode="QUAL">
  <ext:code>
    <originalText>Bachelor of Pharmacy </originalText>
  </ext:code>
</ext:asQualifications>
</assignedPerson>
<!-- PractitionerRole organization -->
<representedOrganization>
  <!-- representedOrganization (Base Organization) templateId-->
  <templateId root="1.2.36.1.2001.1001.102.101.100039" extension="1.0"/>
  <id root="0c267071-8a7b-4cba-a3cc-9b571cc09ab3"/>
  <!-- Organization name -->
  <name>Test Org - Retail Pharmacy</name>
  <!-- Organization address -->
  <addr use="WP">
    <streetAddressLine>570 Whatcha St</streetAddressLine>
    <city>GLEBE</city>
    <state>NSW</state>
    <postalCode>2037</postalCode>
    <country>AU</country>
  </addr>
  <!-- Organization type-->
  <standardIndustryClassCode code="4271" codeSystem="1.2.36.1.2001.1005.47"
    codeSystemName="1292.0 - ANZIC - Australian and New Zealand Standard Industrial Classification"
    displayName="Retail Pharmacy"/>
  <!-- Organization identifier -->
  <ext:asEntityIdentifier classCode="IDENT">
    <ext:id assigningAuthorityName="HPI-O"
      root="1.2.36.1.2001.1003.0.8003629900033370"/>
    <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
    </ext:assigningGeographicArea>
  </ext:asEntityIdentifier>
</representedOrganization>
</assignedAuthor>
</author>
<!-- Composition custodian -->
<custodian>
  <!-- custodian (Organization with Mandatory Identifier) templateId-->
  <templateId root="1.2.36.1.2001.1001.102.101.100002" extension="1.0"/>
  <assignedCustodian>
    <representedCustodianOrganization>
      <id root="0c267071-8a7b-4cba-a3cc-9b571cc09ab3"/>
      <!-- Organization name -->
      <name>Test Org - Retail Pharmacy</name>
      <!-- Organization address -->
      <addr use="WP">
        <streetAddressLine>570 Whatcha St</streetAddressLine>
        <city>GLEBE</city>
        <state>NSW</state>
        <postalCode>2037</postalCode>
        <country>AU</country>
      </addr>
      <!-- Organization identifier -->
      <ext:asEntityIdentifier classCode="IDENT">
        <ext:id assigningAuthorityName="HPI-O"
          root="1.2.36.1.2001.1003.0.8003629900033370"/>
        <ext:assigningGeographicArea classCode="PLC">
          <ext:name>National Identifier</ext:name>
        </ext:assigningGeographicArea>
      </ext:asEntityIdentifier>
    </representedCustodianOrganization>
  </assignedCustodian>
</custodian>
<!-- Composition attester (Legal Attester) -->
<legalAuthenticator>
  <templateId root="1.2.36.1.2001.1001.102.101.100012" extension="1.0"/>
  <time value="201812111330+1000"/>
  <signatureCode code="S"/>
  <assignedEntity>
    <id root="01f1aae7-a212-4f3d-bb97-b26e7a476559"/>
    <assignedPerson>
      <!-- Practitioner name -->
      <name>
        <prefix>Mr.</prefix>
        <given>Zane</given>
        <family>Sinclair</family>
      </name>
      <!-- Practitioner identifier -->
      <ext:asEntityIdentifier classCode="IDENT">
        <ext:id root="1.2.36.1.2001.1003.0.8003611566708354"
          assigningAuthorityName="HPI-I"/>
        <ext:assigningGeographicArea classCode="PLC">
          <ext:name>National Identifier</ext:name>
        </ext:assigningGeographicArea>
      </ext:asEntityIdentifier>
    </assignedPerson>
  </assignedEntity>
</legalAuthenticator>
```

```
<!-- Patient generalPractitioner -->
<participant typeCode="PART">
    <!-- participant (generalPractitioner Base Organization) templateId-->
    <templateId root="1.2.36.1.2001.1001.102.101.100036" extension="1.0"/>
    <functionCode code="PCP"/>
    <associatedEntity classCode="PROV">
        <id root="fdb10052-30e9-4425-b771-8b8a81ae7107"/>
        <!--Organization type -->
        <code code="288565001" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
            displayName="Medical centre"/>
        <scopingOrganization>
            <!-- Organization name -->
            <name>Test Medical Centre</name>
        </scopingOrganization>
    </associatedEntity>
</participant>
<!-- Composition encounter-->
<componentOf>
    <encompassingEncounter>
        <!-- encompassingEncounter (Summary of an Encounter for an Event) templateId-->
        <templateId root="1.2.36.1.2001.1001.102.101.100064" extension="1.0"/>
        <id root="a2201099-367c-46a1-a611-e7c143a25a92"/>
        <!-- Encounter period-->
        <effectiveTime xsi:type="IVL_TS">
            <low value="201812111000+1000"/>
            <high value="201812111330+1000"/>
        </effectiveTime>
    </encompassingEncounter>
</componentOf>
<component>
    <structuredBody>
        <component>
            <!-- Composition section -->
            <section>
                <!-- section (Medicines List) templateId-->
                <templateId root="1.2.36.1.2001.1001.102.101.100077" extension="1.0"/>
                <id root="23d67386-2098-437a-94ff-b45c7b402d4b"/>
                <!-- section code -->
                <code code="10160-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
                    displayName="History of Medication use Narrative"/>
                <!-- section title -->
                <title>Medicines List</title>
                <!-- section text -->
                <text mediaType="text/x-hl7-text+xml" ID="ML1">
                    <table>
                        <caption>Current medicines</caption>
                        <thead>
                            <tr>
                                <th>Medicine</th>
                                <th>Brand name</th>
                                <th>Direction</th>
                                <th>Medicine purpose</th>
                                <th>Medicine status</th>
                                <th>Expected end date</th>
                                <th>Special instructions</th>
                                <th>Medicine Image</th>
                                <th>Physical Description</th>
                            </tr>
                        </thead>
                        <tbody>
                            <tr ID="medicationstatement-ferro-grad-c">
                                <td></td>
                                <td>Ferro-Grad C</td>
                                <td>Take one tablet daily</td>
                                <td>Iron Supplement</td>
                                <td>Unchanged</td>
                                <td></td>
                                <td></td>
                                <td></td>
                                <td></td>
                            </tr>
                            <tr ID="medicationstatement-amoxicillin-875mg">
                                <td></td>
                                <td>Amoxicillin 875 mg + clavulanic acid 125 mg tablet</td>
                                <td>Augmentin Duo Forte</td>
                                <td>Take one tablet twice a day</td>
                                <td>To treat chest infection</td>
                                <td>New</td>
                                <td>20/01/2019</td>
                                <td></td>
                                <td></td>
                            </tr>
                            <tr ID="medicationstatement-metformin-500mg">
                                <td></td>
                                <td>Metformin 500mg tablet</td>
                                <td>Sandoz</td>
                                <td>Take one tablet twice a day</td>
                                <td>Reduce blood sugar</td>
                                <td>Dose increased from 250mg to 500mg</td>
                                <td></td>
                                <td></td>
                                <td>White and round with 227 imprinted</td>
                            </tr>
                            <tr ID="medicationstatement-multi-vitamins">
                                <td></td>
                                <td>Multi-vitamins</td>
                                <td></td>
                                <td>Take one tablet daily</td>
                                <td></td>
                                <td></td>
                            </tr>
                        </tbody>
                    </table>
                </text>
            </section>
        </component>
    </structuredBody>
</component>
```

```
<td/>
<td/>
<td/>
<td/>
</tr>
<tr ID="medicationstatement-paracetamol-665mg">
<td>Paracetamol 665 mg tablet</td>
<td>Panadol Osteo</td>
<td>Take two tablets every 6 to 8 hours when required</td>
<td>Osteoarthritis, pain relief</td>
<td/>
<td/>
<td>No more than 6 tablets in 24 hours</td>
<td/>
<td/>
</tr>
</tbody>
</table>
<table>
<caption>Ceased medicines</caption>
<thead>
<tr>
<th>Medicine</th>
<th>Reason for ceasing medicine</th>
<th>Ceased date</th>
</tr>
</thead>
<tbody>
<tr ID="medicationstatement-paracetamol-500mg">
<td></td>
<td>Paracetamol 500mg tablet</td>
<td>Stopped; duplicated medicine</td>
<td>Dec 2018</td>
</tr>
<tr ID="medicationstatement-ibuprofen">
<td>Ibuprofen</td>
<td>Allergic Reaction</td>
<td/>
</tr>
</tbody>
</table>
<p>Packed medicines: No</p>
<p>Please review this list with your pharmacist on or soon after  
02/Apr/2019. Community pharmacy medicine review</p>
</text>
<!-- section entry -->
<entry typeCode="COMP">
<act classCode="ACT" moodCode="EVN">
<!-- act (List of Medicine Items with Change Information Authored by Practitioner) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100067" extension="1.0"/>
<id root="27e20cfe-2684-4612-a05e-a4d2d75c25cd"/>
<!-- List code-->
<code code="10160-0" codeSystem="2.16.840.1.113883.6.1"
codeSystemName="LOINC"
displayName="History of Medication use Narrative"/>
<text><reference value="#M11"/></text>
<!-- List status -->
<statusCode code="active"/>
<!-- List date -->
<effectiveTime value="201812111330+1000"/>
<!-- List author-role / List source -->
<author>
<!-- author (PractitionerRole with Practitioner with Mandatory Identifier) templateId-->
<templateId root="1.2.36.1.2001.1001.102.101.100006" extension="1.0"/>
<!-- List date -->
<time value="201812111330+1000"/>
<assignedAuthor>
<id root="0f1aaee7-a212-4f3d-bb97-b26e7a476559"/>
<!-- PractitionerRole code -->
<code code="251513" codeSystem="2.16.840.1.113883.13.62"
codeSystemName="Australian and New Zealand Standard Classification of Occupations"
displayName="Retail Pharmacist"
<originalText>Pharmacist</originalText>
</code>
<!--PractitionerRole telecom-->
<telecom use="WB" value="mailto:zsin@gmail.com"/>
<!-- PractitionerRole practitioner -->
<assignedPerson>
<!-- assignedPerson (Practitioner with Mandatory Identifier) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100040"
extension="1.0"/>
<!-- Practitioner name -->
<name>
<prefix>Mr.</prefix>
<given>Zane</given>
<family>Sinclair</family>
</name>
<!-- PractitionerRole identifier / Practitioner identifier -->
<ext:asEntityIdentifier classCode="IDENT">
<ext:id root="1.2.36.1.2001.1003.0.8003611566708354"
assigningAuthorityName="HPI-I"/>
<ext:assigningGeographicArea classCode="PLC">
<ext:name>National Identifier</ext:name>
</ext:assigningGeographicArea>
</ext:asEntityIdentifier>
<!--Practitioner qualification-->
<ext:asQualifications classCode="QUAL">
<ext:code>
<originalText>Bachelor of Pharmacy </originalText>
```

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        </ext:code>
        </ext:asQualifications>
    </assignedPerson>
<!-- PractitionerRole organization -->
<representedOrganization>
    <!-- representedOrganization (Base Organization) templateId-->
    <templateId root="1.2.36.1.2001.1001.102.101.100039"
        extension="1.0"/>
    <id root="0c267071-8a7b-4cba-a3cc-9b571cc09ab3"/>
    <!-- Organization name -->
    <name>Test Org - Retail Pharmacy</name>
    <!-- Organization address -->
    <addr use="WP">
        <streetAddressLine>570 Whatcha St</streetAddressLine>
        <city>GLEBBE</city>
        <state>NSW</state>
        <postalCode>2037</postalCode>
        <country>AU</country>
    </addr>
    <!-- Organization type-->
    <standardIndustryClassCode code="4271"
        codeSystem="1.2.36.1.2001.1005.47"
        codeSystemName="1292.0 - ANZIC - Australian and New Zealand Standard Industrial Classification"
        displayName="Retail Pharmacy"/>
    <!-- Organization identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
        <ext:id assigningAuthorityName="HPI-O"
            root="1.2.36.1.2001.1003.0.8003629900033370"/>
        <ext:assigningGeographicArea classCode="PLC">
            <ext:name>National Identifier</ext:name>
        </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>
    </representedOrganization>
</assignedAuthor>
</author>
<!-- List note -->
<entryRelationship typeCode="COMP">
    <act classCode="INFRM" moodCode="EVN">
        <id root="leff70fc-9c71-45b8-aab8-2a9c4alfaf6e"/>
        <code code="103.16044" codeSystem="1.2.36.1.2001.1001.101"
            codeSystemName="NCTIS Data Components"
            displayName="Additional Comments"/>
        <text xsi:type="ST">Packed Medicines: No; Please review this
            list with your pharmacist on or soon after
            02/Apr/2019.</text>
        <author>
            <time value="201812111330+1000"/>
            <assignedAuthor>
                <id root="01flaee7-a212-4f3d-bb97-b26e7a476559"/>
                <!-- PractitionerRole code -->
                <code code="251513" codeSystem="2.16.840.1.113883.13.62"
                    codeSystemName="Australian and New Zealand Standard Classification of Occupations"
                    displayName="Retail Pharmacist">
                    <originalText>Pharmacist</originalText>
                </code>
            </assignedAuthor>
        </author>
    </act>
</entryRelationship>
<!-- List encounter-->
<entryRelationship typeCode="COMP">
    <encounter classCode="ENC" moodCode="EVN">
        <!-- encounter (Summary of an Encounter for an Event) templateId-->
        <templateId root="1.2.36.1.2001.1001.102.101.100062"
            extension="1.0"/>
        <id root="a2201099-367c-46a1-a611-e7c143a25a92"/>
        <!--Encounter status-->
        <statusCode code="completed"/>
        <!--Encounter period-->
        <effectiveTime xsi:type="IVL_TS">
            <low value="201812111000+1000"/>
            <high value="201812111330+1000"/>
        </effectiveTime>
        <!--Encounter type-->
        <entryRelationship typeCode="COMP">
            <observation classCode="OBS" moodCode="EVN">
                <code code="103.17018"
                    codeSystem="1.2.36.1.2001.1001.101"
                    codeSystemName="NCTIS Data Components"
                    displayName="Category"/>
                <value xsi:type="CD" code="1348961000168104"
                    codeSystem="2.16.840.1.113883.6.96"
                    codeSystemName="SNOMED CT"
                    displayName="Community pharmacy medicines review">
                    <originalText>Community pharmacy medicine
                    review</originalText>
                </value>
            </observation>
        </entryRelationship>
    </encounter>
</entryRelationship>
<!-- List entry item -->
<entryRelationship typeCode="COMP">
    <!-- MedicationStatement taken="y" -->
    <substanceAdministration classCode="SBADM" moodCode="EVN">
        <!-- substanceAdministration (Medicine Item Statement) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100066"
            extension="1.0"/>
        <id root="0bla1969-134e-46d7-84ad-c61fada43a63"/>
    </substanceAdministration>
</entryRelationship>
```

