Medical Discharge Referral Reporting Standard (MDRRS)

Summary This document is to be used to guide the development of standardised medical discharge referral reports. It contains a minimum set of items that will enable the recipients (GPs, specialists, other facilities) to know what to expect, and how to interpret it, irrespective of local differences in the formatting and presentation of a referral report. The standard can be applied to electronic or paper based discharge referral reports. It supports the state baseline build for the Electronic Medical Record (eMR) and is consistent with the minimum requirements for discharge referral specified in the Policy for Discharge Planning: Responsive Standards PD2006_054

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Distributed to Public Health System, Community Health Centres, Divisions of General Practice, NSW Ambulance Service, Ministry of Health, Public Hospitals, Private Hospitals and Day Procedure Centres

Audience All clinicians;health information mgrs;discharge planners;GPs;system developers & implementers

Medical Discharge Referral Report Standard (MDRRS)

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Part 1: Explanatory notes

The purpose of this document

The information needs of health care have changed rapidly in a few short years. It is no longer enough for hospital systems to operate in isolation. Integrating administration systems with clinical systems and interconnecting with related systems within the hospital was a major technological leap, but it was not enough. As technological sophistication increased, the potential for communication with the wider health community was realised. The IT world raced to develop their own products and implement them as far and wide as possible. However, the demands of the health world were greater than "solutions" for a stand-alone administrative unit and interoperability has become a key issue. The emergence of the electronic medical record (eMR) and electronic health record (eHR) brought with them even greater demands for interoperability. Interoperability relies absolutely on communicating the same information in the same way. That is, it is driven by standards.

However, standardisation for communication of health data is a relatively new field worldwide, and particularly so in Australia. Many of the standards that will support it are still in development or in the process of being adapted for the Australian situation. Intra- and inter-state differences need to be recognised and reconciled in the standardisation process. The more technologically advanced users have adopted standards for their own interoperability, but these are not necessarily consistent with those of other systems. In NSW, where there are systems that have evolved to meet the needs of individual jurisdictions, there is a legacy of systems at differing stages of development, and following different standards.

NSW Health will adopt and mandate national clinical and electronic delivery standards for discharge reporting and referral, as for patient administration. This document provides a solution for producing a medical discharge report from the varying systems and standards that currently exist within the NSW health system, during the transition to fully compliant electronic discharge referral systems (eDRS). This document specifies an agreed minimum set of output items, which the NSW Department of Health expects to be incorporated in a discharge referral report to a patient's GP, specialist or community health clinician.

The Department will continue to feed the needs and viewpoints of the State's health system owners, frontline users and stakeholders into the national development processes.

The information required in this document should be able to be obtained from data that is systematically collected and recorded during the patient's admission or visit to the health facility. It is used to provide a summary of the patient's care during their encounter and indicate a summary of the requirements for continuation of care after discharge.

This document describes only the minimum items to appear in a generic discharge referral report. Other data items may be added to suit local needs, or to cater to the special requirements of certain kinds of admissions, such as paediatric, aged care, obstetrics.

The structure of this document

This document has three parts:

- Part 1 (this section) contains the **Explanatory Notes** pertaining to parts 2 and 3.
- Part 2: **Definitions and Details** contains the minimum data set items, their definitions, labels and relevant standards
- Part 3: **Sample Layout Examples** to illustrate how the standard might be formatted to produce a discharge referral document.

Standard(s) that NSW Health is working towards implementing

In this document such standards have been identified where they exist and it is expected that implementers will work towards using these standards.

Standards referenced in this document

The following standards have been used in the construction of this data set. The order of priority for the application of standards in NSW Health is as follows:

First point of reference -	NSW Health Data Dictionary Version 1.2, 2004 (NSW Health)
Second point of reference -	National Health Data Dictionary Version 12, 2004 (National Health Data Committee, Australian Institute of Health and Welfare, Canberra)
Specifically for this document:	
Third point of reference -	NSW Electronic Medical Record eMR State Base Build standards for Allergies & other Adverse Reactions and Alerts (http://internal.health.nsw.gov.au/emr/sbb.html)
Subsequent points of reference -	Admitted Patient Data Dictionary – From 1 July 2004, NSW Health Approved Terminology For Medicines July 1999: Therapeutic Goods Administration, Dept of Health and Ageing, Canberra AS 4700 Implementation of Health Level Seven (HL7) Version 2.3.1(Standards Australia) AS 4700.1 - 1999 Part 1: Patient Administration AS 4700.2 - 2004 Part 2: Pathology Orders and Results AS/NZS 4700.3 -2002 Part 3: Electronic Messages for Exchange of Information on Drug Prescription AS 4700.6 – 2004 Part 6: Referral and Discharge Summary CHIME code set Version 3.1, NSW Health, 2004 NSW Health Policy Directive 2005_206: Handling of Medication in NSW Public Hospitals - Policy Broadsheet No. 29 SI Units Revisited. The Royal College of Pathologists of Australasia, Sydney, 1986

Logical Observation Identifier Names and Codes, Users Guide: Regenstreif Institute, Indiannapolis, 2003

ICD-10-AM International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification.

NEHTA : Clinical Information Project,draft specification for national hospital discharge summary, 2004

Effective Discharge Planning Framework and Implementation Strategy: a blueprint for NSW Health. Models of Care Implementation Working Group , 2003: NSW Health Government Action Plan for Health

Definitions

Sourced from *AS 4700.6 Part 6: Referral and Discharge Summary*

Discharge: The relinquishing of patient care in whole or part by a health care provider or organisation.

Discharge referral: A referral occurring in the context of discharge.

Discharge summary: A collection of information about events during care by a provider or organization.

Referral: The communication, with the intention of initiating care transfer, from the provider making the referral to the receiver. Referral can take several forms most notably:

(a) *Request* for management of a problem or provision of a service, eg a request for an investigation, intervention or treatment.

