DPHR-HI-Issues and plans HI.115a

Here is the CI specification for the Issues and Plans HI. This is a consumer entered data. The objective is to present a digital form to a Consumer asking the list of questions as mentioned in the table below:

ISSUES AND PLANS HEALTH INTERACTION (*Name change - Issues (Complicating this pregnancy (TREATMENT PLAN)										
Data Source	Conceptual Data Item	Logical Data Item	Logical Data Item Description	Logical Data Item Code	Logical Data Item Field Type	ValueSet Value	ValueSet Code & Description	Format	Cardinality	ValueSet Reference
Harmonised (H) or Operational (Op)	BOLD equals Harmonised data	Name of the Data Item	The description of the logical data item	SNOMED Code and description or FHIR (if handled by FHIR values)	Eg Text, Date	BOLD equals Harmonised data	eg. SNOMED, LOINC	Format and Example	Relationship of x to y eg IHI is 1..1	Link to NCTS, FHIR or Sharepoint
Complication Of Pregnancy | SNOMED 609496007 complication occurring during pregnancy										
H	Current Pregnancy Complications	Current Pregnancy Complications	Complication occurring during pregnancy	SNOMED 609496007 complication occurring during pregnancy	Valueset / Free Text	Problem/Diagnosis reference set	SNOMED 32570581000036105 Problem/Diagnosis reference set	Text	0..*	http://hl7.org.au/fhir/ch/v1/ValueSet/ncdhc-pregnancy-complications-1
Op	Treating clinician	Under Care of / Treating Clinican	Under care of person / team	SNOMED 312884005 Under care of person	Text			Text	0..1	
Op	Date	Date	Date of recorded observation	FHIR	Date			Date	0..1	
Op	Plan	Plan Details / Comments	Detailed description of plan		FreeText			FreeText	0..1	
Operational										
OP	Patient Indentier	IHI	The numerical individual healthcare identifier (IHI) that uniquely identifies each individual in the Australian healthcare system.	FHIR	Text				1..1	
		First Name	First Name of individual	FHIR	Text				1..1	
		Last Name	Last Name of individual	FHIR	Text				1..1	
		DOB	The date of birth of the person	FHIR	Date				1..1	
		Sex	Sex used to identify the patient against the HI Service (Administrative Gender - Possibly)	FHIR	Text				1..1	
	Examiner (Person who is clinically responsible for the undetaking of the exam)	First Name	First Name of Examiner	Derived from other information sources / systems	Text				0..1	
		Last Name	Last Name of Examiner	Derived from other information sources / systems	Text				0..1	

		Designation	The designation of the professional completing the examination	SNOMED 223366009 | Healthcare professional (occupation) (Derived from other information sources / systems)	Text				0..1	
		Venue	Venue of where examination/ assessmmen t took place	Derived from other information sources / systems	Text				0..1	
		Signature (eSignature)	Digital signature of the examiner	FHIR					1..1	
	Interaction Type	Interaction Type	This will be used to identify the Interaction Type	FHIR					1..1	
	Attestation	Attestation	Used to indicate the author of the composition	FHIR					1..1	
		Date and Time	Date and Time of Examiner attesting the information	FHIR	Date (YYYY-MM-DD) Time (HH-MM-SS)				0..1	
	Author	Author	Used to indicate where the information has been sent from i.e. System	FHIR					1..1	