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<!-- MedicationStatement dosage text-->
<text>
    <reference value="#medicationstatement-ferro-grad-c" />
</text>
<!-- MedicationStatement status -->
<statusCode code="active" />
<!--MedicationStatement dosage timing-->
<effectiveTime xsi:type="PIVL_TS">
    <!-- timing repeat frequency=1, timing repeat period=1, timing repeat periodUnit=d-->
    <period value="1" unit="d"/>
</effectiveTime>
<!-- MedicationStatement dosage dose -->
<doseQuantity value="1" />
<!-- MedicationStatement medication[x] -->
<consumable typeCode="CSM">
    <manufacturedProduct classCode="MANU">
        <!-- manufacturedProduct (Base Medication) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100068"
            extension="1.0" />
        <id root="c5171380-e169-4465-925e-dd0c46f6c9e4" />
        <manufacturedMaterial determinerCode="KIND">
            <!-- Medication code -->
            <code code="53373011000036103" 
                codeSystem="2.16.840.1.113883.6.96"
                codeSystemName="SNOMED CT"
                displayName="Ferro-Grad C">
                <originalText>Ferro-Grad C</originalText>
            </code>
            <!-- Medication form -->
            <ext:formCode code="154011000036109" 
                codeSystem="2.16.840.1.113883.6.96"
                codeSystemName="SNOMED CT" displayName="tablet" />
        </manufacturedMaterial>
    </manufacturedProduct>
</consumable>
<!-- MedicationStatement reasonCode -->
<entryRelationship typeCode="RSON" >
    <observation classCode="OBS" moodCode="EVN">
        <id root="bb1d6c85-42cc-4754-b86a-72b5163b2b95" />
        <code code="103.10141" 
            codeSystem="1.2.36.1.2001.1001.101"
            codeSystemName="NCTIS Data Components"
            displayName="Clinical Indication" />
        <value xsi:type="CD" 
            code="nochange" 
            codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
            codeSystemName="MedicineItemChange"
            displayName="Unchanged" />
        <originalText>Iron supplement</originalText>
    </value>
</observation>
</entryRelationship>
<!-- List entry flag -->
<entryRelationship typeCode="SUBJ" inversionInd="true" >
    <observation classCode="OBS" moodCode="EVN">
        <id root="ddfa1314-d687-4953-8404-b38fd4f0c4d0" />
        <code code="288533004" 
            codeSystem="2.16.840.1.113883.6.96"
            codeSystemName="SNOMED CT"
            displayName="Change values" />
        <value xsi:type="CD" code="nochange" 
            codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
            codeSystemName="MedicineItemChange"
            displayName="Unchanged" />
    </observation>
</entryRelationship>
</substanceAdministration>
</entryRelationship>
<!-- List entry item -->
<entryRelationship typeCode="COMP" >
    <!-- MedicationStatement taken="y" -->
    <substanceAdministration classCode="SBADM" moodCode="EVN" >
        <!-- substanceAdministration (Medicine Item Statement) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100066"
            extension="1.0" />
        <id root="ed657e-8a44-4f29-b40d-ed3821c9cd0a" />
        <!-- MedicationStatement dosage -->
        <text>
            <reference value="#medicationstatement-amoxicillin-875mg" />
        </text>
        <!-- MedicationStatement status -->
        <statusCode code="active" />
        <!--MedicationStatement effective[x] -->
        <effectiveTime xsi:type="IVL_TS" operator="A" >
            <high value="20190120" />
        </effectiveTime>
        <!--MedicationStatement dosage timing-->
        <effectiveTime xsi:type="PIVL_TS">
            <!-- timing repeat frequency=2, timing repeat period=1, timing repeat periodUnit=d-->
            <period value="12" unit="h" />
        </effectiveTime>
        <!-- MedicationStatement dosage dose -->
        <doseQuantity value="1" />
        <!-- MedicationStatement medication[x] -->
        <consumable typeCode="CSM">
            <manufacturedProduct classCode="MANU">
                <!-- manufacturedProduct (Base Medication) templateId -->
                <templateId root="1.2.36.1.2001.1001.102.101.100068"
                    extension="1.0" />
                <id root="78548cc2-88a8-4571-b691-c5e865ffa895" />
                <manufacturedMaterial determinerCode="KIND">
                    <!-- Medication code -->
                    <code code="28152011000036108" />
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codeSystem="2.16.840.1.113883.6.96"
codeSystemName="SNOMED CT"
displayName="amoxicillin 875 mg + clavulanic acid 125 mg tablet, 10"
<originalText>Amoxicillin 875 mg + clavulanic acid
125 mg tablet, Augmentin Duo Forte</originalText>
<translation code="5006L"
codeSystem="1.2.36.1.2001.1004.200.10009"
codeSystemName="Australian Pharmaceutical Benefits Scheme Schedule Item"
displayName="amoxicillin 875 mg + clavulanic acid 125 mg tablet, 10"
/>
</code>
</manufacturedMaterial>
</manufacturedProduct>
</consumable>
<!-- Medication medication-brand-name -->
<entryRelationship typeCode="COMP">
<act classCode="ACT" moodCode="EVN">
<id root="346ca17d-9b3a-40be-9bc9-c3e645fb0bf9"/>
<code code="TBD" codeSystem="2.16.840.1.113883.6.96"
codeSystemName="SNOMED CT" displayName="Brand Name"/>
<text>Augmentin Duo Forte</text>
</act>
</entryRelationship>
<!-- MedicationStatement reasonCode -->
<entryRelationship typeCode="RSON">
<observation classCode="OBS" moodCode="EVN">
<id root="ec99aab9-53da-448a-b2b5-6afd464181de"/>
<code code="103.10141"
codeSystem="1.2.36.1.2001.1001.101"
codeSystemName="INCTIS Data Components"
displayName="Clinical Indication"/>
<value xsi:type="CD">
<originalText>Chest infection</originalText>
</value>
</observation>
</entryRelationship>
<!-- List entry flag -->
<entryRelationship typeCode="SUBJ" inversionInd="true">
<observation classCode="OBS" moodCode="EVN">
<id root="lef533a8-878a-4383-b70f-0da61cd785cf"/>
<code code="288533004"
codeSystem="2.16.840.1.113883.6.96"
codeSystemName="SNOMED CT"
displayName="Change values"/>
<!-- List entry change-description -->
<text>To treat chest infection</text>
<value xsi:type="CD" code="new"
codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
codeSystemName="MedicineItemChange"
displayName="New"/>
</observation>
</entryRelationship>
</substanceAdministration>
</entryRelationship>
<!-- List entry item -->
<entryRelationship typeCode="COMP">
<!-- MedicationStatement taken="y" -->
<substanceAdministration classCode="SBADM" moodCode="EVN">
<!-- substanceAdministration (Medicine Item Statement) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.10006"
extension="1.0"/>
<id root="217584d0-6c18-4007-b1ec-690c92b188db"/>
<!-- MedicationStatement dosage -->
<text>
<reference value="#medicationstatement-metformin-500mg"/>
</text>
<!-- MedicationStatement status -->
<statusCode code="active"/>
<!-- MedicationStatement dosage timing-->
<effectiveTime xsi:type="PIVL_TS">
<!-- timing repeat frequency=2, timing repeat period=1, timing repeat periodUnit=d-->
<period value="12" unit="h"/>
</effectiveTime>
<!-- MedicationStatement dosage dose -->
<doseQuantity value="1"/>
<!-- MedicationStatement medication[x] -->
<consumable typeCode="CSM">
<manufacturedProduct classCode="MANU">
<!-- manufacturedProduct (Base Medication) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100068"
extension="1.0"/>
<id root="b1914fb8-61be-47dc-84b2-4cf376f69002"/>
<manufacturedMaterial determinerCode="KIND">
<!-- Medication code -->
<code code="23358011000036102"
codeSystem="2.16.840.1.113883.6.96"
codeSystemName="SNOMED CT"
displayName="metformin hydrochloride 500 mg tablet">
<originalText>Metformin 500mg tablet,
Sandoz</originalText>
<translation code="2430X"
codeSystem="1.2.36.1.2001.1004.200.10009"
codeSystemName="Australian Pharmaceutical Benefits Scheme Schedule Item"
displayName="metformin hydrochloride 500 mg tablet, 100"
/>
</code>
</manufacturedMaterial>
</manufacturedProduct>
</consumable>
```

```
<!-- Medication medication-brand-name -->
<entryRelationship typeCode="COMP">
  <act classCode="ACT" moodCode="EVN">
    <id root="26e0f1d6-e226-4b40-8fd3-bd0c0f51889f"/>
    <code code="TBD" codeSystem="2.16.840.1.113883.6.96"
      codeSystemName="SNOMED CT" displayName="Brand Name"/>
    <text>Sandoz</text>
  </act>
</entryRelationship>
<!-- MedicationStatement reasonCode -->
<entryRelationship typeCode="RSON">
  <observation classCode="OBS" moodCode="EVN">
    <id root="85b7ec11-da45-4b0a-af9e-edb271577f01"/>
    <code code="103.10141"
      codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components"
      displayName="Clinical Indication"/>
    <value xsi:type="CD">
      <originalText>Reduce blood sugar</originalText>
    </value>
  </observation>
</entryRelationship>
<!-- List entry flag -->
<entryRelationship typeCode="SUBJ" inversionInd="true">
  <observation classCode="OBS" moodCode="EVN">
    <id root="a75edb7e-d0be-46ab-b496-36ec580380c0"/>
    <code code="288533004"
      codeSystem="2.16.840.1.113883.6.96"
      codeSystemName="SNOMED CT"
      displayName="Change values"/>
    <text>Dose increased from 250mg to 500mg</text>
    <value xsi:type="CD" code="amended"
      codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
      codeSystemName="MedicineItemChange"
      displayName="Amended"/>
  </observation>
</entryRelationship>
</substanceAdministration>
</entryRelationship>
<!-- List entry item -->
<entryRelationship typeCode="COMP">
  <!-- MedicationStatement taken="y" -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!-- substanceAdministration (Medicine Item Statement) templateId -->
    <templateId root="1.2.36.1.2001.1001.102.101.100066"
      extension="1.0"/>
    <id root="07c6bad3-926c-458b-b434-79246cb45fda"/>
    <!-- MedicationStatement dosage -->
    <text>
      <reference value="#medicationstatement-multi-vitamins"/>
    </text>
    <!-- MedicationStatement status -->
    <statusCode code="active"/>
    <!-- MedicationStatement dosage timing-->
    <effectiveTime xsi:type="PIVL_TS">
      <!-- timing repeat frequency=1, timing repeat period=1, timing repeat periodUnit=d-->
      <period value="1" unit="d"/>
    </effectiveTime>
    <!-- MedicationStatement dosage dose -->
    <doseQuantity value="1"/>
    <!-- MedicationStatement medication[x] -->
    <consumable typeCode="CSM">
      <manufacturedProduct classCode="MANU">
        <!-- manufacturedProduct (Base Medication) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100068"
          extension="1.0"/>
        <id root="e9bfa7ef-573c-46bb-90d3-12a3b2f6c05e"/>
        <manufacturedMaterial determinerCode="KIND">
          <!-- Medication code -->
          <code>
            <originalText>Multi-vitamins</originalText>
          </code>
          <!-- Medication form -->
          <ext:formCode code="154011000036109"
            codeSystem="2.16.840.1.113883.6.96"
            codeSystemName="SNOMED CT" displayName="tablet"/>
        </manufacturedMaterial>
      </manufacturedProduct>
    </consumable>
    <!-- List entry flag -->
    <entryRelationship typeCode="SUBJ" inversionInd="true">
      <observation classCode="OBS" moodCode="EVN">
        <id root="92dd8e7c-f402-4ef5-b033-10f602be14c1"/>
        <code code="288533004"
          codeSystem="2.16.840.1.113883.6.96"
          codeSystemName="SNOMED CT"
          displayName="Change values"/>
        <value xsi:type="CD" code="nochange"
          codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
          codeSystemName="MedicineItemChange"
          displayName="Unchanged"/>
      </observation>
    </entryRelationship>
  </substanceAdministration>
</entryRelationship>
<!-- List entry item -->
<entryRelationship typeCode="COMP">
  <!-- MedicationStatement taken="y" -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
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<!-- substanceAdministration (Medicine Item Statement) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100066"
  extension="1.0"/>
<id root="fca75696-c85f-4664-9712-8be2f9adade6"/>
<!-- MedicationStatement dosage -->
<text>
  <reference value="#medicationstatement-paracetamol-665mg"/>
</text>
<!-- MedicationStatement status -->
<statusCode code="active"/>
<!-- MedicationStatement dosage timing -->
<effectiveTime xsi:type="IVL_TS" operator="A">
  <!-- timing repeat frequency=1, timing repeat period=6, timing repeat periodUnit=h, timing repeat periodMax=8-->
  <period xsi:type="IVL_PQ">
    <low value="6" unit="h"/>
    <high value="8" unit="h"/>
  </period>
</effectiveTime>
<!-- MedicationStatement dosage dose -->
<doseQuantity value="2"/>
<!-- MedicationStatement dosage maxDosePerPeriod -->
<maxDoseQuantity>
  <!-- maxDosePerPeriod numerator=6; maxDosePerPeriod denominator unit=h and value=24-->
  <numerator unit="6"/>
  <denominator unit="h" value="24"/>
</maxDoseQuantity>
<!-- MedicationStatement medication[x] -->
<consumable typeCode="CSM">
  <manufacturedProduct classCode="MANU">
    <!-- manufacturedProduct (Base Medication) templateId -->
    <templateId root="1.2.36.1.2001.1001.102.101.100068"
      extension="1.0"/>
    <id root="ecfa16da-a430-44ca-ae24-79f692384bc8"/>
    <manufacturedMaterial determinerCode="KIND">
      <!-- Medication code -->
      <code code="22075011000036103"
        codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMED CT"
        displayName="paracetamol 665 mg modified release tablet">
        <originalText>Paracetamol 665mg tablet; Panadol Osteo</originalText>
        <translation code="8814X"
          codeSystem="1.2.36.1.2001.1004.200.10009"
          codeSystemName="Australian Pharmaceutical Benefits Scheme Schedule Item"
          displayName="paracetamol 665 mg modified release tablet, 96"
        />
      </code>
      <!-- Medication ingredient -->
      <ext:asIngredient classCode="INGR">
        <!-- Medication ingredient item -->
        <ext:ingredientManufacturedMaterial
          classCode="MMAT" determinerCode="KIND">
          <ext:code code="90332006"
            codeSystem="2.16.840.1.113883.6.96"
            codeSystemName="SNOMED CT"
            displayName="Paracetamol"/>
          </ext:ingredientManufacturedMaterial>
        <!-- Medication ingredient amount -->
        <ext:quantity>
          <numerator unit="mg" value="665"/>
          <denominator value="1"/>
        </ext:quantity>
      </ext:asIngredient>
      <!-- Medication form -->
      <ext:formCode code="261011000036101"
        codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMED CT"
        displayName="modified release tablet"/>
    </manufacturedMaterial>
  </manufacturedProduct>
</consumable>
<!-- Medication medication-generic-name -->
<entryRelationship typeCode="COMP">
  <act classCode="ACT" moodCode="EVN">
    <id root="2ddbef9e-5268-4a96-9f4d-c4545683b380"/>
    <code code="TBD" codeSystem="2.16.840.1.113883.6.96"
      codeSystemName="SNOMED CT"
      displayName="Generic Name"/>
    <text>Paracetamol 665mg tablet</text>
  </act>
</entryRelationship>
<!-- Medication medication-brand-name -->
<entryRelationship typeCode="COMP">
  <act classCode="ACT" moodCode="EVN">
    <id root="8e538a16-0d07-41aa-8d30-9dd064b76003"/>
    <code code="TBD" codeSystem="2.16.840.1.113883.6.96"
      codeSystemName="SNOMED CT" displayName="Brand Name"/>
    <text>Panadol Osteo</text>
  </act>
</entryRelationship>
<!-- MedicationStatement reasonCode -->
<entryRelationship typeCode="RSON">
  <observation classCode="OBS" moodCode="EVN">
    <id root="39c066c4-fba4-490e-aael-a0f823e2aaaa"/>
    <code code="103.10141"
      codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components"
      displayName="Clinical Indication"/>
    <value xsi:type="CD">
```