(b) *Notification* of a problem with hope, expectation, or imposition of its management, eg a discharge summary in a setting which imposes care responsibility on the recipient.

Content of Part 2

Part 2 of this document describes **the content of the medical discharge referral report standard** in terms of the data items, the acceptable labels for the data items, and the data item definitions. This standard applies to electronic or paper output.

Relevant guidelines have been included with the definition in the Guide for Use section. Where NSW State electronic communication standards or data standards are available, they have been included in the right hand column of the report.

As electronic health messaging is a relatively new field, many standards are still in draft stages and will be subject to review. For this reason the standards have not been made mandatory for discharge referral reporting at this point in time and are provided to give direction on NSW Health's intended path. Feedback on the use of, or issues with these standards may be directed to the Informatics Unit of NSW Health.

Section headings

The section headings are presented in large bold letters, at the top of each page of Section 2. These headings represent logical groupings of the minimum data set items.

Data items

Optional data items

Some data items are designated as optional items. These items do not need to be included in the report if there is no corresponding information for them. For example, if a patient had no radiology services performed, the radiology component may be omitted from the report.

Mandatory data items

In the interest of patient safety, some data items are designated as mandatory even if there is no "positive" information to correspond to them. For example, allergy and alert information, where a response must be given to establish that the information has been obtained. For mandatory data items, there must always be a heading present on the discharge referral report.

Labels to be shown on discharge report

To meet the business requirements of discharge reporting, this document specifies the labels for the data items as they are to appear in the discharge report. The labels are plain English versions of data item names. For most data items there are a choice of labels that are considered acceptable. In some cases, data items are grouped to form commonly known composite data items such as "address".

Optional labels

Some labels may become redundant or self-evident in the context of the report layout. Such data items include the label <blank> in the *Allowable Labels* column of this document. For example (1) if the patient's name was preceded by a section heading of Patient Details, the label Patient Name would be redundant, and (2) the label Sex may be considered redundant information because the word "Male" is self explanatory in the context of the discharge summary report header.

Mandatory labels

If the <blank> option is not present in the Allowable Labels column then a label is mandatory for that data item. This is a safety measure included to help prevent critical information being overlooked by omission.

"Definition and Guide for Use" column

This column contains the definition of the data item described by the label. The Guide for Use section contains any rules, constraints and dependencies that are specific to that data item.

Content of Part 3

Part 3 of this document shows two **suggested layouts** for a medical discharge referral report. Its purpose is to show an overview of how the information might be used or grouped for presentation purposes.

Sequencing of the major headings

The order of presentation is governed by the major section headings shown in Part 2 of this document. The order of the section headings is immutable, however, in many cases the sections themselves will not be present. With the exception of Medications and Adverse Reactions and Alerts, if there is no information for the data items grouped by the section heading, the heading itself does not need to be shown in the report.

Sequencing of data items within the major groupings

The data items that appear under the major headings may be presented in order of your preference.

Graphical representation

Ideally, the discharge referral document should be as concise as possible. The receiving clinicians surveyed during the research phase of this project indicated a strong preference for the discharge referral report to be kept to one page in length. The choice of font, font size and other graphical characteristics is left to your choice, bearing in mind the necessity to keep the physical report as succinct and user-friendly possible.

PART 2: Details and Definitions

Referring service/clinician contact information

Section definition Information provided to inform the receiving provider where the discharge referral has come from, and to facilitate contact follow-up

Data item	*Allowable Labels*	*Definition and Guide for use*	*Acceptable standards*
Facility name **MANDATORY ITEM**	Facility name Facility <blank>	**Definition** The name of the facility discharging or referring the patient on.	
Facility address **MANDATORY ITEM**	Facility address Address <blank>	**Definition** The street address of the facility from which the patient is being discharged. **Guide for use** "Address Type" must be either "Business Address" or "Mailing Address" Mandatory components of address are: • Flat and Street number, Street Name, Type and Suffix **OR** PO Box number • Suburb/locality • State Abbreviation • Postcode	**NSW Health Data Dictionary Version 1.2** Composite data element "Address".
Facility phone number **MANDATORY ITEM**	Phone number Phone no Phone Ph <blank>	**Definition** The phone number that is best for enabling the receiving provider to follow up on the discharge report, eg the facility switchboard. **Guide for use** This is a repeatable item	**NSW Health Data Dictionary Version 1.2** "Telecommunications number/address" Telecommunications mode: 02 (Fixed (land line) phone)
Attending clinician **MANDATORY ITEM**	Attending clinician Attended by: Attending <role name>	**Definition** The name title and preferred full name of the clinician who has the most knowledge of the patient's case. Mandatory components of name are: • Name title • Family name	**NSW Health Data Dictionary Version 1.2** "Name Title" "Given Name(s)" and "Family Name"
Attending clinician's contact number **MANDATORY ITEM**	Phone number Phone no Phone Ph <blank>	**Definition** The direct phone number or number plus pager number, or mobile phone number on which the attending clinician can be contacted. **Guide for use** Telecommunications Mode must be either Fixed (land line) phone or Mobile phone This is a repeatable item	**NSW Health Data Dictionary Version 1.2** "Telecommunications number/address" Telecommunications Mode"

Intended recipient(s)

Section definition The name and contact details of the receivers of the discharge referral report.
Guide for use There may be more than one recipient.

