CDHR-HI-FH & RF Consumer Ent.HI.23

Here is the details on the Clinical Information Specification we discussed during the meeting:

FAMILY HISTORY & RISK FACTORS CONSUMER ENTERED Interaction										
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..2	Link to NCTS, FHIR or Sharepoint
OP	Identity Identifier (Child)	IHI	The numerical identifier that uniquely identifies each individual in the Australian healthcare system	FHIR	Numeric			Numeric	1..1	
		DOB	The date of birth of the person	FHIR	Date			Date	1..1	
		First Name	First Name of individual	FHIR	Text			Text	1..1	
		Last Name	Last Name of individual	FHIR	Text			Text	1..1	
		Sex	Sex used to identify the patient against the HI Service	FHIR	Text			Text	1..1	
Risk Factors | SNOMED 80943009										
H	Need Oxygen > 48hrs	At Birth did your baby need oxygen for 48 hours or longer?	Did the baby at birth require oxygen for 48hrs or more	SNOMED 1402861000168108 | H/O: neonate requiring oxygen for 48 hours or more	Value Set	Yes	SNOMED 373066001 | Yes	Text	0..1	http://build.fhir.org/ig/hl7au/au-fhir-childhealth/ValueSet-ncdhc-generic-yes-no-1.html
						No	SNOMED 373067005 | No			
H	Birth Weight <1500gms	At birth did your baby weigh less than 1500 grams?	Did the baby at birth weigh 1500gms or less	SNOMED 1376591000168102 | H/O: low birth weight status, less than 1500 g	Value Set	Yes	SNOMED 373066001 | Yes	Text	0..1	http://build.fhir.org/ig/hl7au/au-fhir-childhealth/ValueSet-ncdhc-generic-yes-no-1.html
						No	SNOMED 373067005 | No			
H	Intensive Care >24hrs	At birth did your baby need to stay in the intensive care unit or special care nursery for more than two days?	Did the baby stay in the Intensive Care Unit or Special Care Nursery for more than 24hrs	SNOMED 1402871000168102 | H/O: neonate requiring intensive care for 24 hours or more	Value Set	Yes	SNOMED 373066001 | Yes	Text	0..1	http://build.fhir.org/ig/hl7au/au-fhir-childhealth/ValueSet-ncdhc-generic-yes-no-1.html
						No	SNOMED 373067005 | No			
Familial Risk Factor | SNOMED 102486008										
H	Hearing / Deafness / Hearing Problems	Have any of your baby's close relatives been deaf or had a hearing problem from childhood?	Questionnaire around family history associated with hearing problems	SNOMED 439750006 | Family history of hearing loss	Value Set	Yes	SNOMED 373066001 | Yes	Text	0..1	http://build.fhir.org/ig/hl7au/au-fhir-childhealth/ValueSet-ncdhc-generic-yes-no-1.html
						No	SNOMED 373067005 | No			
H	Vision / Sight / Blindness / Eye Problems	Did anyone in the family have eye problems in childhood?	Questionnaire around family history associated with vision problems	SNOMED 430723005 | Family history of visual disturbance	Value Set	Yes	SNOMED 373066001 | Yes	Text	0..1	http://build.fhir.org/ig/hl7au/au-fhir-childhealth/ValueSet-ncdhc-generic-yes-no-1.html
						No	SNOMED 373067005 | No			

H	Dysplasia of the Hips / Hip Problems	Is there family history of hip problems in childhood? Example - dysplasia of the hips	Questionnaire around family history associated with hip problems	SNOMED 700191004 | Family history of developmental hip dysplasia	Value Set	Yes	SNOMED 373066001 | Yes	Text	0..1	http://build.fhir.org/ig/hl7au/au-fhir-childhealth/ValueSet-ncdhc-generic-yes-no-1.html
						No	SNOMED 373067005 | No			
~~H~~	~~Allergies / Adverse Reactions~~	~~Agent~~	~~Name of Allergy~~	-	~~Text~~	-	-	~~Text~~	~~0..*~~	19/03 - Out of Scope
		~~Description~~	~~Description about the allergy~~	-	~~Text~~	-	-	~~Text~~	~~0..*~~	
Op	Interaction Type	Interaction Type	This will be used to identify the health interaction type	FHIR				Text	1..1	
Op	Attestation	Attestation	Used to indicate the author of the composition	FHIR				Text	1..1	
		Date and Time	Date and Time of Examiner attesting the information	FHIR	Date (YYYY-MM-DD) Time (HH-MM-SS)			Date	0..1	
Op	Author	Author	Used to indicate where the information has been sent from i.e. System	FHIR				Text	1..1	