```
<originalText>Osteoarthritis, pain
relief</originalText>
</value>
</observation>
</entryRelationship>
<!-- List entry flag -->
<entryRelationship typeCode="SUBJ" inversionInd="true">
<observation classCode="OBS" moodCode="EVN">
<id root="91ab74ac-eb52-4bc3-8f10-37efc7fe0741"/>
<code code="288533004"
codeSystem="2.16.840.1.113883.6.96"
codeSystemName="SNOMED CT"
displayName="Change values"/>
<value xsi:type="CD" code="nochange"
codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
codeSystemName="MedicineItemChange"
displayName="Unchanged"/>
</observation>
</entryRelationship>
<!-- MedicationStatement dosage asNeeded -->
<precondition typeCode="PRCN">
<criterion>
<code code="ASSERTION"
codeSystem="2.16.840.1.113883.5.4"/>
<value xsi:type="BL" value="true"/>
</criterion>
</precondition>
</substanceAdministration>
</entryRelationship>
<!-- List entry item -->
<entryRelationship typeCode="COMP">
<!-- MedicationStatement taken="y" -->
<substanceAdministration classCode="SBADM" moodCode="EVN">
<!-- substanceAdministration (Medicine Item Statement) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100066"
extension="1.0"/>
<id root="f9a3d6e1-6de2-4e35-88ef-531940e2929a"/>
<!-- MedicationStatement dosage -->
<text>
<reference value="#medicationstatement-paracetamol-500mg"/>
</text>
<!-- MedicationStatement status -->
<statusCode code="aborted"/>
<!--MedicationStatement effective[x] -->
<effectiveTime xsi:type="IVL_TS">
<high value="201812"/>
</effectiveTime>
<!-- MedicationStatement medication[x] -->
<consumable typeCode="CSM">
<manufacturedProduct classCode="MANU">
<!-- manufacturedProduct (Base Medication) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100068"
extension="1.0"/>
<id root="3c086c5e-5218-4035-82b9-a856f6f49e61"/>
<manufacturedMaterial determinerCode="KIND">
<!-- Medication code -->
<code code="22464011000036101"
codeSystem="2.16.840.1.113883.6.96"
codeSystemName="SNOMED CT"
displayName="Paracetamol 500 mg tablet">
<originalText>Paracetamol 500 mg
tablet</originalText>
</code>
</manufacturedMaterial>
</manufacturedProduct>
</consumable>
<!-- List entry flag -->
<entryRelationship typeCode="SUBJ" inversionInd="true">
<observation classCode="OBS" moodCode="EVN">
<id root="8a4cfbc3-5f08-4fc0-8661-b55b3e0e2e6f"/>
<code code="288533004"
codeSystem="2.16.840.1.113883.6.96"
codeSystemName="SNOMED CT"
displayName="Change values"/>
<!-- List entry change-description -->
<text>Duplicated medicine</text>
<value xsi:type="CD" code="ceased"
codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
codeSystemName="MedicineItemChange"
displayName="Ceased"/>
</observation>
</entryRelationship>
</substanceAdministration>
</entryRelationship>
<!-- List entry item -->
<entryRelationship typeCode="COMP">
<!-- MedicationStatement taken="y" -->
<substanceAdministration classCode="SBADM" moodCode="EVN">
<!-- substanceAdministration (Medicine Item Statement) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100066"
extension="1.0"/>
<id root="0b6f1a8a-fe8c-4746-9ec8-3a4a2bbeb61a"/>
<!-- MedicationStatement dosage -->
<text>
<reference value="#medicationstatement-ibuprofen"/>
</text>
<!-- MedicationStatement status -->
<statusCode code="aborted"/>
<!-- MedicationStatement medication[x] -->
```

```
<consumable typeCode="CSM">
    <manufacturedProduct classCode="MANU">
        <!-- manufacturedProduct (Base Medication) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100068" extension="1.0"/>
        <id root="6be58051-819d-49cd-be37-c0d964d3d416"/>
        <manufacturedMaterial determinerCode="KIND">
            <!-- Medication code -->
            <code code="21885011000036105" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Ibuprofen">
                <originalText>Ibuprofen</originalText>
                <translation code="3192B" codeSystem="1.2.36.1.2001.1004.200.10009" codeSystemName="Australian Pharmaceutical Benefits Scheme Schedule Item" displayName="IBUPROFEN"/>
            </code>
        </manufacturedMaterial>
    </manufacturedProduct>
</consumable>
<!-- List entry flag -->
<entryRelationship typeCode="SUBJ" inversionInd="true">
    <observation classCode="OBS" moodCode="EVN">
        <id root="b75442a1-b13d-4306-878c-2e733e836bd0"/>
        <code code="288533004" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Change values"/>
        <!-- List entry change-description -->
        <text>Allergic reaction</text>
        <value xsi:type="CD" code="ceased" codeSystem="2.16.840.1.113883.2.3.4.1.2.6" codeSystemName="MedicineItemChange" displayName="Ceased"/>
    </observation>
</entryRelationship>
</substanceAdministration>
</entryRelationship>
</act>
</entry>
</section>
</component>
<!-- Composition section (Allergies) -->
<component>
    <section>
        <!-- section (Allergies) templateId-->
        <templateId root="1.2.36.1.2001.1001.102.101.100069" extension="1.0"/>
        <id root="e5616571-74e8-4986-9a58-4e51261091cd"/>
        <!-- section code-->
        <code code="48765-2" codeSystem="2.16.840.1.113883.6.1" displayName="Allergies & or adverse reactions"/>
        <!-- section title-->
        <title>Allergies</title>
        <!-- section text-->
        <text mediaType="text/x-hl7-text+xml">
            <table>
                <caption>Allergies</caption>
                <thead>
                    <tr>
                        <th>Substance/Agent</th>
                        <th>Reaction Type</th>
                        <th>Reaction</th>
                        <th>Reaction Onset Date</th>
                    </tr>
                </thead>
                <tbody>
                    <tr>
                        <td>ibuprofen</td>
                        <td>Allergic reaction</td>
                        <td>Anaphylaxis</td>
                        <td>October 2016</td>
                    </tr>
                </tbody>
            </table>
        </text>
        <!--section entry -->
        <entry typeCode="COMP">
            <observation classCode="OBS" moodCode="EVN">
                <!-- observation (Summary Statement of Allergy or Intolerance) templateId-->
                <templateId root="1.2.36.1.2001.1001.102.101.100014" extension="1.0"/>
                <id root="134649c9-53c9-41fe-984c-2b3123646800"/>
                <code code="allergy" codeSystem="2.16.840.1.113883.4.642.1.122" codeSystemName="AllergyIntoleranceType" displayName="Allergy"/>
                <!-- AllergyIntolerance onset[x]-->
                <effectiveTime>
                    <low value="201610"/>
                </effectiveTime>
                <!--AllergyIntolerance code-->
                <value xsi:type="CD" code="21885011000036105" codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT" displayName="Ibuprofen">
                    <originalText>ibuprofen</originalText>
                </value>
                <!-- AllergyIntolerance clinicalStatus -->
                <entryRelationship typeCode="COMP">
                    <observation classCode="OBS" moodCode="EVN">
                        <id root="80b36cc2-b70b-4351-a542-b65958c3f20f"/>
                        <code code="103.32013" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components">

```

```
        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>

<entryRelationship typeCode="COMP">
  <observation classCode="OBS" moodCode="EVN">
    <id root="ce0c2a55-be02-4f9d-b3be-95c4abb1caf3"/>
    <code code="103.32012" codeSystem="1.2.36.1.2001.1001.101"
        codeSystemName="NCTIS Data Components"
        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>