Data item	*Allowable Labels*	*Definition and Guide for use*	*Acceptable Standards*
Intended Recipient **MANDATORY ITEM**	Intended recipient	**Definition** The full name of the person to whom the report is directed. **Guide for use** This is a repeatable item Mandatory components of name are: • Name title • Family name	**NSW Health Data Dictionary Version 1.2** "Name Title" "Given Name(s)" and "Family Name"
Recipient's contact address **MANDATORY ITEM**	Address <blank>	**Definition** The recipient's preferred address for delivery of the discharge report. **Guide for use** This is a repeatable item The address may be a physical location or a mail delivery address. Mandatory components of address are: • Flat and Street number, Street Name, Type and Suffix **or** PO Box number • Suburb/locality • State Abbreviation • Postcode	**NSW Health Data Dictionary Version 1.2** Composite data element "Address"
Recipient's Fax number	Fax no Facsimile Fax	**Definition** The facsimile number of the intended recipient of the discharge report **Guide for use** This is a repeatable item Telecommunications mode must be Facsimile Only required if the discharge document is to be delivered faxed	**NSW Health Data Dictionary Version 1.2** "Telecommunications number/address" "Telecommunications mode:"
Recipient's Email address	Email	**Definition** The email address of the intended recipient of the discharge report **Guide for use** This is a repeatable item Only required if the discharge document is to be delivered by email Telecommunications Mode must be Email	**NSW Health Data Dictionary Version 1.2** "Telecommunications number/address" "Telecommunications Mode"
Recipient's phone number	Phone number Phone no Phone Ph <blank>	**Definition** The direct phone number or number plus pager number, or mobile phone number on which the recipient can be contacted. **Guide for use** This is a repeatable item "Telecommunications Mode" must be either Fixed (land line) phone or Mobile phone	**NSW Health Data Dictionary Version 1.2** "Telecommunications number/address" "Telecommunications Mode":

Patient

note: this information must appear on every page of the report

Section definition Information that will facilitate identification of the patient

Data item	*Allowable Labels*	*Definition and Guide for use*	*Acceptable Standards*
Patient's full name **MANDATORY ITEM**	Patient Patient's name <blank>	**Definition** The name title (if available), the legal given names and family name of the patient as recorded for the current admission or visit. **Guide for use** Mandatory components of name are: • first Given Name • Family name	**NSW Health Data Dictionary V 1.2** "Name Title" "Given Name(s)" and "Family Name"
Age **MANDATORY ITEM**	Age <n> yrs <n>Yrs <n> Mths	**Definition** The age of the person, in years, on the day of discharge. **Guide for use** If the person is a child under 12 years, the age is to be given in years and months.	Derived item
Date of birth **MANDATORY ITEM**	DoB Date of Birth	**Definition** The day, month and year on which the patient was born.	**NSW Health Data Dictionary V 1.2** "Date of birth"
Facility MRN **MANDATORY ITEM**	MRN <facility name> MRN Patient Identifier Patient ID [no]	**Definition** The medical record number or unit number that identifies this client at the facility.	**NSW Health Data Dictionary V1.2** "Person identifier"
Sex **MANDATORY ITEM**	Sex	**Definition** The sex of the patient at admission. Guide for use: use the Domain Description, not the code.	**NSW Health Data Dictionary V 1.2** "Sex".

Contact information for the patient

Section definition Information that will allow the receiving provider to contact the patient or the person(s) responsible for their care.

Data item	*Allowable Labels*	*Definition and Guide for use*	*Acceptable Standards*
Home address **MANDATORY ITEM**	Address Home Address <blank>	**Definition** The patient's current residential address **Guide for use** Mandatory components of address are: • Flat and Street number • Street Name, Type and Suffix • Suburb/locality • State Abbreviation • Postcode If the patient is not an Australian resident, the country is also required.	NSW Health Data Dictionary Version 1.2 Composite data element "Address".
Patient's phone number(s)	Phone Home phone Best Contact No Ph H: Mobile Mob M:	**Definition** The phone number(s) that are best for contacting the patient after discharge. **Guide for use** This is a repeatable item Telecommunications mode must be either Fixed (land line) phone or Mobile phone	**NSW Health Data Dictionary Version 1.2** "Telecommunications number/address" "Telecommunications mode
Preferred language if interpreter required	Language Interpreter required	Definition The language (incl. sign language) most preferred by the person for communication. Guide for use Record only if an interpreter is required	**NSW Health Data Dictionary Version 1.2** "Preferred language "
Contact person's name	Contact person's name Contact Person to contact	Definition The preferred name and name title of the person to contact about the patient after discharge. Guide for use Required only if the patient is a child or an adult who is not capable of being responsible for themselves at the time of discharge. Mandatory components of name are: Name title first Given name Family name	**NSW Health Data Dictionary Version 1.2** "Name Title" "Given Name(s)" and "Family Name"
Contact person's phone number	Phone Home phone Best Contact No Ph H: Mobile Mob M:	Definition The phone number(s) that are best for reaching the patient's contact person. Guide for use Required only if the patient is a child or an adult who is not capable of being responsible for themselves at the time of discharge. This is a repeatable item	**NSW Health Data Dictionary Version 1.2** "Telecommunications number/address"

Admission [Visit] summary

Data item	*Allowable Labels*	*Definitions and guide for use*	*Acceptable Standards*
Admission [visit] date **MANDATORY ITEM**	Admission date Date admitted Admitted	**Definition** The date on which the patient was admitted to, or attended the facility from which the discharge report originates.	Date format as per NSW Health Data Dictionary Version 1.2: DD/MM/YYYY
Discharge date	Discharge Date Date Discharged Discharged	**Definition** The date on which the patient was discharged or separated from, the facility. Guide for Use: Record date of death where the patient died while in the care of the discharging facility or is DOA	Date format as per NSW Health Data Dictionary Version 1.2: DD/MM/YYYY
Expected Discharge date	Expected Discharge Date Expected Discharge	**Definition** The date on which the patient is expected to be discharged or separated from, the facility, if not already discharged/separated. Guide for Use: Record date of death where the patient died while in the care of the discharging facility or is DOA	Date format as per NSW Health Data Dictionary Version 1.2: DD/MM/YYYY
Mode of separation	Mode of Separation Separation Status Separation	**Definition** The status of the patient (discharge, transfer death) and the place to which the patient is released **Guide for use** Applies to discharged patients only Applies to inpatients only.	NSW Statewide Data Standards "Mode of Separation" Version 3
Discharged To location	Discharged to:	The name of the facility that the patient is discharged to. **Guide for use** **Use** NSW Health Facility Code description or one of the values: "Not referred" "Other", "Unknown"	NSW Health Facility Code set plus values: "Not referred" "Other", "Unknown"
Admitted via Emergency Department **MANDATORY IF PATIENT IS ADMITTED VIA ED**	Admitted via ED	**Definition** Specify whether the patient sought care in ED and was subsequently admitted.	Valid values: "yes", "no" or blank

