

General Data Category Mappings MD3

D e m o g r a p h i c	Medical Director Mapping
G e n d e r	Patient Details screen > Sex

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Patient Details screen > ATSI > Drop down list for Aboriginal and/or TSI, non ATSI, Not Recorded

The screenshot shows the 'Patient Details' screen. At the top, there are fields for 'Date of Birth' (23/06/1967) and 'Gender' (Female). Below these is the 'ATSI' dropdown menu, which is currently open, showing the following options: 'Neither Aboriginal nor Torres Strait Islander' (selected), 'Aboriginal', 'Torres Strait Islander', 'Aboriginal and Torres Strait Islander', and 'Neither Aboriginal nor Torres Strait Islander'. Below the dropdown is the 'Ethnicity' field, which is currently empty. At the bottom of the screen, there are fields for 'Contact Detail', 'Residential', 'Postal', 'Preferred Mailing Address', 'Residential', and 'Postal'.

Patient Details screen > Ethnicity > ... button will open up a list of countries/ethnicities. Multiple selections can be made

The screenshot shows the 'Select Ethnicity' dialog box. It has a search bar at the top with the text 'Search...'. Below the search bar is a list of checkboxes for various ethnicities. The 'Most Commonly Used' section is expanded, showing the following options: 'Australian Aboriginal' (checked), 'Torres Strait Islander' (unchecked), and 'Asian' (checked). Other options include 'Inadequately Described', 'Not Stated', 'Eurasian', 'Asian' (checked), 'African' (highlighted), 'European', 'Caucasian', 'Creole', 'Oceanian', 'North-West European', 'Southern and Eastern European', 'North African and Middle Eastern', 'South-East Asian', 'North-East Asian', 'Southern and Central Asian', 'People of the Americas', and 'Sub-Saharan African'. At the bottom of the dialog box are 'OK' and 'Cancel' buttons.

D
VA Patient Details Screen >
the Pension Status set to 'Full DVA' or 'Limited DVA'
or the DVA No. field has a value

A
ge Patient Details screen > DOB

F a m i l y H i s t o r y	Family/Social Hx tab - any entry (free text) in the Family History box will be counted
S m o k i n g	Patient Details > Smoking tab > [Note that smoking data from the Diabetes record is not used. Adding data to the diabetes record does not update the smoking tab which is taken as the primary MD smoking data.]
D a i l y S m o k e r	Smoker = Smoker is selected and frequency is daily
I r r e g u l a r S m o k e r	Smoker = Smoker is selected and frequency is not daily
E x S m o k e r	Smoker = Ex-Smoker is selected
N e v e r S m o k e d	Smoker = Never smoked is selected
N o t h i n g R e c o r d e d	Smoker has nothing selected

S ta te of C h a n g e A s s e s s m e nt	Not ready = not ready Unsure = Intends to quit Ready = Ready Recent quitter = Other
R e v i e w D ate	Date of Assessment [Note that this date only gets updated if something on the screen is changed]
Al c o h ol	Patient Details > Alcohol tab > Frequency = days a week patient usually drinks alcohol
D r i n k er	Frequency = any except Never
N o n D r i n k er	Frequency = Never
N o t h i n g R e c o r d ed	Alcohol tab has nothing selected
R e v i e w D ate	Date of Assessment [Note that this date only gets updated if something on the screen is changed]

M e a s u r e m e n t s / P a t h o l o g y *	
B MI	Clinical > Diabetes Record > Add Values or Assessment OR Tools > Weight Calculator
W ai st	Tools > Weight Calculator

Birth weight

For the Maternal Health Care report, CAT can extract the birth weight of the child from two sources. One is the child's record, which needs the weight entered and the date backdated to the child's birthday - this will be picked up under the 'Patient Record' report.

For the Mother's Antenatal report the birth weight of the child has to be recorded in the mother's record. Under the Obstetric tab the 'Past Pregnancy' button will open a new window where the details of the baby, including the birth weight, can be entered.

Past Obstetric History

Pregnancy No. 1Finish date: 29/08/20Gestation (wks):

Outcome

Normal vaginal delivery

☒ Para☐ Termination☐ Miscarriage

Notes:

Labour

Stage 1: 24hrsStage 2: 35minStage 3: 20min

Episiotomy/tear: Episiotomy

Baby

Name: BABE BABE

Birth weight (gms): 3200Gender: Female

Apgar 1:Apgar 5:

Feeding

☒ Breast☐ Bottle

Save

Cancel

FBG (BSLF)

Clinical > Diabetes Record > Add Values or Assessment
OR
Pathology HL7 results with LOINC codes 14771-0, 14996-3

Cholesterol

Clinical > Diabetes Record > Add Values or Assessment
OR
Pathology HL7 results

HDL

Clinical > Diabetes Record > Add Values or Assessment
OR
Pathology HL7 results

LDL

Clinical > Diabetes Record > Assessment
OR
Pathology HL7 results

T r i g l y c e r i d e s	Clinical > Diabetes Record > Add Values or Assessment OR Pathology HL7 results
C r e a t i n e	Clinical > Diabetes Record > Add Values or Assessment OR Pathology HL7 results
U r i n a r y c r e a t i n e	Pathology HL7 results with LOINC code 14683-7
M i c r o a l b u m i n	Clinical > Diabetes Record > Assessment (Microalbumin in units mg/L) OR Pathology HL7 results
A C R (M i c r o a l b u m i n C r e a t i n e R a t i o)	Clinical > Diabetes Record > Assessment (Microalbumin ratio) OR Pathology HL7 results with LOINC code 32294-1, 30000-4, 9318-7 or 14959-1 (units mg/mmol or g/mol) OR calculated from Microalbumin and Urinary Creatinine if results are on the same day
H b A 1c	Clinical > Diabetes Record > Add Values or Assessment OR Pathology HL7 results OR Additional test name 'Blood haemoglobin A 1 c'
BP	Clinical > Diabetes Record > Add Values or Assessment OR Tools > BP Monitor > Sitting