<entryRelationship typeCode="COMP">
  <observation classCode="OBS" moodCode="EVN">
    <id root="75a6e6d8-7d66-472f-97af-5fd6c64258c9"/>
    <code code="102.16474" codeSystem="1.2.36.1.2001.1001.101"
        codeSystemName="NCTIS Data Components"
        displayName="Reaction Event"/>
  <!-- AllergyIntolerance reaction substance-->
  <participant typeCode="CAGNT">
    <participantRole classCode="ADMM">
      <id root="c0a73810-08ad-418e-a559-1897ecfe60b6"/>
      <playingEntity classCode="ENT">
        <code code="21885011000036105"
            codeSystem="2.16.840.1.113883.6.96"
            codeSystemName="SNOMED CT" displayName="Ibuprofen">
          <originalText>ibuprofen</originalText>
        </code>
      </playingEntity>
    </participantRole>
  </participant>
  <!-- AllergyIntolerance reaction manifestation -->
  <entryRelationship typeCode="MFST" inversionInd="true">
    <observation classCode="OBS" moodCode="EVN">
      <id root="05424437-4ae8-4542-9b7c-672f036980bf"/>
      <code code="39579001"
          codeSystem="2.16.840.1.113883.6.96"
          codeSystemName="SNOMED CT" displayName="Anaphylaxis">
        <originalText>Anaphylaxis</originalText>
      </code>
    </observation>
  </entryRelationship>
</observation>
</entryRelationship>
</observation>
</structuredBody>
</component>
</component>
</ClinicalDocument>
```

B.2 Shared Meds List example 2

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

Example B.2. Shared Medicines List 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="urn:hl7-org:v3"  
    xmlns:ex="urn:hl7-org/v3-example"  
    xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"  
    xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"  
>  
<typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>  
    <!-- ClinicalDocument templateId -->  
    <templateId root="1.2.36.1.2001.1001.102.101.100033" extension="1.0"/>  
    <!-- ClinicalDocument (Shared Medicines List Authored by Practitioner) templateId -->  
    <templateId root="1.2.36.1.2001.1001.102.101.100065" extension="1.0"/>  
    <!-- CDA Rendering Specification templateId-->  
    <templateId root="1.2.36.1.2001.1001.100.226" extension="1.0"/>  
    <id root="ae22a11e-bca4-11e9-9cb5-2a2ae2dbcce4"/>  
    <!-- Composition type-->  
    <code code="56445-0" codeSystem="2.16.840.1.113883.6.1" displayName="Medication summary"/>  
    <!-- Composition title-->  
    <title>Home Medicines Review Report for Mr. Lenny Matterson</title>  
    <effectiveTime value="20190205"/>  
    <confidentialityCode nullFlavor="NA"/>  
    <languageCode code="en-AU"/>  
    <setId root="41699a72-e0b1-4300-9d4a-aac3149feffc"/>  
    <versionNumber value="2"/>  
    <!-- Composition status-->  
    <ext:completionCode code="F" codeSystem="1.2.36.1.2001.1001.101.104.20104" displayName="Final"/>  
    <!-- Composition subject -->  
    <recordTarget>  
        <!-- recordTarget (Patient with Mandatory Identifier) templateId-->  
        <templateId root="1.2.36.1.2001.1001.102.101.100004" extension="1.0"/>  
        <patientRole>  
            <id root="c0afb854-3c7f-4f26-98ba-9c6fbcd0d7777"/>  
            <!-- Patient telecom -->  
            <telecom use="MC" value="tel:0491 570 006"/>  
            <!-- Patient telecom -->  
            <telecom use="H" value="tel:(08) 5550 1234"/>  
            <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"  
                    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 assigningAuthorityName="IHI"  
                        root="1.2.36.1.2001.1003.0.8003608166895854"/>  
                    <ext:assigningGeographicArea classCode="PLC">  
                        <ext:name>National Identifier</ext:name>  
                    </ext:assigningGeographicArea>  
                </ext:asEntityIdentifier>  
                <!-- Patient identifier -->  
                <ext:asEntityIdentifier classCode="IDENT">  
                    <ext:id assigningAuthorityName="Medicare Card Number" root="1.2.36.1.5001.1.0.7"  
                        extension="5950890021"/>  
                    <ext:code code="MC" codeSystem="2.16.840.1.113883.12.203"  
                        displayName="Patient's Medicare number"/>  
                </ext:asEntityIdentifier>  
                <!-- Patient communication language-->  
                <languageCommunication>  
                    <languageCode code="pjt"/>  
                </languageCommunication>  
            </patient>  
        </patientRole>  
    </recordTarget>  
    <!-- Composition composition-author-role and Composition author -->  
    <author>  
        <!-- author (PractitionerRole with Practitioner with Mandatory Identifier) templateId-->  
        <templateId root="1.2.36.1.2001.1001.102.101.100006" extension="1.0"/>  
        <!-- Composition date -->  
        <time value="20190205"/>  
        <assignedAuthor>  
            <id root="cc61a87e-c467-4aa9-9f6a-ea4f8a1d5d16"/>  
            <!-- PractitionerRole code -->  
            <code code="251513" codeSystem="2.16.840.1.113883.13.62" displayName="Retail Pharmacist"/>  
            <!-- Practitioner address -->
```

```
<addr use="WP">34 Queen St, Coburg, VIC 3058</addr>
<!-- Practitioner telecom -->
<telecom use="WP" value="fax:0370102020"/>
<!-- PractitionerRole practitioner -->
<assignedPerson>
  <!-- assignedPerson (Practitioner with Mandatory Identifier) templateId -->
  <templateId root="1.2.36.1.2001.1001.102.101.100040" extension="1.0"/>
  <!-- Practitioner name -->
  <name use="L">
    <prefix>Mr.</prefix>
    <given>Ned</given>
    <family>DEACON</family>
  </name>
  <!-- PractitionerRole identifier / Practitioner identifier -->
  <ext:asEntityIdentifier classCode="IDENT">
    <ext:id root="1.2.36.1.2001.1003.0.8003616566708106"
      assigningAuthorityName="HPI-I"/>
    <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
    </ext:assigningGeographicArea>
  </ext:asEntityIdentifier>
  <!-- PractitionerRole identifier -->
  <ext:asEntityIdentifier classCode="IDENT">
    <ext:id root="1.2.36.174030967.0.2" extension="5544887B"
      assigningAuthorityName="Medicare Provider Number"/>
    <ext:code code="PRN" codeSystem="2.16.840.1.113883.12.203"/>
    <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
    </ext:assigningGeographicArea>
  </ext:asEntityIdentifier>
  </assignedPerson>
</assignedAuthor>
<!-- 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="728b84ca-9b80-4999-ac54-95973dce08ad"/>
      <!-- Organization.name -->
      <name>Big Pharmacy</name>
      <!-- Organization identifier -->
      <ext:asEntityIdentifier classCode="IDENT">
        <ext:id assigningAuthorityName="HPI-O"
          root="1.2.36.1.2001.1003.0.800362656699734"/>
        <ext:assigningGeographicArea classCode="PLC">
          <ext:name>National Identifier</ext:name>
        </ext:assigningGeographicArea>
      </ext:asEntityIdentifier>
    </representedCustodianOrganization>
  </assignedCustodian>
</custodian>
<!-- Composition attester (Legal Attester) -->
<legalAuthenticator>
  <templateId root="1.2.36.1.2001.1001.102.101.100012" extension="1.0"/>
  <time value="20190205"/>
  <signatureCode code="S"/>
  <assignedEntity>
    <id root="cc61a87e-c467-4aa9-9f6a-ea4f8ald5d16"/>
    <assignedPerson>
      <!-- Practitioner name -->
      <name use="L">
        <prefix>Mr.</prefix>
        <given>Ned</given>
        <family>DEACON</family>
      </name>
      <!-- Practitioner identifier -->
      <ext:asEntityIdentifier classCode="IDENT">
        <ext:id root="1.2.36.1.2001.1003.0.8003616566708106"
          assigningAuthorityName="HPI-I"/>
        <ext:assigningGeographicArea classCode="PLC">
          <ext:name>National Identifier</ext:name>
        </ext:assigningGeographicArea>
      </ext:asEntityIdentifier>
      </assignedPerson>
    </assignedEntity>
  </legalAuthenticator>
<!-- Composition encounter-->
<componentOf>
  <encompassingEncounter>
    <!-- encompassingEncounter (Summary of an Encounter for an Event) templateId-->
    <templateId root="1.2.36.1.2001.1001.102.101.100064" extension="1.0"/>
    <id root="8b0c25e2-7098-486a-89d5-38b6e8dd4e95"/>
    <!-- Encounter class -->
    <code code="HH" codeSystem="2.16.840.1.113883.5.4" displayName="home health"/>
    <!-- Encounter period -->
    <effectiveTime xsi:type="IVL_TS">
      <low value="20190205100000+1000"/>
      <high value="20190205111500+1000"/>
    </effectiveTime>
  </encompassingEncounter>
</componentOf>
<component>
  <structuredBody>
    <component>
      <!-- Composition section -->
      <section>
        <!-- section (Medicines List) templateId-->
```

```
<templateId root="1.2.36.1.2001.1001.102.101.100077" extension="1.0"/>
<id root="5a0ac820-2507-4f72-b164-ac3d4bc353fb"/>
<!-- section code -->
<code code="101.32009" codeSystem="1.2.36.1.2001.1001.101"
      displayName="Current Medicines"/>
<!-- section title -->
<title>Current Medicines</title>
<!-- section text -->
<text mediaType="text/x-hl7-text+xml">
    <table border="1">
        <caption>Home Medicines Review</caption>
        <thead>
            <tr>
                <th>Date of Interview</th>
                <th/>
                <th>General Assessment</th>
            </tr>
        </thead>
        <tbody>
            <tr>
                <td>5 Feb 2019 10:00AM - 5 Feb 2019 11:15AM</td>
                <td>Home medicines review</td>
                <td>Patient has his medications packed into blister packs via
                    ABC pharmacy. He finds them easy to use and they promote
                    good adherence to his regime. His Bluecare nurse, Nurse B,
                    was present for the interview. Of the medication listed on
                    the referral, he is not currently taking Aldara 5% cream and
                    Chloramphenicol ointment. In addition to the medication
                    listed on the referral, he is also taking coQ10 150mg tab -
                    1 nocte. He reports occasional dizziness if he changes
                    position quickly, and does report falling outside in the
                    garden; he wears a falls alarm buzzer. He reports that he
                    generally only experiences chest pain when he becomes
                    stressed (doesn't like paperwork). His blood pressure at the
                    time of the interview was 158 /76.</td>
            </tr>
        </tbody>
    </table>
    <table border="1">
        <caption>Current Medicines</caption>
        <thead>
            <tr>
                <th>Medicine</th>
                <th>Directions</th>
                <th>Medicine purpose</th>
                <th>Medicine status</th>
                <th>Status Reason/Comment</th>
            </tr>
        </thead>
        <tbody>
            <tr>
                <td>Amiodarone 200mg tab</td>
                <td>1 in the morning</td>
                <td/>
                <td>Unchanged</td>
                <td/>
            </tr>
            <tr>
                <td>Bisoprolol 2.5mg tab</td>
                <td>1/2 tablet in the morning</td>
                <td/>
                <td>Unchanged</td>
                <td/>
            </tr>
            <tr>
                <td>CoQ10 150mg tab</td>
                <td>1 at night</td>
                <td/>
                <td>New</td>
                <td>In pack - new finding of Atrial fibrillation</td>
            </tr>
        </tbody>
    </table>
    <p>Packed medicines: Yes</p>
</text>
<!-- section entry -->
<entry>
    <act classCode="ACT" moodCode="EVN">
        <!-- act (List of Medicine Items with Change Information Authored by Practitioner) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100067" extension="1.0"/>
        <!-- List code-->
        <code code="101.32009" codeSystem="1.2.36.1.2001.1001.101"
              displayName="Current Medicines"/>
        <!-- List status -->
        <statusCode code="active"/>
        <!-- List date -->
        <effectiveTime value="20190205"/>
        <!-- List author-role / List source -->
        <author>
            <!-- author (PractitionerRole with Practitioner with Mandatory Identifier) templateId-->
            <templateId root="1.2.36.1.2001.1001.102.101.100006" extension="1.0"/>
            <time value="20190205"/>
            <assignedAuthor>
                <!-- author (PractitionerRole with Practitioner with Mandatory Identifier) templateId-->
                <id root="cc61a87e-c467-4aa9-9f6a-ea4f8ald5d16"/>
                <!-- PractitionerRole code -->
                <code code="251513" codeSystem="2.16.840.1.113883.13.62"
                      displayName="Retail Pharmacist"/>
                <!-- Practitioner address -->
                <addr use="WP">34 Queen St, Coburg, VIC 3058</addr>
            
```

```
<!-- Practitioner telecom -->
<telecom use="WP" value="fax:0370102020" />
<!-- PractitionerRole practitioner -->
<assignedPerson>
    <!-- assignedPerson (Practitioner with Mandatory Identifier) templateId -->
    <templateId root="1.2.36.1.2001.1001.102.101.100040"
        extension="1.0" />
    <!-- Practitioner name -->
    <name use="T" >
        <prefix>Mr.</prefix>
        <given>Ned</given>
        <family>DEACON</family>
    </name>
    <!-- PractitionerRole identifier / Practitioner identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
        <ext:id root="1.2.36.1.2001.1003.0.8003616566708106"
            assigningAuthorityName="HPI-I" />
        <ext:assigningGeographicArea classCode="PLC">
            <ext:name>National Identifier</ext:name>
        </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>
    <!-- PractitionerRole identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
        <ext:id root="1.2.36.174030967.0.2" extension="5544887B"
            assigningAuthorityName="Medicare Provider Number" />
        <ext:code code="PRN"
            codeSystem="2.16.840.1.113883.12.203" />
        <ext:assigningGeographicArea classCode="PLC">
            <ext:name>National Identifier</ext:name>
        </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>
    </assignedPerson>
    </assignedAuthor>
</author>
<!-- List entry item -->
<entryRelationship typeCode="COMP">
    <!-- MedicationStatement taken="y" -->
    <substanceAdministration classCode="SBADM" moodCode="EVN">
        <!-- substanceAdministration (Medicine Item Statement) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100066"
            extension="1.0" />
        <id root="41f2a705-b51c-41a7-a573-529457ead1d7" />
        <!-- MedicationStatement dosage -->
        <text>Amiodarone 200mg tab; 1 in the morning</text>
        <!-- MedicationStatement status -->
        <statusCode code="active" />
        <!-- MedicationStatement medication[x] -->
        <consumable>
            <manufacturedProduct>
                <!-- manufacturedProduct (Base Medication) templateId -->
                <templateId root="1.2.36.1.2001.1001.102.101.100068"
                    extension="1.0" />
                <manufacturedMaterial determinerCode="KIND">
                    <!-- Medication code -->
                    <code>
                        <originalText>Amiodarone 200mg tab</originalText>
                    </code>
                </manufacturedMaterial>
            </manufacturedProduct>
        </consumable>
        <!-- List entry flag -->
        <entryRelationship typeCode="SUBJ" inversionInd="true">
            <observation classCode="OBS" moodCode="EVN">
                <code code="288533004"
                    codeSystem="2.16.840.1.113883.6.96"
                    displayName="Change values" />
                <value xsi:type="CD" code="nochange"
                    codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
                    displayName="Unchanged" />
            </observation>
        </entryRelationship>
    </substanceAdministration>
</entryRelationship>
<!-- List entry item -->
<entryRelationship typeCode="COMP">
    <!-- MedicationStatement taken="y" -->
    <substanceAdministration classCode="SBADM" moodCode="EVN">
        <!-- substanceAdministration (Medicine Item Statement) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100066"
            extension="1.0" />
        <id root="8ec35b86-7a65-4721-8698-6abd4745f4c2" />
        <!-- MedicationStatement dosage -->
        <text>Bisoprolol 2.5mg tab; 1/2 tablet in the morning</text>
        <!-- MedicationStatement status -->
        <statusCode code="active" />
        <!-- MedicationStatement medication[x] -->
        <consumable>
            <manufacturedProduct>
                <!-- manufacturedProduct (Base Medication) templateId -->
                <templateId root="1.2.36.1.2001.1001.102.101.100068"
                    extension="1.0" />
                <manufacturedMaterial determinerCode="KIND">
                    <!-- Medication code -->
                    <code code="23281011000036106"
                        codeSystem="2.16.840.1.113883.6.96"
                        displayName="bisoprolol fumarate 2.5 mg tablet" />
                    <originalText>Bisoprolol 2.5mg tab</originalText>
                </code>
            </manufacturedMaterial>
        </consumable>
    </substanceAdministration>
</entryRelationship>
```

```
</manufacturedProduct>
</consumable>
<!-- List entry flag -->
<entryRelationship typeCode="SUBJ" inversionInd="true">
    <observation classCode="OBS" moodCode="EVN">
        <code code="288533004"
            codeSystem="2.16.840.1.113883.6.96"
            displayName="Change values"/>
        <value xsi:type="CD" code="nochange"
            codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
            displayName="Unchanged"/>
    </observation>
</entryRelationship>
</substanceAdministration>
</entryRelationship>
<!-- List entry item -->
<entryRelationship typeCode="COMP">
    <!-- MedicationStatement taken="y" -->
    <substanceAdministration classCode="SBADM" moodCode="EVN">
        <!-- substanceAdministration (Medicine Item Statement) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100066"
            extension="1.0"/>
        <id root="222ac944-5bc8-4205-9d71-eb3a69817ebb"/>
        <!-- MedicationStatement dosage -->
        <text>CoQ10 150mg tab; 1 at night; New; In pack - new finding of
            Atrial fibrillation</text>
        <!-- MedicationStatement status -->
        <statusCode code="active"/>
        <!-- MedicationStatement medication[x] -->
        <consumable>
            <manufacturedProduct>
                <!-- manufacturedProduct (Base Medication) templateId -->
                <templateId root="1.2.36.1.2001.1001.102.101.100068"
                    extension="1.0"/>
                <manufacturedMaterial determinerCode="KIND">
                    <!-- Medication code -->
                    <code code="920941011000036100"
                        codeSystem="2.16.840.1.113883.6.96"
                        displayName="CoQ10 (Blackmores)">
                        <originalText>CoQ10 150mg tab</originalText>
                    </code>
                </manufacturedMaterial>
            </manufacturedProduct>
        </consumable>
        <!-- List entry flag -->
        <entryRelationship typeCode="SUBJ" inversionInd="true">
            <observation classCode="OBS" moodCode="EVN">
                <code code="288533004"
                    codeSystem="2.16.840.1.113883.6.96"
                    displayName="Change values"/>
                <!-- List entry change-description -->
                <text>New finding of Atrial fibrillation</text>
                <value xsi:type="CD" code="new"
                    codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
                    displayName="New"/>
            </observation>
        </entryRelationship>
    </substanceAdministration>
</entryRelationship>
<!-- List note -->
<entryRelationship typeCode="COMP">
    <act classCode="INPRM" moodCode="EVN">
        <code code="103.16044" codeSystem="1.2.36.1.2001.1001.101"
            displayName="Additional Comments"/>
        <text xsi:type="ST">Packed medicines: Yes</text>
    </act>
</entryRelationship>
<!-- List encounter -->
<entryRelationship typeCode="COMP">
    <encounter classCode="ENC" moodCode="EVN">
        <!-- encounter (Summary of an Encounter for an Event) templateId-->
        <templateId root="1.2.36.1.2001.1001.102.101.100062"
            extension="1.0"/>
        <id root="8b0c25e2-7098-486a-89d5-38b6e8dd4e95"/>
        <!-- Encounter class-->
        <code code="HH" codeSystem="2.16.840.1.113883.5.4"
            displayName="home health"/>
        <!-- Encounter encounter-description -->
        <text>Patient has his medications packed into blister packs via
            ABC pharmacy. He finds them easy to use and they promote
            good adherence to his regime. His Bluecare nurse, Nurse B,
            was present for the interview. Of the medication listed on
            the referral, he is not currently taking Aldara 5% cream and
            Chloramphenicol ointment. In addition to the medication
            listed on the referral, he is also taking coQ10 150mg tab -
            1 nocte. He reports occasional dizziness if he changes
            position quickly, and does report falling outside in the
            garden; he wears a falls alarm buzzer. He reports that he
            generally only experiences chest pain when he becomes
            stressed (doesn't like paperwork). His blood pressure at the
            time of the interview was 158 /76.</text>
        <!--Encounter status-->
        <statusCode code="completed"/>
        <!--Encounter period-->
        <effectiveTime xsi:type="IVL_TS">
            <low value="20190205100000+1000"/>
            <high value="20190205111500+1000"/>
        </effectiveTime>
        <!--Encounter type-->
```

```
<entryRelationship typeCode="COMP">
  <observation classCode="OBS" moodCode="EVN">
    <code code="103.17018"
      codeSystem="1.2.36.1.2001.1001.101"
      displayName="Category"/>
    <value xsi:type="CD" code="1348931000168107"
      codeSystem="2.16.840.1.113883.6.96"
      displayName="Home medicines review">
      <originalText>Home medicines review</originalText>
    </value>
  </observation>
</entryRelationship>
</encounter>
</entryRelationship>
</act>
</entry>
</section>
</component>
<component>
  <!-- Composition section -->
<section>
  <!-- section (Medicines List) templateId-->
  <templateId root="1.2.36.1.2001.1001.102.101.100077" extension="1.0"/>
  <id root="0b7fbad6-c5a0-42c6-bd66-8a983ed69a2a"/>
  <!-- section code -->
  <code code="101.32027" codeSystem="1.2.36.1.2001.1001.101"
    displayName="Ceased Medicines"/>
  <!-- section title -->
  <title>Ceased medicines</title>
  <!-- section text -->
  <text mediaType="text/x-hl7-text+xml">
    <table border="1">
      <caption>Ceased medicines</caption>
      <thead>
        <tr>
          <th>Ceased medicine</th>
          <th>Reason for ceasing</th>
        </tr>
      </thead>
      <tbody>
        <tr>
          <td>Aldara 5% cream (apply as required)</td>
          <td>Completed 8-week course</td>
        </tr>
        <tr>
          <td>Chloramphenicol 1% eye ointment (apply as required)</td>
          <td>Stopped due to burning sensation in the eye.</td>
        </tr>
      </tbody>
    </table>
  </text>
  <!-- section entry -->
<entry>
  <act classCode="ACT" moodCode="EVN">
    <!-- act (List of Medicine Items with Change Information Authored by Practitioner) templateId -->
    <templateId root="1.2.36.1.2001.1001.102.101.100063" extension="1.0"/>
    <!-- List code -->
    <code code="101.32027" codeSystem="1.2.36.1.2001.1001.101"
      displayName="Ceased Medicines"/>
    <!-- List status -->
    <statusCode code="active"/>
    <!-- List date -->
    <effectiveTime value="20190205"/>
    <!-- List author-role / List source -->
    <author>
      <!-- author (PractitionerRole with Practitioner with Mandatory Identifier) templateId-->
      <templateId root="1.2.36.1.2001.1001.102.101.100006" extension="1.0"/>
      <!-- List date -->
      <time value="20190205"/>
      <assignedAuthor>
        <id root="cc61a87e-c467-4aa9-9f6a-ea4f8ald5d16"/>
        <!-- PractitionerRole code -->
        <code code="251513" codeSystem="2.16.840.1.113883.13.62"
          displayName="Retail Pharmacist"/>
        <!-- Practitioner address -->
        <addr use="WB">34 Queen St, Coburg, VIC 3058</addr>
        <!-- Practitioner telecom -->
        <telecom use="WP" value="fax:0370102020"/>
        <!-- PractitionerRole practitioner -->
        <assignedPerson>
          <!-- assignedPerson (Practitioner with Mandatory Identifier) templateId -->
          <templateId root="1.2.36.1.2001.1001.102.101.100040"
            extension="1.0"/>
          <!-- Practitioner name -->
          <name use="T">
            <prefix>Mr.</prefix>
            <given>Ned</given>
            <family>DEACON</family>
          </name>
          <!-- PractitionerRole identifier / Practitioner identifier -->
          <ext:asEntityIdentifier classCode="IDENT">
            <ext:id root="1.2.36.1.2001.0.8003616566708106"
              assigningAuthorityName="HPI-I"/>
            <ext:assigningGeographicArea classCode="PLC">
              <ext:name>National Identifier</ext:name>
            </ext:assigningGeographicArea>
          </ext:asEntityIdentifier>
          <!-- PractitionerRole identifier -->
          <ext:asEntityIdentifier classCode="IDENT">
```

```
<ext:id root="1.2.36.174030967.0.2" extension="5544887B"
    assigningAuthorityName="Medicare Provider Number"/>
<ext:code code="PRN"
    codeSystem="2.16.840.1.113883.12.203"/>
<ext:assigningGeographicArea classCode="PLC">
    <ext:name>National Identifier</ext:name>
</ext:assigningGeographicArea>
</ext:asEntityIdentifier>
</assignedPerson>
</assignedAuthor>
</author>
<!-- List entry item -->
<entryRelationship typeCode="COMP">
    <!-- MedicationStatement taken="y" -->
    <substanceAdministration classCode="SBADM" moodCode="EVN">
        <!-- substanceAdministration (Medicine Item Statement) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100066"
            extension="1.0"/>
        <id root="dcde2dd2-a577-4bca-8951-727666c9bcaa"/>
        <!-- MedicationStatement dosage -->
        <text>Aldara 5% cream; apply as required; Completed 8-week
            course</text>
        <!-- MedicationStatement status -->
        <statusCode code="completed"/>
        <!-- MedicationStatement medication[x] -->
        <consumable>
            <manufacturedProduct>
                <!-- manufacturedProduct (Base Medication) templateId -->
                <templateId root="1.2.36.1.2001.1001.102.101.100068"
                    extension="1.0"/>
                <manufacturedMaterial determinerCode="KIND">
                    <!-- Medication code -->
                    <code code="119411000036106"
                        codeSystem="2.16.840.1.113883.6.96"
                        displayName="Aldara 5% cream"
                        <originalText>Aldara 5% cream</originalText>
                    </code>
                </manufacturedMaterial>
            </manufacturedProduct>
        </consumable>
        <!-- List entry flag -->
        <entryRelationship typeCode="SUBJ" inversionInd="true">
            <observation classCode="OBS" moodCode="EVN">
                <code code="288533004"
                    codeSystem="2.16.840.1.113883.6.96"
                    displayName="Change values"/>
                <!-- List entry change-description-->
                <text>Completed 8-week course</text>
                <value code="ceased"
                    codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
                    displayName="Ceased" xsi:type="CD"/>
            </observation>
        </entryRelationship>
    </substanceAdministration>
</entryRelationship>
<!-- List entry item -->
<entryRelationship typeCode="COMP">
    <!-- MedicationStatement taken="y" -->
    <substanceAdministration classCode="SBADM" moodCode="EVN">
        <!-- substanceAdministration (Medicine Item Statement) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100066"
            extension="1.0"/>
        <id root="0039beb1-b916-4a7c-bd48-c9a196887b8e"/>
        <!-- MedicationStatement dosage -->
        <text>Chloramphenicol 1% eye ointment; apply as required;
            Stopped due to burning sensation in the eye</text>
        <!-- MedicationStatement status -->
        <statusCode code="completed"/>
        <!-- MedicationStatement medication[x] -->
        <consumable>
            <manufacturedProduct>
                <!-- manufacturedProduct (Base Medication) templateId -->
                <templateId root="1.2.36.1.2001.1001.102.101.100068"
                    extension="1.0"/>
                <manufacturedMaterial determinerCode="KIND">
                    <!-- Medication code -->
                    <code code="22717011000036101"
                        codeSystem="2.16.840.1.113883.6.96"
                        displayName="chloramphenicol 1% eye
                        ointment">
                        <originalText>Chloramphenicol 1% eye
                        ointment</originalText>
                    </code>
                </manufacturedMaterial>
            </manufacturedProduct>
        </consumable>
        <!-- List entry flag -->
        <entryRelationship typeCode="SUBJ" inversionInd="true">
            <observation classCode="OBS" moodCode="EVN">
                <code code="288533004"
                    codeSystem="2.16.840.1.113883.6.96"
                    displayName="Change values"/>
                <!-- List entry change-description -->
                <text>Stopped due to burning sensation in the
                    eye.</text>
                <value code="ceased"
                    codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
                    displayName="Ceased" xsi:type="CD"/>
            </observation>
        </entryRelationship>
    </substanceAdministration>
</entryRelationship>
```

```
</substanceAdministration>
</entryRelationship>
</act>
</entry>
</section>
</component>
</structuredBody>
</component>
</ClinicalDocument>
```