Adverse reactions and Alerts

Section Definition Notification of issues (medical or otherwise), which may influence decisions about ongoing or future treatment or delivery of care or which are flagged for further assessment, follow up and referral.

Data item	*Allowable Labels*	*Definition and Guide for use*	*Acceptable Standards*
No Adverse Reaction Flag **MANDATORY ITEM IF NO ADVERSE REACTIONS ARE KNOWN**	No known adverse reactions	A flag to indicate that the patient is not known to have any allergies and other adverse reactions. **Guide for use** This indicator must be present if there are no adverse reactions reported for the patient. Must not be present if adverse reactions reported.	NSW Health standards for eMR: Allergy and Other Adverse Reactions codeset
No Alert Flag **MANDATORY ITEM IF NO ALERTS KNOWN**	No known alerts	A flag to indicate that the patient is not known to have any alerts. **Guide for use** This indicator must be present if there are no alerts reported for the patient. Must not be present if alerts are reported.	
Adverse reaction type **MANDATORY IF ADVERSE REACTION HAS BEEN RECORDED**	Reaction <name of reaction type> Type	**Definition** Classification of any harmful or unintended effect of a specific substance or agent, including medication.	NSW Health Standard for eMR: Allergy - Reaction Type codeset: Valid values: “allergy”, “intolerance”, “side effect”, “toxicity”, “idiosyncratic”, “unknown” EHR code set EHR011 Allergy/Alert Type
Adverse reaction-allergen	To <allergen description> Allergen	**Definition** The identification of the substance or agent suspected or known to have caused or be responsible for the type of adverse reaction. **Guide for use** Record an allergen for each type of adverse reaction recorded.	NSW Health standards for eMR: Select from Allergy Type codesets for Food, Environmental or Drugs
Adverse reaction-reaction symptom	Symptom[s]	**Definition** The signs and symptoms experienced or exhibited by the patient as a consequence of the adverse reaction.	NSW Health standards for eMR recommend SNOMED CT

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Adverse reactions and Alerts **(continued)**

Data item	*Allowable Labels*	*Definition and Guide for use*	*Acceptable Standards*
Adverse Reaction-Reaction severity	Adverse Reaction Severity Reaction severity Severity Allergy Severity	**Definition** The degree of acuteness or intensity of an observed or anticipated reaction symptom.	NSW Health Standard for eMR Allergy - Severity codes Valid values: "mild", "moderate", "severe", "unknown"
Alerts **MANDATORY IF ALERTS ARE RECORDED**	Alert[s]	**Definition** Factors that need special consideration to prevent an unfavourable event or that need to be known in order to influence treatment, service or care decisions for the patient This includes clinical, behavioural, administrative and patient preference issues. **Guide for use** Consideration should be given to fact that the discharge referral report is being sent outside of the facility. Release of sensitive or confidential information should be carried out in accordance with the NSW Health Privacy Manual	NSW Health standards for eMR: Alerts – Categories code sets (select either Category level, Generic Data Item level or Specific Data item level)

Reason for admission [visit]

Section Definition The health reasons for which the patient was admitted to or attended the facility.

Data item	*Allowable Labels*	*Definition and Guide for use*	*Acceptable Standards*
Presenting Problem **MANDATORY ITEM**	Presenting Issue Provisional Diagnosis Working Diagnosis	**Definition** A symptom, disorder, or concern expressed by the patient when seeking care.	ICD-10-AM version 4 CHIME IssueV3.1 DOCLE
Principal diagnosis description **MANDATORY ITEM**	Principal diagnosis Diagnosis	**Definition** The diagnosis established after study to be chiefly responsible for occasioning the patient's care at the facility.	ICD-10-AM version 4 CHIME IssueV3.1 DOCLE
Additional diagnoses	Additional diagnosis[es] <blank>	**Definition** Conditions or complaints either coexisting with the principal diagnosis or arising during the admission or visit at the facility. This may be used for the primary diagnosis for a procedure that is carried out. **Guide for use** This is a repeatable item	ICD-10-AM version 4 CHIME IssueV3.1 DOCLE

Significant interventions and results

Section Definition The surgical procedures and non-surgical interventions or investigations (diagnostic tests) performed on or for the patient during their admission or visit to the facility, deemed by the attending clinician to be significant to the admission/visit and/or impact on the continuation of care.