R e s p i r a t o r y – S p i r o m e t r y	Tools > Toolbox > Respiratory Calculator > FEV1 and FVC post values (entered manually or collected via a device)  Please note that currently only POST results are extracted by CAT4
I N R	Tools > Toolbox > INR Record > INR
P h y s i c a l A c t i v i t y	Assessment > Physical Activity (or running man icon) A physical activity assessment is deemed as done if either an assessment or a prescription is recorded. Where an assessment has been done, if the score is > 5 the patient meets the physical activity guidelines, otherwise they do not meet the guidelines. We are reporting: • Low (< 3 points) = Sedentary • Nearly there (>=3 points) = Insufficient • Active (>=5 points) = Sufficient
F O B T	Pathology HL7 results with LOINC code 2335-8, 27396-1, 14563-1, 14564-9, 14565-6, 12503-9, 12504-7, 27401-9, 27925-7, 27926-5, 57905-2, 56490-6, 56491-4, 29771-3 or with test names Faecal Occult Blood ,Faecal occult blood screening, Faecal Occult Blood Test, FOB, FOBT, Occult blood – faeces, Stool occult blood test, OCCULT BLOOD, faecal human haemoglobin, Insure FOBT, FOBT1, FOBT2, FOBT3, FOB1, FOB2, FOB3, Faecal Occult Blood1, Faecal Occult Blood2, Faecal Occult Blood3, BOW, IFOBT, OCCULT BLOOD (OCB-0), OCCULT BLOOD (OCB-1), OCCULT BLOOD (OCB-2), OCB NATIONAL SCREENING, FHB, FAECAL BLOOD, %FOBT%, %OCCULT%, Faecal Immunochemical Test, FAECAL HAEMOGLOBIN FOBT test orders are extracted with any of the test names above. The % indicates a wild card search which will pick up any test name with FOBT or OCCULT in the name. If no FOBT test is displayed on your list of available tests on the pathology request screen, you can add a new test. Please see here for details: Add Custom Pathology Requests to MD3
e G F R	Pathology HL7 results with LOINC code 33914-3 OR Renal Function Calculator OR Calculation (Refer Clinical Audit User Guide – Part 2 Functionality)
P a p S m e a r	Female Patient Record > Smears tab
R e c o r d e d	An entry is present on the tab
D o n e D a t e	Date of most recent entry
	Pathology HL7 Results

R e c o r d e d	True if a result exists
D o n e D a t e	Date of test result

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CAT checks for the test names in the list below:

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CERVICAL CONVENTIONAL SMEAR

CERVICAL CYTOLOGY

CERVICAL SMEAR

CERVICAL SMR

CYTOLOGY GYNAECOLOGICAL

CYTOLOGY GYNAECOLOGICAL (PAP-0)

GYNAE CYTOLOGY

GYNAECOLOGICAL CYTOLOGY

GYNEA CYTOLOGY

NON SCREENING PAP

NON SCREENING SMEAR

PAN-O

PAP

PAP (BALLARAT)

PAP (GEELONG)

PAP NS

PAP SMEAR

PAP SMEAR (PAN-0)

PAP SMEAR +/- THIN PREP

PAP SMEAR OLD

PAP SMEARS

PAP TEST

PAP-0 (PAP SMEAR)

PAPFU

PAPR

PAPR NS

THIN PREP ONLY

THINP

VAG SM

VAGINAL SMR

VAULT CYTOLOGY

VAULT SMEAR

Practices should check the test names appearing in the results tab and advise PCS if there is a test name that should be added to this list.

- 1) Smear tab – ticked to exclude OR
- 2) Coded condition of Hysterectomy:

! If you are not receiving your results electronically, you will have to enter the test results manually using one of the names specified in the mapping guides. Please check the links below for details. Also please note that CAT4 can't pick up a mammogram test from your conditions or past history list - it has to be a test name!

Mammogram results are not sent electronically in all states, but if test names are entered manually into the results tab CAT4 will pick up that the test has been done. The following test names are recognised:

- Breast Mammogram Screening
- Bilateral Mammography
- Ultrasound Breast Bilateral
- Wesley Breast Clinic Consultation Report
- Mammogram
- Mammogram-normal
- Breast Mammography
- Mammography - Bilateral
- Mammogram Breastscreen NSW
- Screening Mammogram - BreastScreen Queensland

To add a test name manually to the Results tab in MD3 and right click in the results area to bring up the 'Add' option:

Then add one of the test names above and save the result (there has to be some text in the result field but CAT4 will only extract the test name from the 'Subject' field:

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Past History screen > Checks the condition selected on history items, where Conditions are selected from a coded list.

Refer to the Appendices for a list of conditions mapping to each CAT condition.

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Current Rx screen >
Checks the Drugs listed, where Drugs are selected from a coded list

Refer to the Appendices for a list of medications mapping to each CAT medication.

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Current Rx screen > Counts All Drugs listed as current medications

* Refer to pathology note at the start of this manual