DRAFT

B.3 Shared Meds List example 3

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

Example B.3. Shared Medicines List example 3

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

```
<ClinicalDocument classCode="DOCLIN" moodCode="EVN" xmlns="urn:hl7-org:v3"
xmlns:ex="urn:hl7-org/v3-example"
xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
>
<typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>
<!-- ClinicalDocument templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100033" extension="1.0"/>
<!--ClinicalDocument (Shared Medicines List Authored by Practitioner) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100065" extension="1.0"/>
<!--CDA Rendering Specification templateId-->
<templateId root="1.2.36.1.2001.1001.100.226" extension="1.0"/>
<id root="a25c2e86-62ee-49b5-9c3e-7daf545a2dfd"/>
<!-- Composition type-->
<code code="56445-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
 displayName="Medication summary"/>
<!-- Composition title-->
<title>Shared Medicines List</title>
<effectiveTime value="20190812"/>
<confidentialityCode nullFlavor="NA"/>
<languageCode code="en-AU"/>
<setid root="2bd59445-4773-4a75-bee8-c84a67f1e5cd"/>
<versionNumber value="1"/>
<!-- 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 (Patient with Mandatory Identifier) templateId-->
<templateId root="1.2.36.1.2001.1001.102.101.100004" extension="1.0"/>
<patientRole>
<id root="c7445b1a-a31f-4626-9681-dc6d97481d8e"/>
<patient>
<!-- Patient name -->
<name use="L">
<prefix>Mrs</prefix>
<given>Bonny</given>
<family>Goodwin</family>
</name>
<!-- Patient gender -->
<administrativeGenderCode code="female" codeSystem="2.16.840.1.113883.4.642.1.2"
 codeSystemName="AdministrativeGender" displayName="Female"/>
<!-- Patient maritalStatus-->
<maritalStatusCode code="M" codeSystem="2.16.840.1.113883.5.2"
 codeSystemName="v3 Code System MaritalStatus" displayName="Married">
<originalText>Married</originalText>
</maritalStatusCode>
<!-- Patient identifier -->
<ext:asEntityIdentifier classCode="IDENT">
<ext:id assigningAuthorityName="IHI"
 root="1.2.36.1.2001.1003.0.8003608000228445"/>
<ext:assigningGeographicArea classCode="PLC">
<ext:name>National Identifier</ext:name>
</ext:assigningGeographicArea>
</ext:asEntityIdentifier>
<!-- Patient identifier -->
<ext:asEntityIdentifier classCode="IDENT">
<ext:id assigningAuthorityName="Medicare Card Number" root="1.2.36.1.5001.1.0.7"
 extension="3951032981"/>
<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>
<!-- Composition composition-author-role and Composition author -->
<author>
<!-- author (PractitionerRole with Practitioner with Mandatory Identifier) templateId-->
<templateId root="1.2.36.1.2001.1001.102.101.100006" extension="1.0"/>
<!-- Composition date -->
<time value="20190812"/>
<assignedAuthor>
<id root="cd1f53e1-c922-446b-9ef6-ee43740b653e"/>
<!-- PractitionerRole code -->
<code code="46255001" codeSystem="2.16.840.1.113883.6.96" displayName="Pharmacist"/>
<!-- PractitionerRole practitioner -->
<assignedPerson>
<!-- assignedPerson (Practitioner with Mandatory Identifier) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100040" extension="1.0"/>
<!-- PractitionerRole identifier / Practitioner identifier -->
```

```
<ext:asEntityIdentifier classCode="IDENT">
  <ext:id root="1.2.36.1.2001.1003.0.8003619900041630"
    assigningAuthorityName="HPI-I"/>
  <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="0c267071-8a7b-4cba-a3cc-9b571cc09ab3"/>
      <!-- Organization name -->
      <name>Test Hospital</name>
      <!-- Organization telecom -->
      <telecom use="WP" value="tel:(03) 7010 3248"/>
      <!-- Organization identifier -->
      <ext:asEntityIdentifier classCode="IDENT">
        <ext:id assigningAuthorityName="HPI-O"
          root="1.2.36.1.2001.1003.0.8003623233366573"/>
        <ext:assigningGeographicArea classCode="PLC">
          <ext:name>National Identifier</ext:name>
        </ext:assigningGeographicArea>
      </ext:asEntityIdentifier>
    </representedCustodianOrganization>
  </assignedCustodian>
</custodian>
<!-- Composition attester (Legal Attester) -->
<legalAuthenticator>
  <templateId root="1.2.36.1.2001.1001.102.101.100012" extension="1.0"/>
  <time value="20190902100015+1000"/>
  <signatureCode code="S"/>
  <assignedEntity>
    <id root="cd3f53e1-c922-446b-9ef6-ee43740b653e"/>
    <assignedPerson>
      <ext:asEntityIdentifier classCode="IDENT">
        <ext:id root="1.2.36.1.2001.1003.0.8003619900041630"
          assigningAuthorityName="HPI-I"/>
        <ext:assigningGeographicArea classCode="PLC">
          <ext:name>National Identifier</ext:name>
        </ext:assigningGeographicArea>
      </ext:asEntityIdentifier>
    </assignedPerson>
  </assignedEntity>
</legalAuthenticator>
<!-- Patient generalPractitioner -->
<participant typeCode="PART">
  <!-- participant (generalPractitioner Base Practitioner) templateId-->
  <templateId root="1.2.36.1.2001.1001.102.101.100037" extension="1.0"/>
  <functionCode code="PCP"/>
  <associatedEntity classCode="PROV">
    <id root="1467c67b-8ael-4c83-8b36-fde8667bec94"/>
    <associatedPerson>
      <!-- Practitioner name -->
      <name>Dr. G. Practitioner</name>
    </associatedPerson>
  </associatedEntity>
</participant>
</participant>
<!-- Composition encounter-->
<componentOf>
  <encompassingEncounter>
    <!-- encompassingEncounter (Summary of an Encounter for an Event) templateId-->
    <templateId root="1.2.36.1.2001.1001.102.101.100064" extension="1.0"/>
    <id root="7c67f842-la80-4463-8953-a954373ca7cb"/>
    <!-- Encounter period-->
    <effectiveTime xsi:type="IVL_TS">
      <low value="20190812090000+1000"/>
      <high value="20190812103000+1000"/>
    </effectiveTime>
  </encompassingEncounter>
</componentOf>
<component>
  <structuredBody>
    <!-- Composition section -->
    <component>
      <section>
        <!-- section (Allergies) templateId-->
        <templateId root="1.2.36.1.2001.1001.102.101.100069" extension="1.0"/>
        <!-- section code-->
        <code code="48765-2" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"
          displayName="Allergies &or adverse reactions"/>
        <!-- section title-->
        <title>Allergies and Intolerances</title>
        <!-- section text-->
        <text mediaType="text/x-hl7-text+xml">
          <paragraph>No known allergies</paragraph>
        </text>
        <!--section entry -->
        <entry typeCode="DRIV">
          <observation classCode="OBS" moodCode="EVN">
            <!-- observation (Summary Statement of Allergy or Intolerance) templateId-->
            <templateId root="1.2.36.1.2001.1001.102.101.100014" extension="1.0"/>