Data item	*Allowable Labels*	*Definition and Guide for use*	*Acceptable Standards*
Procedure/investigation name	Procedure Investigation Test Intervention	**Definition** The name or a textual description of the procedure or diagnostic test/service performed on the patient. **Guide for use** All investigations performed during this admission/visit that the clinician considers would be in the interest of furthering the patient's care once discharged. For example, blood cross matches done in preparation for surgery would not be included, but microbial studies would be included, irrespective of the result. Where applicable this data may also include a procedure code and the type of classification system used eg ICPC. Procedures/Investigations must complement the principal diagnosis as per ICDCM guidelines.	Procedure: NHDD Version 12 CHIME activities V3.1 LOINC codeset Pathology: AS 4700.2-2004 "Implementation of Health Level Seven (HL7) Version 2.3.1 Part 2: Pathology Orders and Requests." AS4700.2-2004 recommends the use of Australian Pathology "Pathology Request Codes" Version 0.1 (28 Oct 2003) and Pathology Report Codes" which are available from www.austpath.uow.edu.au and for units of measure, Broadsheet No.29 "SI Units Revisited" The Royal College of Pathologists of Australasia, Sydney 1986
Procedure/investigation date	Test date Investigation Date Procedure Date Date	**Definition** The date on which the procedure or investigation took place, or the specimen was collected for testing.	Date format as per NSW Health Data Dictionary Version 1.2: DD/MM/YYYY
Laboratory contact number	Phone Best Contact No Ph <blank>	**Definition** The best phone number for following up investigations or results. This is a repeatable item	**NSW Health Data Dictionary Version 1.2** "Telecommunications number/address"

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Significant interventions and results

Section Definition The surgical procedures and non-surgical interventions or investigations (diagnostic tests) performed on or for the patient during their admission or visit to the facility, deemed by the attending clinician to be significant to the admission/visit and/or impact on the continuation of care.

Data item	*Allowable Labels*	*Definition and Guide for use*	*Acceptable Standards*
Results reporting reference range	Reference Range Ref Range	**Definition** The upper and lower values that represent the normal limits of the range for the specified test. **Guide for use** Not applicable to all observations. When the observation quantifies the amount of a toxic substance, then the upper limit of the range identifies the toxic limit. When the observation quantifies a drug, the lower limits identify the lower therapeutic bounds above which toxic side effects are common.	The reference range to be reported is the reference range provided by the laboratory that performs the test. If using Abnormal Flags, use AS4700.2 2004 values
Procedure/investigation result	Result[s]	**Definition** The observed description of the result of a surgical procedure and/or the value observed in a non- surgical procedure or diagnostic test/service. This may be the result as it comes directly from the observation producer, or as summarised by the clinician preparing the discharge report. **Guide for use** Depending upon the observation type, the data type may be a number, a coded answer, short text or a combination of data types. Some systems may report only the normalcy/abnormality of the result. Where results are not available at the time of writing the discharge report, the results should be flagged as “pending”.	AS4700.2-2004 recommends the use of Australian Pathology “Pathology Request Codes” Version 0.1 (28 Oct 2003) and Pathology Report Codes” which are available from www.austpath.uow.edu.au and for units of measure, Broadsheet No.29 “SI Units Revisited” The Royal College of Pathologists of Australasia, Sydney 1986 Or LOINC codeset

Medication

Definition Details of medications that the patient will take after discharge. Includes all medications taken by the patient, ie prescription, over-the-counter and complementary medicines. Record "None" if no medication to be taken after discharge.

Guide for use

Consideration should be given to fact that the discharge report is being sent outside of the facility. To avoid confusion and misinterpretation abbreviations should not be used other than those specifically authorised for use in the facility by the Drug Committee. This principle applies to all elements of the medication section.

NOTE: THIS INFORMATION IS NOT FOR THE PURPOSE OF PRESCRIBING

Data item	*Allowable Labels*	*Definition and Guide for use*	*Acceptable Standards*
Generic name **MANDATORY ITEM**	Generic name name <blank>	**Definition** The full generic name of the medication or substance used to treat the patient, or used by the patient to treat his/her self. **Guide for use** The generic name should be listed before the brand name. *No medication to be taken after discharge:* record "None" *Self-reporting for complementary and over-the-counter (OTC) medicines:* In most cases the only source of this information will be from the word of the patient his/herself. Self-reporting is allowed for these data. *No generic name*: Where there is no generic name, such as multi-additive drug preparations, record "No Generic"	AS/NZS 4700.3 -2002 Part 3: Electronic Messages for Exchange of Information on Drug Prescription recommends Therapeutic Drug Administration (TGA) approved name.
Generic name (*continued*)		*Neither generic name nor brand name*: For compounds that have neither a generic name nor a brand name, record the elements of the compound in the generic name location. *Generic name not known:* In the case of complementary medicines and over-the-counter preparations where the generic name is not known insert "Not Known" in the generic name location but you must record a brand name. *A brand name only:* If there is only a brand name for substance, insert "No Generic" in this location.	

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Medication (continued)

Data item	*Allowable Labels*	*Definition and Guide for use*	*Acceptable Standards*
Brand name	Brand name (Brand Name)	**Definition** The retail name (in full) for the finished drug product. **Guide for use** It is preferable to use only the generic name for the drug, however if the brand name is to be used, it should appear after the generic name, and be enclosed in brackets.	AS/NZS 4700.3 -2002 Part 3: Electronic Messages for Exchange of Information on Drug Prescription
Dose	Dose	**Definition** The amount of the specified form and strength (see below for definitions) of the drug to be given in a single dose. **Guide for use** Depending on the drug, it may be expressed in a variety of ways. Eg, as a number of units of the specified form (eg 2), a number plus a unit of measure (eg 1.5 mL) or a description (eg 2 inhalations/puffs) or in a ratio to the patient's weight (eg 50 Units /kg). Doses less than 1 mL that are reported as decimal values must be written with a leading zero. Ie 0.3 mL and NOT .3 mL. Doses of less than 1 milligram are to be written with leading zeros. Ie 0.5 mg and NOT .5 mg. Abbreviations should not be used other than those specifically authorised for use in the hospital by the Drug Committee.	NSW Health Circular 2001/64 : Policy on the Handling of Medication in Public Hospitals (now known as PD 2005_206) AS/NZS 4700.3 -2002 Part 3: Electronic Messages for Exchange of Information on Drug Prescription
Form	Form	**Definition** The form into which substance of the medication is aggregated for dispensing, e.g. tablets, capsules, suppositories.	TGA *Approved Terminology for Medicines* "Dosage Forms"
Strength	Strength	**Definition** The strength or concentration of the drug **Guide for use** As per NSW Health Policy on the Handling of Medication in Public Hospitals (PD2005_206, amounts of less than 1 mL that are reported as decimal values must be written with a leading zero. Ie) 0.3 mL and NOT .3 mL. Doses of less than 1 milligram are to be written with leading zeros. Ie 0.5 mg and NOT .5 mg.	