```

```
<code code="102.05517" codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components"
      displayName="Adverse Reaction"/>
<!--AllergyIntolerance code-->
<value xsi:type="CD" code="716186003"
      codeSystem="2.16.840.1.113883.6.96" codeSystemName="SNOMED CT"
      displayName="No known allergy">
    <originalText>No known allergies</originalText>
</value>
<!-- 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"
          displayName="Clinical Status"/>
    <value code="active" codeSystem="2.16.840.1.113883.4.642.1.118"
          codeSystemName="AllergyIntoleranceClinicalStatus"
          displayName="Active" xsi:type="CD"/>
  </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"
          displayName="Verification Status"/>
    <value code="unconfirmed"
          codeSystem="2.16.840.1.113883.4.642.1.116"
          codeSystemName="AllergyIntoleranceVerificationStatus"
          displayName="Unconfirmed" xsi:type="CD"/>
  </observation>
</entryRelationship>
</observation>
</entry>
</section>
</component>
<component>
  <!-- Composition section -->
  <section>
    <!-- section (Medicines List) templateId-->
    <templateId root="1.2.36.1.2001.1001.102.101.100077" extension="1.0"/>
    <!-- section code -->
    <code code="101.32009" codeSystem="1.2.36.1.2001.1001.101"
          codeSystemName="NCTIS Data Components" displayName="Current Medicines"/>
    <!-- section title -->
    <title>Current Medicines</title>
    <!-- section text -->
    <text mediaType="text/x-hl7-text+xml">
      <paragraph>Medicines review: 10:30AM 12-08-2019</paragraph>
      <table border="1">
        <caption>Current Medicines</caption>
        <thead>
          <tr>
            <th>Medicine</th>
            <th>Medicine brand name</th>
            <th>Directions</th>
            <th>Purpose</th>
            <th>Status</th>
            <th>Status reason</th>
          </tr>
        </thead>
        <tbody>
          <tr ID="med1reference">
            <td></td>
            <td>Tritace</td>
            <td>Take one tablet in the morning daily.</td>
            <td>To reduce high blood pressure; treat heart failure after a
                heart attack; prevent progression of kidney failure; reduce
                the risk of heart attack, stroke and stenting</td>
            <td>Unchanged</td>
            <td></td>
          </tr>
          <tr ID="med2reference">
            <td>docusate sodium 50 mg + sennoside B 8 mg tablet</td>
            <td>Co-Senna</td>
            <td>Take two tablets twice a day.</td>
            <td>Laxative for constipation, works by softening the stools and
                also assists by stimulating the gut to achieve bowel
                movements.</td>
            <td>New</td>
            <td>Laxative for constipation.</td>
          </tr>
          <tr ID="med3reference">
            <td>Oxycodone</td>
            <td>Endone</td>
            <td>Take one to two tablets every four hours when required.</td>
            <td>For relief of moderate to severe pain.</td>
            <td>Amended</td>
            <td>Dose increased</td>
          </tr>
        </tbody>
      </table>
    </text>
    <!-- section entry -->
    <entry typeCode="DRIV">
      <act classCode="ACT" moodCode="EVN">
        <!-- act (List of Medicine Items with Change Information Authored by Practitioner) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100067" extension="1.0"/>
        <!-- List code -->
    </entry>
  </section>
</component>
```

```
<code code="101.32009" codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components"
      displayName="Current Medicines"/>
<!-- List status -->
<statusCode code="active"/>
<!-- List date -->
<effectiveTime value="20190812"/>
<!-- List author-role / List source -->
<author>
  <!-- author (PractitionerRole with Practitioner with Mandatory Identifier) templateId-->
  <templateId root="1.2.36.1.2001.1001.102.101.100006" extension="1.0"/>
  <!-- List date -->
  <time value="20190812"/>
  <assignedAuthor>
    <!-- author (PractitionerRole with Practitioner with Mandatory Identifier) templateId -->
    <templateId root="1.2.36.1.2001.1001.102.101.100040" extension="1.0"/>
    <!-- PractitionerRole identifier / Practitioner identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
      <ext:id root="1.2.36.1.2001.1003.0.8003619900041630"
        assigningAuthorityName="HPI-I"/>
      <ext:assigningGeographicArea classCode="PLC">
        <ext:name>National Identifier</ext:name>
      </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>
  </assignedAuthor>
</author>
<!-- List entry item -->
<entryRelationship typeCode="COMP">
  <!-- MedicationStatement taken="y" -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!-- substanceAdministration (Medicine Item Statement) templateId -->
    <templateId root="1.2.36.1.2001.1001.102.101.100066" extension="1.0"/>
    <!-- MedicationStatement dosage -->
    <text>
      <reference value="#med1reference"/>
    </text>
    <!-- MedicationStatement status -->
    <statusCode code="active"/>
    <!-- MedicationStatement medication[x] -->
    <consumable>
      <manufacturedProduct>
        <!-- manufacturedProduct (Base Medication) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100068" extension="1.0"/>
        <manufacturedMaterial determinerCode="KIND">
          <code>
            <originalText>Tritace</originalText>
          </code>
        </manufacturedMaterial>
      </manufacturedProduct>
    </consumable>
    <!-- Medication medication-brand-name -->
    <entryRelationship typeCode="COMP">
      <act classCode="ACT" moodCode="EVN">
        <code code="TBD" codeSystem="2.16.840.1.113883.6.96"
          codeSystemName="SNOMED CT" displayName="Brand Name"/>
        <text>Tritace</text>
      </act>
    </entryRelationship>
    <!-- MedicationStatement reasonCode -->
    <entryRelationship typeCode="RSON">
      <observation classCode="OBS" moodCode="EVN">
        <code code="103.10141"
          codeSystem="1.2.36.1.2001.1001.101"
          codeSystemName="NCTIS Data Components"
          displayName="Clinical Indication" > </code>
        <value xsi:type="CD">
          <originalText>To reduce high blood pressure; treat
            heart failure after a heart attack; prevent
            progression of kidney failure; reduce the risk of
            heart attack, stroke and stenting</originalText>
        </value>
      </observation>
    </entryRelationship>
    <!-- List entry flag -->
    <entryRelationship typeCode="SUBJ" inversionInd="true">
      <observation classCode="OBS" moodCode="EVN">
        <code code="288533004"
          codeSystem="2.16.840.1.113883.6.96"
          codeSystemName="SNOMED CT"
          displayName="Change values"/>
        <value code="nochange"
          codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
          codeSystemName="MedicineItemChange"
          displayName="Unchanged" xsi:type="CD"/>
      </observation>
    </entryRelationship>
  </substanceAdministration>
</entryRelationship>
<!-- List entry item -->
```

```

<entryRelationship typeCode="COMP">
    <!-- MedicationStatement taken="y" -->
    <substanceAdministration classCode="SBADM" moodCode="EVN">
        <!-- substanceAdministration (Medicine Item Statement) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100066"
            extension="1.0"/>
        <!-- MedicationStatement dosage -->
        <text>
            <reference value="#med2reference"/>
        </text>
        <!-- MedicationStatement status -->
        <statusCode code="active"/>
        <!-- MedicationStatement medication[x] -->
        <consumable>
            <manufacturedProduct>
                <!-- manufacturedProduct (Base Medication) templateId -->
                <templateId root="1.2.36.1.2001.1001.102.101.100068"
                    extension="1.0"/>
                <manufacturedMaterial determinerCode="KIND">
                    <!-- Medication code -->
                    <code code="33690011000036100"
                        codeSystem="2.16.840.1.113883.6.96"
                        codeSystemName="SNOMED CT"
                        displayName="docusate sodium 50 mg + sennoside B 8 mg tablet">
                        <originalText>docusate sodium 50 mg + sennoside B
                            8 mg tablet</originalText>
                    </code>
                </manufacturedMaterial>
            </manufacturedProduct>
        </consumable>
        <!-- Medication medication-brand-name -->
        <entryRelationship typeCode="COMP">
            <act classCode="ACT" moodCode="EVN">
                <code code="TBD" codeSystem="2.16.840.1.113883.6.96"
                    codeSystemName="SNOMED CT" displayName="Brand Name"/>
                <text>Co-Senna</text>
            </act>
        </entryRelationship>
        <!-- Medication medication-generic-name -->
        <entryRelationship typeCode="COMP">
            <act classCode="ACT" moodCode="EVN">
                <code code="TBD" codeSystem="2.16.840.1.113883.6.96"
                    codeSystemName="SNOMED CT"
                    displayName="Generic Name"/>
                <text>docusate sodium 50 mg + sennoside B 8 mg
                    tablet</text>
            </act>
        </entryRelationship>
        <!-- MedicationStatement reasonCode -->
        <entryRelationship typeCode="RSON">
            <observation classCode="OBS" moodCode="EVN">
                <code code="103.10141"
                    codeSystem="1.2.36.1.2001.1001.101"
                    codeSystemName="NCTIS Data Components"
                    displayName="Clinical Indication"/>
                <value xsi:type="CD" code="14760008"
                    codeSystem="2.16.840.1.113883.6.96"
                    codeSystemName="SNOMED CT"
                    displayName="Constipation">
                    <originalText>Laxative for constipation, works by
                        softening the stools and also assists by
                        stimulating the gut to achieve bowel
                        movements.</originalText>
                </value>
            </observation>
        </entryRelationship>
        <!-- List entry flag -->
        <entryRelationship typeCode="SUBJ" inversionInd="true">
            <observation classCode="OBS" moodCode="EVN">
                <code code="288533004"
                    codeSystem="2.16.840.1.113883.6.96"
                    codeSystemName="SNOMED CT"
                    displayName="Change values"/>
                <!--List entry change-description -->
                <text>Laxative for constipation.</text>
                <value code="new"
                    codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
                    codeSystemName="MedicineItemChange"
                    displayName="New" xsi:type="CD"/>
            </observation>
        </entryRelationship>
    </substanceAdministration>
</entryRelationship>
<!-- List entry item -->
<entryRelationship typeCode="COMP">
    <!-- MedicationStatement taken="y" -->
    <substanceAdministration classCode="SBADM" moodCode="EVN">
        <!-- substanceAdministration (Medicine Item Statement) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100066"
            extension="1.0"/>
        <!-- MedicationStatement dosage -->
        <text>
            <reference value="#med3reference"/>
        </text>
        <!-- MedicationStatement status -->
        <statusCode code="active"/>
        <!-- MedicationStatement medication[x] -->
        <consumable>
            <manufacturedProduct>

```

```
<!-- manufacturedProduct (Base Medication) templateId -->
<templateId root="1.2.36.1.2001.1001.102.101.100068"
  extension="1.0"/>
<manufacturedMaterial determinerCode="KIND">
  <!-- Medication code -->
  <code code="5195K"
    codeSystem="1.2.36.1.2001.1004.200.10009"
    codeSystemName="Australian Pharmaceutical Benefits Scheme Schedule Item"
    displayName="oxycodone hydrochloride 5 mg tablet, 20">
    <originalText>Endone Oxycodone</originalText>
    <translation code="2622B"
      codeSystem="1.2.36.1.2001.1004.200.10009"
      codeSystemName="Australian Pharmaceutical Benefits Scheme Schedule Item"
      displayName="OXYCODONE" />
  </code>
  </manufacturedMaterial>
</manufacturedProduct>
</consumable>
<!-- Medication medication-brand-name -->
<entryRelationship typeCode="COMP">
  <act classCode="ACT" moodCode="EVN">
    <code code="TBD" codeSystem="2.16.840.1.113883.6.96"
      codeSystemName="SNOMED CT" displayName="Brand Name" />
    <text>Endone</text>
  </act>
</entryRelationship>
<!-- Medication medication-generic-name -->
<entryRelationship typeCode="COMP">
  <act classCode="ACT" moodCode="EVN">
    <code code="TBD" codeSystem="2.16.840.1.113883.6.96"
      codeSystemName="SNOMED CT"
      displayName="Generic Name" />
    <text>Oxycodone</text>
  </act>
</entryRelationship>
<!-- MedicationStatement reasonCode -->
<entryRelationship typeCode="RSON">
  <observation classCode="OBS" moodCode="EVN">
    <code code="103.10141"
      codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components"
      displayName="Clinical Indication" />
    <value xsi:type="CD" code="428346000"
      codeSystem="2.16.840.1.113883.6.96"
      codeSystemName="SNOMED CT"
      displayName="Pain relief by medication" />
    <originalText>For relief of moderate to severe
      pain</originalText>
    </value>
  </observation>
</entryRelationship>
<!-- List entry flag -->
<entryRelationship typeCode="SUBJ" inversionInd="true">
  <observation classCode="OBS" moodCode="EVN">
    <code code="288533004"
      codeSystem="2.16.840.1.113883.6.96"
      codeSystemName="SNOMED CT"
      displayName="Change values" />
    <!-- List entry change-description -->
    <text>Dose increased</text>
    <value code="amended"
      codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
      codeSystemName="MedicineItemChange"
      displayName="Amended" xsi:type="CD" />
  </observation>
</entryRelationship>
</substanceAdministration>
</entryRelationship>
<!-- List encounter-->
<entryRelationship typeCode="COMP">
  <encounter classCode="ENC" moodCode="EVN">
    <!-- encounter (Summary of an Encounter for an Event) templateId-->
    <templateId root="1.2.36.1.2001.1001.102.101.100062"
      extension="1.0"/>
    <id root="7c67f842-1a80-4463-8953-a954373ca7cb" />
    <!--Encounter status-->
    <statusCode code="completed" />
    <!--Encounter period-->
    <effectiveTime xsi:type="IVL_TS">
      <low value="20190812090000+1000" />
      <high value="20190812103000+1000" />
    </effectiveTime>
    <!-- Encounter type -->
    <entryRelationship typeCode="COMP">
      <observation classCode="OBS" moodCode="EVN">
        <code code="103.17018"
          codeSystem="1.2.36.1.2001.1001.101"
          codeSystemName="NCTIS Data Components"
          displayName="Category" />
        <value xsi:type="CD" code="182836005"
          codeSystem="2.16.840.1.113883.6.96"
          codeSystemName="SNOMED CT"
          displayName="Review of medication" />
        <originalText>Medicines review</originalText>
      </value>
    </observation>
  </entryRelationship>
</encounter>
</entryRelationship>
```

```
</act>
</entry>
</section>
</component>
</structuredBody>
</component>
</ClinicalDocument>
```

DRAFT

B.4 Shared Meds List example 4

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

Example B.4. Shared Medicines List 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="urn:hl7-org:v3"  
    xmlns:xes="urn:hl7-org/v3-example"  
    xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"  
    xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"  
    >  
    <typeId root="2.16.840.1.113883.1.3" extension="POCD_HD000040"/>  
    <!-- ClinicalDocument templateId -->  
    <templateId root="1.2.36.1.2001.1001.102.101.100033" extension="1.0"/>  
    <!--ClinicalDocument (Shared Medicines List Authored by Practitioner) templateId -->  
    <templateId root="1.2.36.1.2001.1001.102.101.100065" extension="1.0"/>  
    <!--CDA Rendering Specification templateId-->  
    <templateId root="1.2.36.1.2001.1001.100.226" extension="1.0"/>  
    <id root="2.25.22689776786320758428768491731646875697"/>  
    <!-- Composition type-->  
    <code code="56445-0" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"  
        displayName="Medication summary"/>  
    <!-- Composition title-->  
    <title>Ceased medicines list</title>  
    <effectiveTime value="20190902100015+1000"/>  
    <confidentialityCode nullFlavor="NA"/>  
    <languageCode code="en"/>  
    <setId root="7ba2ddcd-9af0-4396-82cb-0ad19cbb9b32"/>  
    <versionNumber value="1"/>  
    <!-- Composition status-->  
    <ext:completionCode code="I" codeSystem="1.2.36.1.2001.1001.101.104.20104"  
        codeSystemName="NCTIS Document Status Values" displayName="Interim"/>  
    <!-- Composition subject -->  
    <recordTarget  
        <!-- recordTarget (Patient with Mandatory Identifier) templateId-->  
        <templateId root="1.2.36.1.2001.1001.102.101.100004" extension="1.0"/>  
        <patientRole  
            <id root="be81d9f-144b-4064-9bbe-3ae2a142170e"/>  
            <!--Patient address-->  
            <addr  
                <streetAddressLine>1 Caboolture Street</streetAddressLine>  
                <city>Caboolture</city>  
                <state>QLD</state>  
                <postalCode>4510</postalCode>  
                <country>AU</country>  
            </addr>  
            <patient>  
                <!-- Patient name -->  
                <name>Bert Gainey</name>  
                <!-- Required CDA Schema element when a sending system is sending a Patient without a gender element -->  
                <administrativeGenderCode nullFlavor="NI"/>  
                <!-- Patient identifier -->  
                <ext:asEntityIdentifier classCode="IDENT">  
                    <ext:id root="1.2.36.1.2001.1005.29.8003621566684455" extension="542181"  
                        assigningAuthorityName="Croydon GP Centre"/>  
                    <ext:code code="MR" codeSystem="2.16.840.1.113883.12.203"  
                        codeSystemName="Identifier Type (HL7)"/>  
                </ext:asEntityIdentifier>  
            </patient>  
        </patientRole>  
    </recordTarget>  
    <!-- Composition composition-author-role and Composition author -->  
    <author>  
        <!-- author (PractitionerRole with Practitioner with Mandatory Identifier) templateId-->  
        <templateId root="1.2.36.1.2001.1001.102.101.100006" extension="1.0"/>  
        <!-- Composition date -->  
        <time value="20190902100015+1000"/>  
        <assignedAuthor>  
            <id root="5ae15755-07d5-42b7-ab7d-266d64391fd2"/>  
            <!-- PractitionerRole code -->  
            <code>  
                <originalText>General Practitioner</originalText>  
            </code>  
            <!-- PractitionerRole practitioner -->  
            <assignedPerson>  
                <!-- assignedPerson (Practitioner with Mandatory Identifier) templateId -->  
                <templateId root="1.2.36.1.2001.1001.102.101.100040" extension="1.0"/>  
                <!-- Practitioner name -->  
                <name>  
                    <given>North</given>  
                    <family>Black</family>  
                    <suffix>M.D.</suffix>  
                </name>  
                <!-- PractitionerRole identifier / Practitioner identifier -->  
                <ext:asEntityIdentifier classCode="IDENT">  
                    <ext:id root="1.2.36.1.2001.1005.70.51824994455" extension="north27"  
                        assigningAuthorityName="Ascot Vale Family Medical Centre"/>  
                    <ext:code code="EI" codeSystem="2.16.840.1.113883.12.203"/>  
                </ext:asEntityIdentifier>  
            </assignedPerson>  
        </author>
```

```

        </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="28733845-6b31-41c6-b43a-b8fc708375da"/>
            <!-- Organization name-->
            <name>Ascot Vale Family Medical Centre</name>
            <!-- Organization identifier -->
            <ext:asEntityIdentifier classCode="IDENT">
                <ext:id assigningAuthorityName="ABN" root="1.2.36.51824994455"/>
                <ext:code code="XX" codeSystem="2.16.840.1.113883.12.203"/>
                <ext:assigningGeographicArea classCode="PLC">
                    <ext:name>National Identifier</ext:name>
                </ext:assigningGeographicArea>
            </ext:asEntityIdentifier>
        </representedCustodianOrganization>
    </assignedCustodian>
</custodian>
<!-- Composition attester (Legal Attester) -->
<legalAuthenticator>
    <templateId root="1.2.36.1.2001.1001.102.101.100012" extension="1.0"/>
    <time value="20190902100015+1000"/>
    <signatureCode code="S"/>
    <assignedEntity>
        <id root="5ae15755-07d5-42b7-ab7d-266d64391fd2"/>
        <assignedPerson>
            <!-- PractitionerRole identifier / Practitioner identifier -->
            <ext:asEntityIdentifier classCode="IDENT">
                <ext:id root="1.2.36.1.2001.1005.70.51824994455" extension="north27"
                    assigningAuthorityName="Ascot Vale Family Medical Centre"/>
                <ext:code code="EI" codeSystem="2.16.840.1.113883.12.203"/>
            </ext:asEntityIdentifier>
        </assignedPerson>
    </assignedEntity>
</legalAuthenticator>
<component>
    <structuredBody>
        <component>
            <!-- Composition section -->
            <section>
                <!-- section (Medicines List) templateId-->
                <templateId root="1.2.36.1.2001.1001.102.101.100077" extension="1.0"/>
                <!-- section code -->
                <code code="101.32027" codeSystem="1.2.36.1.2001.1001.101"
                    codeSystemName="NCTIS Data Components" displayName="Ceased Medicines"/>
                <!-- section title -->
                <title>Ceased Medicines</title>
                <!-- section text -->
                <text mediaType="text/x-hl7-text+xml">
                    <table border="1">
                        <thead>
                            <tr>
                                <th>Medicine name</th>
                                <th>Other names</th>
                                <th>Number to take/Directions</th>
                                <th>Purpose</th>
                                <th>Special instructions</th>
                            </tr>
                        </thead>
                        <tbody>
                            <tr>
                                <td>RAMIPRIL(TAB) 2.5 mg</td>
                                <td>Tritace</td>
                                <td>Take one in the morning</td>
                                <td>To reduce high blood pressure; treat heart failure after a
                                    heart attack; prevent progression of kidney failure; reduce
                                    the risk of heart attack; stroke and stenting</td>
                                <td>If you feel light-headed, dizzy or faint, get up slowly when
                                    getting out of bed. Make sure you drink enough water during
                                    excercise and hot weather when you are taking this medicine,
                                    especially if you sweat a lot. If you have excessive
                                    vomitting and or diarhoea while taking this medicine tell
                                    your doctor. May cause headache or unusual taste. Do not take
                                    potassium supplements while you are taking this medicine
                                    unless your doctor tells you to. If you develop signs of
                                    swelling of the lips or tongue, a dry cough or a rash see
                                    your doctor.</td>
                            </tr>
                            <tr>
                                <td>ATORVASTATIN(TAB) 80 mg</td>
                                <td>Lipitor</td>
                                <td>Take 1 in the evening</td>
                                <td>To lower cholesterol levels in the blood</td>
                                <td>Seek medical advice promptly if your urine is dark (brown)
                                    or if you have any unexplained muscle pain, tenderness or
                                    weakness. Grapefruit juice should be avoided as it may
                                    increase the amount of this medicine in your bloodstream and
                                    could increase the chances of side effects occurring.</td>
                            </tr>
                            <tr>
                                <td>DOCUSATE SENNA(TAB) 50 mg</td>
                                <td/>
                                <td>Take two tablets in the morning and in the evening</td>
                                <td>Laxative for constipation, works by softening the stools and
                            </tr>
                        </tbody>
                    </table>
                </text>
            </section>
        </component>
    </structuredBody>
</component>

```