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Medication (continued)

Data item	*Allowable Labels*	*Definition and Guide for use*	*Acceptable Standards*
Strength Unit	Unit	**Definition** The unit of measure of the drug's concentration. **Guide for use** The Strength, combined with the Strength Units may be expressed as a number plus units (eg 250 mg), a percentage (eg 1%) or a ratio (eg 100 Units/ 1mL). Abbreviations should not be used other than those specifically authorised for use in the hospital by the Drug Committee.	AS/NZS 4700.3 advises the use of Broadsheet No.29 for Units TGA Approved *Terminology for Medicines, July 1999* "Units and Expression of Proportion"
Frequency	Frequency	**Definition** How often each dose is to be taken by the patient or the explicit time interval(s) at which the medication is to be taken	
Compliance aid recommended **MANDATORY IF MEDICATIONS ARE PRESENT**	Compliance aid recommended	**Definition** An indication of whether the prescribing physician recommends that this patient should use a compliance aid to assist in taking the medications after discharge.	
Route	Route Route of administration	**Definition** The way a medication is to be administered or the site of administration, eg orally, by intravenous injection. **Guide for use** To avoid confusion and misinterpretation the full English description should be used to express the Route.	TGA Approved Terminology for Medicines July 1999 "Routes of Administration"
Supply (days)	Supply <n> days Supplied with <n> days	**Definition** The number of days' medication that the patient has been supplied with. Applies only to hospital discharges.	
Medication course *(see below for sub-components)*	Medication course From <start date> for <length of time>. From<start date> as required	**Definition** The length of the course, expressed as a start date (defined below) and a period of time, in an English sentence structure. It generally takes the form "From <start date> for <length of course>", but for open-ended or variable time periods "as required" may be used.	

This section continued overleaf

Medication (continued)

Data item	*Allowable Labels*	*Definition and Guide for use*	*Acceptable Standards*
Start date *Sub-component of Medication course*	Start Date From <start date>	**Definition** The date on which the patient began, or is to begin, taking the medication. **Guide for use** Used in conjunction with Length of course	Date format as described in **NSW Health Data Dictionary Version 1.2**"Date of Birth"
Length of course *Sub-component of Medication course*	For <length of course> As required for pain As required	**Definition** A statement describing the length of the course in days or weeks, eg "for 2 weeks" "for 3 days" or "as required".	
Medication change	Note change to medication	**Definition** A warning that a change has been made to a medication that the patient was taking prior to admission. **Guide for use** Its purpose is to warn the GP who might have originally prescribed the medication that the medication is now different. Must be present if a change has been made to the strength, dosage, route or form of a medication that was prescribed for the patient prior to admission by an external service provider. It must be made clear to which medication this warning refers. If there is any doubt, the medication name should be repeated immediately after the label.	Derived item

Continued care recommendations

Definition Follow up advice for the intended recipient and details of follow up appointments made.

Data item	*Allowable Labels*	*Definition and Guide for use*	*Acceptable Standards*
Instructions to clinician for follow up	Instructions for clinician	**Definition** Specific requirements of the GP/specialist. **Guide for use** If none required indicate "No specific care transfer required"	**"NSW Health Data Dictionary Version 1.2** "Name Title" "Given Name(s)" and "Family Name"
Referred-to clinician/ service	Referred to Referral to	**Definition** The name of the clinician, practice or facility to which the patient is referred. **Guide for use** This is a repeatable item	
Referred-for service	Service <blank>	**Definition** The service for which the patient is being referred **Guide for use** This is a repeatable item	
Appointments made	Appointment(s) made <blank>	**Definition** For each clinician to which the patient is referred, specify whether an appointment has been scheduled. **Guide for use** This is a repeatable item	Valid values: "yes", "no" or "appointment made"

Authorisation

Definition Identifying information about the author of the discharge report provided for the purpose of authentication.

Data item	*Allowable Labels*	*Definition and Guide for use*	*Acceptable Standards*
Author/compiler of this report **MANDATORY ITEM**	Author of this report Author Compiled by Authored by Authorised by	**Definition** Name title, family name and given name of the person preparing or authorising this report.	**NSW Health Data Dictionary Version 1.2** "Name Title" "Given Name(s)" and "Family Name"
Position **MANDATORY ITEM**	Position Role <blank>	**Definition** The position description or role that the author plays in relation to this discharge report.	
Signature **MANDATORY ITEM**	Signed	**Definition** The handwritten or electronic signature of the person preparing this report.	
Date finalised **MANDATORY ITEM**	Date finalised Date	**Definition** The date that the discharge report is finalised for dispatch.	

PART 3: Report Layout Examples

Following are two examples of how the data items contained in this Standard might be used in designing a discharge referral report. The Allowable labels are shown, followed by the data item name. For example, **Reaction**: <adverse reaction type>.

Both examples show all the headings that might appear in a discharge report. Individual discharge reports may contain all or only a subset of these. Individual reports might also contain a number of repetitions of a particular data item (eg medications, or procedures). In the examples provided, table formats have been used in different contexts to illustrate alternative ways of presenting the data.

EXAMPLE 1

Facility name <facility name>
Address <facility address line 1>
<facility address line 2>
Phone <facility contact number>
Attending Clinician <attending clinician>
Phone <attending clinician's phone number>

DISCHARGE REFERRAL REPORT

INTENDED RECIPIENT:
<intended recipient's name>
<recipient's contact address line 1>
<recipient's contact address line 2>
Phone: <recipient's phone number>
Fax: <recipient's fax number>

PATIENT:
<patient's full name>
MRN: <facility MRN>
DOB:<DOB> (Age:<age> yrs)Sex:<sex>
<home address line 1>
<home address line 2>
Best Contact No: <patient's phone number>
Interpreter required: <preferred lang if interpreter required>
Person to contact: <contact person's name>
Phone: <contact person's phone number>

ADMISSION SUMMARY

Admitted: <admission date>

<Admitted via ED>
Expected Discharge Date <expected discharge date>
Discharged: <discharge date>

Separation status: <mode of separation>
Discharged to: <discharged to location>

ADVERSE REACTIONS AND ALERTS

<No allergy flag>
Adverse reaction: <adverse reaction type> to <allergen description>
Reaction severity: <severity>
Symptoms: <reaction description>
Alerts: <alert type> <No Alert flag>

REASON FOR ADMISSION

<presenting problem>
Principal diagnosis: <principal diagnosis>
Additional diagnoses: <additional diagnosis>, <additional diagnosis>,

SIGNIFICANT INTERVENTIONS AND RESULTS

Procedure: <procedure/investigation name> Date: <procedure/investigation date>
Laboratory: <laboratory> Phone no: <laboratory contact number>
Result: <result>
Reference range: <results reporting reference range>

EXAMPLE 1

<patient's full name> MRN <facility MRN> DOB: <DOB> (Age <Age>)Sex: <sex>

MEDICATIONS

Generic name	strength	form	Route of administration	Dose/Frequency	Course		Supply (days)
					From	For	
<generic name med 1>	<strength>	<form>	<route of administration>	<dose> <frequency>	<med'n start date>	<length of course>	<Supply (days)>
* Note change to medication: <generic name med 2>							

CONTINUED CARE RECOMMENDATIONS

Instructions to clinician: <instructions to clinician>

Referred to:	Service:	Appointment made?
<referred-to clinician/practice>	<referred-for service>	Yes/No

AUTHORISATION

Author of this report: author's name
Position <author's role in the facility>
Signed: <signature>
Date: <date finalised>

EXAMPLE 2

Northern Regions Hospitals

<facility name>
<facility address line 1>
<facility address line 2>
<facility contact number>
Attending Clinician <attending clinician>
Phone <attending clinician's phone number>

DISCHARGE REFERRAL REPORT

INTENDED RECIPIENT: <intended recipient's name> <patient's full name>
<recipient's contact address
Phone: <recipient's phone number
Fax: <recipient's fax number>

PATIENT:
<patient's full name> MRN: <facility MRN>
<home address >
Best Contact No: <patient's phone number>

DOB: <DOB> (Age: <age> yrs <age> mths) Sex: <sex>
Interpreter required: <preferred language if interpreter required>
Person to contact: <contact person's name> Phone: <contact person's phone number>

VISIT SUMMARY

Admitted: <admission date>
<Admitted via ED>
Expected Discharge: <discharge date> Separation status: <mode of separation>
Discharged to: <discharged to location>

ADVERSE REACTIONS AND ALERTS

<No Alerts flag>
Adverse reactions: <adverse reaction type> to <allergen description>
Reaction severity: <severity> Symptoms: <reaction description>
Alerts: <alert type> <No Alerts flag>

REASON FOR VISIT

<presenting problem>
Principal diagnosis: <principal diagnosis>
Additional diagnoses: <additional diagnosis>

SIGNIFICANT INTERVENTIONS AND RESULTS

Procedure/investigation	Date	Laboratory	Phone	Result	Ref range
<procedure/investigation name>	<proc/inv date>	<laboratory>	<lab contact number>	<proc/inv result>	<results reporting ref range>

EXAMPLE 2

<patient's full name> MRN <facility MRN> DOB: <DOB> (Age <Age>)Sex: <sex>

MEDICATIONS

Generic name	Strength	form/dose/route/frequency
<generic name(brand name)>	<strength>	<form><dose><route><frequency>

Medication course: from <medication start date> for <length of time>
Supply (days) <(n) supply days>
Compliance aid recommended <compliance aid recommended>

CONTINUED CARE RECOMMENDATIONS

Instructions to clinician: <instructions to clinician>

Referred to	Service	Appointment name
<referred-to clinician/practice name>	<referred-for service>	<Appointment made>

AUTHORISATION

Author of this report: author's name ***Position <author's role in the facility>***
Signed: <signature> ***Date: <date finalised>***

Appendix 1:
HL7 Version 2.3.1 mappings

The purpose of this Appendix is to indicate, where they exist, the HL7 message segments from which the required data item(s) could be extracted for use in the discharge referral report summary. This document does not contain complete HL7 messages. The supporting HL7 syntax is not included in this document.

This document is not intended as a reference for constructing HL7 messages, but for extracting the relevant components from existing messages for constructing discharge referral reports.

It should also be noted that there are data items for which there are no corresponding messages in version 2.3.1 of HL7. Where such information is stored in individual systems (such as in Z segments) cannot be predicted by this document.