```
        also assists by stimulating the gut to achieve bowel
        movements.</td>
      <td>Take with a glass of fluid. May take 2-3 days for maximum
        effect. Do not take with laxatives containing liquid
        paraffin. Abdominal discomfort, nausea and rash may
        occur.</td>
    </tr>
  </tbody>
</table>
<!-- section entry -->
<entry>
  <act classCode="ACT" moodCode="EVN">
    <!-- act (List of Medicine Items with Change Information Authored by Practitioner) templateId -->
    <templateId root="1.2.36.1.2001.1001.102.101.100067" extension="1.0"/>
    <!-- List code -->
    <code code="101.32027" codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components"
      displayName="Ceased Medicines"/>
    <!-- List status -->
    <statusCode code="active"/>
    <!-- List date -->
    <effectiveTime value="20190902100015+1000"/>
    <!-- List author-role / List source -->
    <author>
      <!-- author (PractitionerRole with Practitioner with Mandatory Identifier) templateId-->
      <templateId root="1.2.36.1.2001.1001.102.101.100006" extension="1.0"/>
      <!-- List date -->
      <time value="20190902100015+1000"/>
      <assignedAuthor>
        <id root="5ae15755-07d5-42b7-ab7d-266d64391fd2"/>
        <!-- PractitionerRole code -->
        <code>
          <originalText>General Practitioner</originalText>
        </code>
        <!-- PractitionerRole practitioner -->
        <assignedPerson>
          <!-- assignedPerson (Practitioner with Mandatory Identifier) templateId -->
          <templateId root="1.2.36.1.2001.1001.102.101.100040"
            extension="1.0"/>
          <!-- Practitioner name -->
          <name>
            <given>North</given>
            <family>Black</family>
            <suffix>M.D.</suffix>
          </name>
          <!-- PractitionerRole identifier / Practitioner identifier -->
          <ext:asEntityIdentifier classCode="IDENT">
            <ext:id root="1.2.36.1.2001.1005.70.51824994455"
              extension="north27"
              assigningAuthorityName="Ascot Vale Family Medical Centre"/>
            <ext:code code="EI"
              codeSystem="2.16.840.1.113883.12.203"/>
          </ext:asEntityIdentifier>
          </assignedPerson>
        </assignedAuthor>
      </author>
      <!-- List entry item -->
      <entryRelationship typeCode="COMP">
        <!-- MedicationStatement taken="y" -->
        <substanceAdministration classCode="SBADM" moodCode="EVN">
          <!-- substanceAdministration (Medicine Item Statement) templateId -->
          <templateId root="1.2.36.1.2001.1001.102.101.100066"
            extension="1.0"/>
          <!-- MedicationStatement dosage -->
          <text>RAMIPRIL(TAB) 2.5 mg; Tritace; Take one in the morning; To
            reduce high blood pressure; treat heart failure after a
            heart attack; prevent progression of kidney failure; reduce
            the risk of heart attack; stroke and stenting; If you feel
            light-headed, dizzy or faint, get up slowly when getting our
            of bed. Make sure you drink enough water during excercise
            and hot weather when you are taking this medicine,
            especially if you sweat a lot. If you have excessive
            vomitting and or diarrhoea while taking this medicine tell
            your doctor. May cause headache or unusal taste. Do not take
            potassium supplements while you are taking this medicine
            unless your doctor tells you to. If you develop signs of
            swelling of the lips or tongue, a dry cough or a rash see
            your doctor.</text>
          <!-- MedicationStatement status -->
          <statusCode code="completed"/>
          <!-- MedicationStatement medication[x] -->
          <consumable>
            <manufacturedProduct>
              <!-- manufacturedProduct (Base Medication) templateId -->
              <templateId root="1.2.36.1.2001.1001.102.101.100068"
                extension="1.0"/>
              <manufacturedMaterial determinerCode="KIND">
                <!-- Medication code -->
                <code>
                  <originalText>RAMIPRIL(TAB) 2.5 mg,
                  Tritace</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"
      codeSystemName="NCTIS Data Components"
      displayName="Clinical Indication"/>
<value xsi:type="CD">
  <originalText>To reduce elevated blood pressure; for
  the prevention of angina; to treat or prevent
  heart attack; for the treatment of heart failure;
  to prevent migraines</originalText>
</value>
</observation>
</entryRelationship>
<!-- MedicationStatement note -->
<entryRelationship typeCode="COMP">
  <act classCode="ACT" moodCode="EVN">
    <code code="103.16044"
          codeSystem="1.2.36.1.2001.1001.101"
          codeSystemName="NCTIS Data Components"
          displayName="Additional Comments"/>
    <text xsi:type="ST">If you feel light-headed, dizzy or
    faint, get up slowly when getting out of bed. Make
    sure you drink enough water during exercise and hot
    weather when you are taking this medicine,
    especially if you sweat a lot. If you have excessive
    vomiting and/or diarrhoea while taking this medicine
    tell your doctor. May cause headache or unusual
    taste. Do not take potassium supplements while you
    are taking this medicine unless your doctor tells
    you to. If you develop signs of swelling of the lips
    or tongue, a dry cough or a rash see your
    doctor.</text>
  </act>
</entryRelationship>
<!-- List entry flag -->
<entryRelationship typeCode="SUBJ" inversionInd="true">
  <observation classCode="OBS" moodCode="EVN">
    <code code="288533004"
          codeSystem="2.16.840.1.113883.6.96"
          codeSystemName="SNOMED CT"
          displayName="Change values"/>
    <value code="nochange"
          codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
          codeSystemName="MedicineItemChange"
          displayName="Unchanged" xsi:type="CD"/>
  </observation>
</entryRelationship>
</substanceAdministration>
</entryRelationship>
<!-- List entry item -->
<entryRelationship typeCode="COMP">
  <!-- MedicationStatement taken="y" -->
  <substanceAdministration classCode="SBADM" moodCode="EVN">
    <!-- substanceAdministration (Medicine Item Statement) templateId -->
    <templateId root="1.2.36.1.2001.1001.102.101.100066"
      extension="1.0"/>
    <!-- MedicationStatement dosage -->
    <text>ATORVASTATIN(TAB) 80 mg; Lipitor; Take 1 in the evening;
    To lower cholesterol levels in the blood; Seek medical advice
    promptly if your urine is dark (brown) or if you have any
    unexplained muscle pain, tenderness or weakness. Grapefruit
    juice should be avoided as it may increase the amount of
    this medicine in your bloodstream and could increase the
    chances of side effects occurring.</text>
    <!-- MedicationStatement status -->
    <statusCode code="completed"/>
    <!-- MedicationStatement medication[x] -->
    <consumable>
      <manufacturedProduct>
        <!-- manufacturedProduct (Base Medication) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100068"
          extension="1.0"/>
        <manufacturedMaterial determinerCode="KIND">
          <!-- Medication code -->
          <code>
            <originalText>ATORVASTATIN(TAB) 80 mg,
            Lipitor</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"
              codeSystemName="NCTIS Data Components"
              displayName="Clinical Indication"/>
        <value xsi:type="CD">
          <originalText>To lower cholesterol levels in the
          blood</originalText>
        </value>
      </observation>
    </entryRelationship>
    <!-- MedicationStatement note -->
    <entryRelationship typeCode="COMP">
      <act classCode="ACT" moodCode="EVN">
        <code code="103.16044"
              codeSystem="1.2.36.1.2001.1001.101"
              codeSystemName="NCTIS Data Components"
```

```
        displayName="Additional Comments"/>
    <text xsi:type="ST">Seek medical advice promptly if your
urine is dark (brown) or if you have any unexplained
muscle pain, tenderness or weakness. Grapefruit
juice should be avoided as it may increase the
amount of this medicine in your bloodstream and
could increase the chances of side effects
occurring.</text>
</act>
</entryRelationship>
<!-- List entry flag -->
<entryRelationship typeCode="SUBJ" inversionInd="true">
    <observation classCode="OBS" moodCode="EVN">
        <code code="288533004"
            codeSystem="2.16.840.1.113883.6.96"
            codeSystemName="SNOMED CT"
            displayName="Change values"/>
        <value xsi:type="CD" code="ceased"
            codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
            codeSystemName="MedicineItemChange"
            displayName="Ceased"/>
    </observation>
    </entryRelationship>
    </substanceAdministration>
</entryRelationship>
<!-- List entry item -->
<entryRelationship typeCode="COMP">
    <!-- MedicationStatement taken="y" -->
    <substanceAdministration classCode="SBADM" moodCode="EVN">
        <!-- substanceAdministration (Medicine Item Statement) templateId -->
        <templateId root="1.2.36.1.2001.1001.102.101.100066"
            extension="1.0"/>
        <!-- MedicationStatement dosage -->
        <text>DOCUSATE SENNA(TAB) 50 mg; Take two tablets in the morning
and in the evening; Laxative for constipation, works by
softening the stools and also assists by stimulating the gut
to achieve bowel movements.; Take with a glass of fluid. May
take 2-3 days for maximum effect. Do not take with laxatives
containing liquid paraffin. Abdominal discomfort, nausea and
rash may occur.</text>
        <!-- MedicationStatement status -->
        <statusCode code="completed"/>
        <!-- MedicationStatement medication[x] -->
        <consumable>
            <manufacturedProduct>
                <!-- manufacturedProduct (Base Medication) templateId -->
                <templateId root="1.2.36.1.2001.1001.102.101.100068"
                    extension="1.0"/>
                <manufacturedMaterial determinerCode="KIND">
                    <!-- Medication code -->
                    <code>
                        <originalText>DOCUSATE SENNA(TAB) 50
mg</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"
                    codeSystemName="NCTIS Data Components"
                    displayName="Clinical Indication"/>
                <value xsi:type="CD">
                    <originalText>Laxative for constipation, works by
softening the stools and also assists by
stimulating the gut to achieve bowel
movements.</originalText>
                </value>
            </observation>
        </entryRelationship>
        <!-- MedicationStatement note -->
        <entryRelationship typeCode="ACT">
            <act classCode="ACT" moodCode="EVN">
                <code code="103.16044"
                    codeSystem="1.2.36.1.2001.1001.101"
                    codeSystemName="NCTIS Data Components"
                    displayName="Additional Comments"/>
                <text xsi:type="ST">Take with a glass of fluid. May take
2-3 days for maximum effect. Do not take with
laxatives containing liquid paraffin. Abdominal
discomfort, nausea and rash may.</text>
            </act>
        </entryRelationship>
        <!-- List entry flag -->
        <entryRelationship typeCode="SUBJ" inversionInd="true">
            <observation classCode="OBS" moodCode="EVN">
                <code code="288533004"
                    codeSystem="2.16.840.1.113883.6.96"
                    codeSystemName="SNOMED CT"/>
                <value code="ceased" codeSystemName="MedicineItemChange"
                    codeSystem="2.16.840.1.113883.2.3.4.1.2.6"
                    displayName="Ceased" xsi:type="CD"/>
            </observation>
        </entryRelationship>
        </substanceAdministration>
    </entryRelationship>

```