Referring service/clinician contact information

Data item	*HL7 Message segment (where applicable)*	*Warnings*
Facility name	CTD-4 Contact Communication Location	
Facility address	CTD-3 Contact Communication Address	
Facility phone number	CTD-5 Contact Communication Information	
Attending clinician	PRD-2 Provider Name where PRD-1 = “PP” Primary Care Provider	HL7 messages can hold multiple providers. Specific rules need to be used to ensure that the correct provider is chosen
Attending clinician’s contact number	PRD-5 Provider Communication Information	

Intended recipient(s)

Data item	*HL7 Message segment (where applicable)*	*Warnings*
Intended Recipient	PRD-2 Provider Name where PRD-1 = “RT” Referred to Provider	HL7 messages can hold multiple providers. Specific rules need to be used to ensure that the correct provider is chosen
Recipient’s contact address	PRD-3 where PRD-1 = “RT” Referred to Provider	
Recipient’s Fax number	PRD-5 Provider Communication	
Recipient’s Email address	PRD-5-4 Email Address	
Recipient’s phone number	PRD-5 Provider Communication Information	

Patient

Data item	*HL& segment (where applicable)*	*Wanrings*
Patient's full name	PID-5 Patient name	PID-10 (Race) is a mandatory element in HL7 (but not required for MDRRS)
Age	Not applicable	
Date of birth	PID-7 Date/time of birth	
Facility MRN	PID-3.1 Identifier type where the Type component + code =016 (MRN-local)	PID 3.4 and PID 3-6 Assigning Authority and Facility must be populated to ensure uniqueness of the ID
Sex	PID-8 Sex	

Contact information for the patient

Data item	*HL7 Message segment (where applicable)*	*Warnings*
Home address	PID-11 Patient address	
Patient's phone number(s)	PID-13 Phone number – home or PID-14 Phone number –business	
Preferred language if interpreter required	PID-15 Primary Language	
Contact person's name	NK1-2 Name	NK1-1 (set ID) is a mandatory element in HL7 (but not required for MDRRS)
Contact person's phone number	NK1-5 Phone number	

Admission [Visit] summary

Data item	*HL7 Message segment (where applicable)*	*Warnings*
Admission [visit] date	PV1-44 Admit Date/Time	Patient referral messages cannot be generated without PV1-2 Patient Class PV1-10 Hosp Service PV1-19 Visit ID (but these are not required for MDRRS)
Discharge date	PV1-45 Discharge Date/Time or EVN-2 Recorded Date/Time (inpatient admissions or) PID-29 Patient Death Date and Time	
Expected Discharge date	PV2-5 Expected Admit/Visit End Date/Time	
Mode of separation	PV1-36 Discharge Disposition	
Discharged To location	PV1-37 Discharged To Location	
Admitted via Emergency Department	No placeholder in HL7	

Adverse reactions and alerts

Data item	*HL7 Message segment (where applicable)*	*Warnings*
No Adverse Reaction Flag	Not applicable	AL1-1 (& IAM in the future) is a mandatory element in HL7 (but not required for MDRRS).
No Alert Flag	Not applicable	
Adverse reaction type	Not applicable	
Adverse reaction-allergen	AL1-3 Allergy Code/Mnemonic/Description.	
Adverse reaction-reaction symptom	AL1-5 Allergy reaction	
Adverse reaction-reaction severity	AL1-4 Allergy Severity	
Alerts	Not applicable	

Reason for admission [visit]

Data item	*HL7 Message segment (where applicable)*	*Warnings*
Presenting problem	DG1-3 Diagnosis Code	DG1-1 is a mandatory segment in HL7 (but not required for MDRRS)
Principal diagnosis description	DG1-3 Diagnosis Code	DG1-6 user defined codes should be used to decide whether the diagnosis is principal, additional etc
Additional diagnoses	DG1-3 Diagnosis Code	DG1-6 user defined codes should be used to decide whether the diagnosis is principal, additional etc

Significant interventions and results

Data item	*HL7 Message segment (where applicable)*	*Warnings*
Procedure/investigation name	PR1-3 Procedure Code	PR1-1 Set ID is a mandatory element for HL7 (but not required for MDRRS)
Procedure/investigation date	PR1-5 Procedure Date/Time; OBX-14 Date/Time of observation	
Laboratory contact number	No placeholder in HL7	
Results reporting reference range	OBX-7 Reference Range. May also require OBX-6 Units, if units not included.	In HL7 a corresponding OBR segment must also be sent
Procedure/investigation result	OBX-5 Observation Value	In HL7 a corresponding OBR segment must also be sent

Medication

Data item	*HL7 Message segment (where applicable)*	*Warnings*
Generic name	RX0-1-4 Requested Give Code	
Brand name	RX0-1-1 Requested Give Code	
Dose	RXO-2 Requested Give Amount – Minimum and if required, RXO-3 Requested Give Amount-Maximum RXO-4 Units If the medication information is supplied as free text it may be found in RXO-6 Providers /Pharmacy Treatment Instructions instead of RXO-2, RXO-3 and RXO-4.	
Form	AS/NZS 4700.3-2004 RXO-5 Requested Dosage Form	
Strength and Strength Unit	RXO-18 Requested Give Strength and RXO-19 Requested Give Strength Units	
Frequency	ORC-7.2 Interval	In HL7 corresponding RXO messages need to be sent with ORC messages
Compliance aid recommended	No specific placeholder in HL7. Might be found in RX0-7 Providers Administration Instructions	
Route	RXR-1 Route	Warning: HL7 code set HL70162 is different to the TGA codeset
Supply (days)	Not applicable	
Medication course *(see below for sub-components)*	See below	
Start date	ORC 7.4 Start Date/Time	In HL7 corresponding RXO messages need to be sent with ORC messages
Length of course	ORC 7.3 Duration alternatively, RXO 7.2 Text eg “for pain”	In HL7 corresponding RXO messages need to be sent with ORC messages
Medication change	No placeholder in HL7 V 2.3.1	

Continued care recommendations

Data item	*HL7 Message segment (where applicable)*	*Warnings*
Instructions to clinician for follow up	Not applicable	
Referred-to clinician/service	PRD-2 Provider Name PRD-3 Provider Address	PRD-1 should be set to “RT”
Referred-for service	PRD-4 Location	PRD-1 should be set to “RT”
Appointments made	Not applicable	

Authorisation

Data item	*HL7 Message segment (where applicable)*	*Warnings*
Author/compiler of this report	Not applicable	
Position	Not applicable	
Signature	Not applicable	
Date finalised	Not applicable	