```
</act>
</entry>
</section>
</component>
</structuredBody>
</component>
</ClinicalDocument>
```

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Appendix C. Mapping from requirements

This informative appendix provides mapping from the data items (i.e. requirements) in [Pharmacist Shared Medicines List Business Requirements \[DH2019m\]](#) | [Pharmacist Shared Medicines List Information Requirements \[DH2019n\]](#).

The table below matches the data items to the elements of the Shared Medicines List (SML) model as shown in the Element column of the CDA Mapping table in the relevant template, and their corresponding CDA schema element(s) path from the root CDA schema element ClinicalDocument.

Mapping from [Pharmacist Shared Medicines List Business Requirements \[DH2019m\]](#)

Data item	Req No.	Element	CDA schema element
Pharmacist shared medicines list	027948	Not directly supported.	This requirement is managed in the implementation.
Components in the PSML document	028321	Not directly supported.	This high-level business requirement cannot be mapped directly. See Mapping from PSML information requirements section for individual component mappings.
Document conformance levels	028315	Not directly supported.	This requirement may be enforced in a rendering specification, conformance profile or handled by an implementation.
Point-to-point transmission	027954	Not directly supported.	This requirement may be enforced in a rendering specification, conformance profile or handled by an implementation.
HPI-I relaxed template package	028394	Not directly supported.	This requirement may be enforced in a rendering specification, conformance profile or handled by an implementation.
Compatible with Prescription and Dispense Record	028323	Not directly supported.	This high-level business requirement cannot be mapped directly.
Prompt to upload recent PSML	028325	Not directly supported.	This requirement is managed in an implementation.
Medicines information presentation	028359	Not directly supported.	This requirement may be enforced in a rendering specification, conformance profile or handled by implementation.
Medicines information presentation	028359	Not directly supported.	This requirement may be enforced in a rendering specification, conformance profile or handled by implementation.
Allergies and Adverse Reactions section	028355	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by an implementation.
Allergies and Adverse Reactions header	028360	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by an implementation.

Data item	Req No.	Element	CDA schema element
No known allergies or adverse reactions	028411	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by implementation.
Current Medicines section	028361	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by implementation.
Current Medicines header	028362	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by implementation.
Ceased Medicines section	028363	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by implementation.
Ceased Medicines header	028364	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by implementation.
Suppressing Ceased Medicines section	028358	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by implementation.
Suppressing codes and medicine identifiers	028625	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by implementation.
Completeness of PSML document	028324	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a conformance profile or handled by implementation.
Identifier for document author[prac_rol]	028317	Practitioner > identifier	ClinicalDocument/author[prac_rol][prac_rol]/assignedauthor/assignedPerson/ext:asEntity-Identifier
No Address for the consumer	028319	Not directly supported.	The business requirements document requires the prohibition of any address for the consumer within the document when uploading to My Health Record. This requirement is not directly managed by a FHIR profile; it may be enforced in a conformance profile or handled by implementation.
No Electronic Communication Detail for the consumer	028320	Not directly supported.	The business requirements document requires the prohibition of any types of electronic communication contact detail for the consumer within the document when uploading to My Health Record. This requirement is not directly managed by a FHIR profile; it may be enforced in a conformance profile or handled by implementation.
Attribute for Healthcare Setting	028349	Encounter > type PractitionerRole > code Composition > section(Medications) > code	encounter/entryRelationship[type]/observation/value author[prac_rol][prac_rol]/assignedauthor/code ClinicalDocument/component/structuredBody/component[meds]/section/code

Data item	Req No.	Element	CDA schema element
Attribute for Dose Administration Aid medicines present	028413	Not directly supported.	The requirements document mandates the inclusion of a statement or an indicator that a medicines list document includes medicine items packed in a dose administration aid (DAA). This requirement is not directly supported in FHIR; a request has been submitted to HL7 AU to consider this requirement on the national level, see https://git-hub.com/hl7au/au-fhir-base/issues/320 . See Known issues for further information on this issue and possible work arounds.
Additional Comment	028348	List > note	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship(note)/act/text
Attribute for Ceased Date	028352	MedicationStatement > effective[x]	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/effectiveTime
Attribute for Substance/ Agent of allergy and adverse reaction	028330	AllergyIntolerance > reaction > substance AllergyIntolerance > code	ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/observation/entryRelationship[react]/observation/participant[agent]/participantRole/playingEntity/code ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/observation/value
Attribute for Reaction Type	028331	AllergyIntolerance > type	ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/observation/entryRelationship[react]/observation/value
Attribute for Reaction	028410	AllergyIntolerance > reaction > manifestation	ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/observation/entryRelationship[react]/observation/entryRelationship[react]/observation/entryRelationship[mfst]/observation/code
Attribute for Reaction Onset Date	023064	AllergyIntolerance > onset	ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/observation/entryRelationship[react]/observation/effectiveTime ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/observation/entryRelationship[react]/observation/entryRelationship[onset]/observation/value
Attribute for Medicine Identifier	028329	Medication > code	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/code
Attribute for Active Ingredient	028333	Medication > ingredient	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/ext:asIngredient

Data item	Req No.	Element	CDA schema element
No Latin words or abbreviations of Active Ingredient	028390	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be handled by an implementation.
Attribute for Brand Name	028335	Medication > code Medication > medication-brand-name	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/manufacturedProduct/manufacturedMaterial/code ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/entryRelationship[brand]/act/text
Active Ingredient or Brand Name	028412	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by implementation.
Attribute for Strength	028392	Medication > ingredient > amount Medication > code	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/manufacturedProduct/manufacturedMaterial/ext:asIngredient/ext:quantity ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/manufacturedProduct/manufacturedMaterial/code
Attribute for Dose Form	028391	Medication > form Medication > code	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/ext:formCode ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/manufacturedProduct/manufacturedMaterial/code
Attribute for Route	028399	MedicationStatement > dosage	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/routeCode
Attribute for Direction	028336	MedicationStatement > dosage	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/text
No Latin words or abbreviations for Direction	028337	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by implementation.

Data item	Req No.	Element	CDA schema element
Attribute for Medicine Purpose	028338	MedicationStatement > reasonCode	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/entryRelationship[reason]/observation/value
Terminology for Medicine Purpose		Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by implementation.
Attribute for Expected End Date	028343	MedicationStatement > effective[x]	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/effectiveTime
Attribute for Special Instruction	028345	MedicationStatement > dosage	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/text
Attribute for Medicine Image	028346	Not directly supported.	<p>Support for medicine image attribute has been removed from the Medication model in the first normative release of FHIR. For this reason the use of medication image is strongly discouraged in the HL7 AU content based on a prior FHIR release (STU3) and unsupported by this implementation guide.</p> <p>Where a sending system can include a medicine image, it is expected to be sent in the narrative for the Medicines List section.</p>
Image sizes	028406	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by implementation.
Attribute for Physical Descriptions	028347	Not directly supported.	This requirement is not directly supported by a FHIR profile. Where a sending system can include physical description of a medicine, it is expected to be sent in the narrative for Medicines List section.
Attribute for reason for ceasing medicine	028351	List > entry > change-description	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/entryRelationship[flag]/observation/text
Attribute for Medicine Status	028342	List > entry > flag	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/entryRelationship[flag]/observation/value
Withheld Medicine	028620	List > entry > change-description	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/entryRelationship[flag]/observation/text
Withheld Medicine Ordering	028626	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by implementation.

Data item	Req No.	Element	CDA schema element
Ceased medicines	028623	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by an implementation.

Mapping from *Pharmacist Shared Medicines List Information Requirements [DH2019n]*

Data item	Req No.	Element	CDA schema element
Individual's address (mandatory)	024041	Patient > address	ClinicalDocument/recordTarget[pat]/patientRole/addr
Individual's electronic communication details (optional)	024042	Patient > telecom	ClinicalDocument/recordTarget[pat]/patientRole/telecom
Individual (subject of care)	027984	Patient	ClinicalDocument/recordTarget[pat]
Individual healthcare identifier (mandatory)	022082	Patient > identifier	ClinicalDocument/recordTarget[pat]/patientRole/patient/ext:asEntityIdentifier
Individual's title (optional)	022081	Patient > name	ClinicalDocument/recordTarget[pat]/patientRole/patient/name
Individual's given name (optional)	023056	Patient > name	ClinicalDocument/recordTarget[pat]/patientRole/patient/name
Individual's family name (mandatory)	023058	Patient > name	ClinicalDocument/recordTarget[pat]/patientRole/patient/name
Individual's name suffix (optional)	023059	Patient > name	ClinicalDocument/recordTarget[pat]/patientRole/patient/name
Individual's gender (mandatory)	027983	Patient > gender	ClinicalDocument/recordTarget[pat]/patientRole/patient/administrativeGenderCode
Individual's sex (optional)	028570	Not directly supported.	<p>The information requirements document includes an optional requirement for recording individual's biological sex, interpreted as sex at birth. This implementation guide only supports including a patient's gender as part of a patient's demographics for identification purposes in line with the Australian Government recommendations. Australian Government Guidelines on the Recognition of Sex and Gender state that patient's biological sex should only be collected when clinically relevant.</p> <p>Biological sex is not directly supported in FHIR; work is underway via HL7 AU to define a nationally agreed model for representing biological sex at birth, see https://git-hub.com/hl7au/au-fhir-base/issues/321.</p>
Individual's date of birth (mandatory)	023060	Patient > birthDate	ClinicalDocument/recordTarget[pat]/patientRole/patient/birthTime
Date of birth accuracy indicator (optional)	024026	Patient > birthDate > date-accuracy-indicator	ClinicalDocument/component/structuredBody/component[admin_obs]/sec-tion/entry[dob_acc]/observation/value
	027005		

Data item	Req No.	Element	CDA schema element
Indigenous status (mandatory)	024033	Patient > indigenous-status	ClinicalDocument/recordTarget[pat]/patientRole/patient/ethnicGroupCode
Document author[prac_rol] (mandatory)	027985	PractitionerRole	ClinicalDocument/author[prac_rol]
Healthcare provider organisation name (mandatory)	023070	Organization > name	ClinicalDocument/author[prac_rol]/assignedAuthor/representedOrganization/name
Healthcare provider individual's workplace address (optional)	024891	Practitioner > address	ClinicalDocument/author[prac_rol]/assignedAuthor/addr
Healthcare provider individual's workplace electronic communication details (optional)	024036	Practitioner > telecom	ClinicalDocument/author[prac_rol]/assignedAuthor/telecom
Healthcare provider professional role (mandatory)	024040	PractitionerRole > code	ClinicalDocument/author[prac_rol]/code
Healthcare Provider Identifier-Individual (mandatory)	024601	Practitioner > identifier	ClinicalDocument/author[prac_rol]/assignedAuthor/assignedPerson[prac]/ext:asEntity-Identifier
Healthcare Provider Identifier-Organisation (mandatory)	024602	Organization > identifier	ClinicalDocument/author[prac_rol]/assignedAuthor/representedOrganization/ext:asEntity-Identifier
Healthcare provider's title (optional)	023061	Practitioner > name	ClinicalDocument/author[prac_rol]/assignedAuthor/assignedPerson[prac]/name
Healthcare provider given name (optional)	023062	Practitioner > name	ClinicalDocument/author[prac_rol]/assignedAuthor/assignedPerson[prac]/name
Healthcare provider family name (mandatory)	023064	Practitioner > name	ClinicalDocument/author[prac_rol]/assignedAuthor/assignedPerson[prac]/name
Healthcare provider name suffix (optional)	023065	Practitioner > name	ClinicalDocument/author[prac_rol]/assignedAuthor/assignedPerson[prac]/name
Primary healthcare provider (optional)	028028	Patient > generalPractitioner	ClinicalDocument/participant[gen_prac_org] ClinicalDocument/participant[gen_prac_prac]
Healthcare Provider Identifier-Individual (mandatory)	024601	Practitioner > identifier	ClinicalDocument/participant[gen_prac_prac]/associatedEntity/associatedPerson/ext:asEntityIdentifier
Healthcare Provider Identifier-Organisation (mandatory)	024602	Organization > identifier	ClinicalDocument/participant[gen_prac_org]/associatedEntity/scopingOrganization/ext:asEntityIdentifier

Data item	Req No.	Element	CDA schema element
Healthcare provider's title (optional)	023061	Practitioner > name	ClinicalDocument/participant[gen_prac_prac]/associatedEntity/associatedPerson/name
Healthcare provider given name (optional)	023062	Practitioner > name	ClinicalDocument/participant[gen_prac_prac]/associatedEntity/associatedPerson/name
Healthcare provider family name (mandatory)	023064	Practitioner > name	ClinicalDocument/participant[gen_prac_prac]/associatedEntity/associatedPerson/name
Healthcare provider name suffix (optional)	023065	Practitioner > name	ClinicalDocument/participant[gen_prac_prac]/associatedEntity/associatedPerson/name
Healthcare provider organisation name (mandatory)	023070	Organization > name	ClinicalDocument/participant[gen_prac_org]/associatedEntity/scopingOrganization/name
Healthcare provider individual's workplace address (optional)	024035	Practitioner > address	ClinicalDocument/participant[gen_prac_prac]/associatedEntity/addr
Healthcare provider individual's workplace electronic communication details (optional)	024036	Practitioner > telecom	ClinicalDocument/participant[gen_prac_prac]/associatedEntity/telecom
Healthcare provider professional Role (mandatory)	024040	Not directly supported.	<p>participant[gen_prac_prac]/associatedEntity/code</p> <p>participant[gen_prac_org]/associatedEntity/code</p>
Healthcare setting (mandatory)	028435 028534	Encounter > type	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[enc]/encounter/entryRelationship[type]/observation/value
Additional comments (optional)	028403	List > note	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[note]/act/text
Dose Administration Aid medicines present (mandatory)	028441	Not directly supported.	<p>The requirements document mandates the inclusion of a statement or an indicator that a medicines list document includes medicine items packed in a dose administration aid (DAA). This requirement is not directly supported in FHIR; a request has been submitted to HL7 AU to consider this requirement on the national level, see https://git-hub.com/hl7au/au-fhir-base/issues/320.</p> <p>See Known issues for further information on this issue and possible work arounds.</p>

Data item	Req No.	Element	CDA schema element
Allergy and Adverse Reaction (optional)	028631	section (Allergies) section (Allergies) > entry	ClinicalDocument/component/structuredBody/component[allergy]/section/ ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/ob- servation/value
	028673	AllergyIntolerance > code section (Allergies) > emptyReason	ClinicalDocument/component/structuredBody/component[allergy]/section/@nullFlavor
Substance/Agent (optional)	028436	AllergyIntolerance > reaction > substance AllergyIntolerance > code	ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/ob- servation/entryRelationship[react]/observation/participant[agent]/participantRole/playin- gEntity/code ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/ob- servation/value
Reaction type (optional)	028437	AllergyIntolerance > type	ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/ob- servation/code
Reaction (optional)	028438	AllergyIntolerance > reaction > manifestation	ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/ob- servation/entryRelationship[react]/observation/entryRelationship[mfst]/observation/code
Reaction Onset Date (optional)	028439	AllergyIntolerance > onset	ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/ob- servation/effectiveTime ClinicalDocument/component/structuredBody/component[allergy]/section/entry[adv]/ob- servation/entryRelationship[react]/observation/value
Medicine Item (mandatory)	028632	Composition.section (Medicines List) Composition.section (Medicines List) > entry	ClinicalDocument/component/structuredBody/component[meds]/section ClinicalDocument/component/structuredBody/component[meds]/sec- tion/entry[meds]/act/entryRelationship[item]
Medicine identifier (mandatory)	028633	Medication > code	ClinicalDocument/component/structuredBody/component[meds]/sec- tion/entry[meds]/act/entryRelationship[item]/substanceAdministration/consumable/man- ufacturedProduct/manufacturedMaterial/code
	028634		

Data item	Req No.	Element	CDA schema element
Active Ingredient (optional)	028014	Medication > ingredient Medication > code	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/ext:asIngredient/ext:ingredientManufacturedMaterial/ext:code ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/code
Brand name (optional)	028442	Medication > code Medication > medication-brand-name	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/manufacturedProduct/manufacturedMaterial/code ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/entryRelationship[brand]/act/text
Medication strength (optional)	028442	Medication > ingredient > amount Medication > code	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/manufacturedProduct/manufacturedMaterial/ext:asIngredient/ext:quantity ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/manufacturedProduct/manufacturedMaterial/code
Dose form (optional)	028026	Medication > form Medication > code	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/ext:formCode ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/manufacturedProduct/manufacturedMaterial/code
Route (optional)	028443	MedicationStatement > dosage	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/routeCode
Direction (mandatory)	028021	MedicationStatement > dosage	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/text

Data item	Req No.	Element	CDA schema element
Dose per administration (optional)	028670	MedicationStatement > dosage	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/text
Frequency of administration (optional)	028668	MedicationStatement > dosage	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/text
Timing of administration (optional)	028669	MedicationStatement > dosage	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/text
Medicine purpose (optional)	028016	MedicationStatement > reasonCode	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/entryRelationship[reason]/observation/value
Expected end date (optional)	028445	MedicationStatement > effective[x]	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/effectiveTime
Special instructions (optional)	028446	MedicationStatement > dosage	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/text
Medicine image (optional)	028018	Not directly supported.	<p>Support for medicine image attribute has been removed from the Medication model in the first normative release of FHIR. For this reason the use of medication image is strongly discouraged in the HL7 AU content based on a prior FHIR release (STU3) and unsupported by this implementation guide.</p> <p>Where a sending system can include a medicine image, it is expected to be sent in the narrative for the Medicines List section.</p>
	028535	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by implementation.
Physical description (optional)	028020	Not directly supported.	This requirement is not directly supported by a FHIR profile. Where a sending system can include physical description of a medicine, it is expected to be sent in the narrative for Medicines List section.
Medicine status (optional)	028017	List > entry > flag	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/entryRelationship[flag]/observation/value
	028027		
	028636	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a conformance profile or handled by an implementation.

Data item	Req No.	Element	CDA schema element
Medicine identifier (mandatory)	028633	Medication > code	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/code
	028634		
Reason for ceasing medicine (optional)	028447	List > entry > change-description	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/entryRelationship[flag]/observation/text
Ceased date (optional)	028629	MedicationStatement > effective[x]	ClinicalDocument/component/structuredBody/component[meds]/section/entry[meds]/act/entryRelationship[item]/substanceAdministration/effectiveTime
Ceased medicines (mandatory)	028636	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a conformance profile or handled by an implementation.
Extensions not permitted (mandatory)	028637	Not directly supported.	This requirement is not directly managed by a FHIR profile; it may be enforced in a rendering specification, conformance profile or handled by an implementation.
Document version number (mandatory)	023068	ClinicalDocument/versionNumber	ClinicalDocument/versionNumber
Document instance identifier (mandatory)	023067	Not directly supported.	ClinicalDocument/id
Date and time of document creation (mandatory)	024025	Not directly supported.	ClinicalDocument/author/time
Document type (mandatory)	024027	Composition > type	ClinicalDocument/code
Document sub-type (mandatory)	028671	Composition > type	ClinicalDocument/code
	028672	Composition > composition-author_role	ClinicalDocument/author[prac_rol]/assignedauthor/code

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