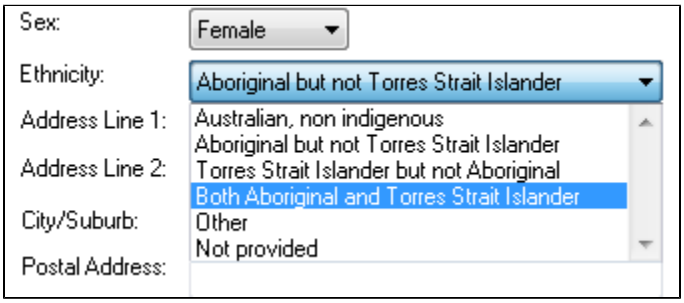
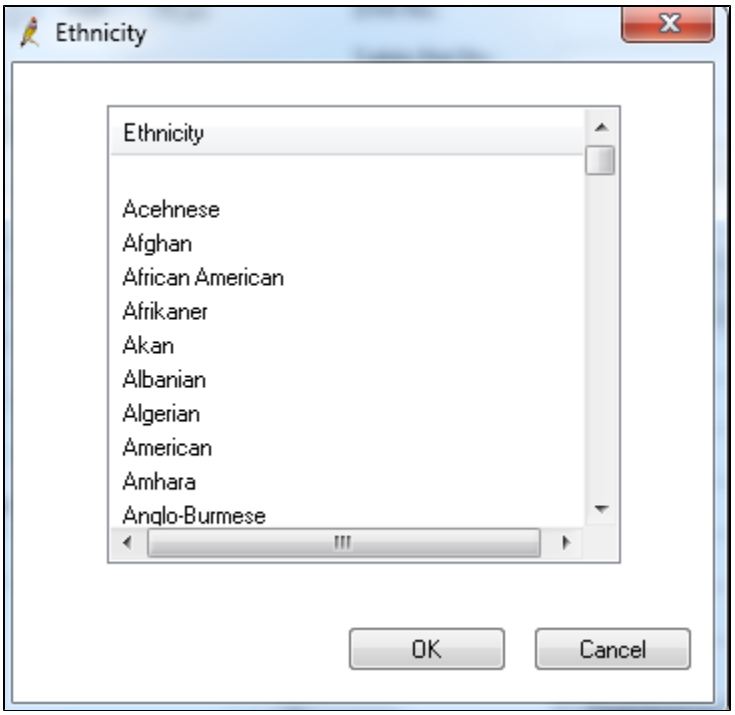
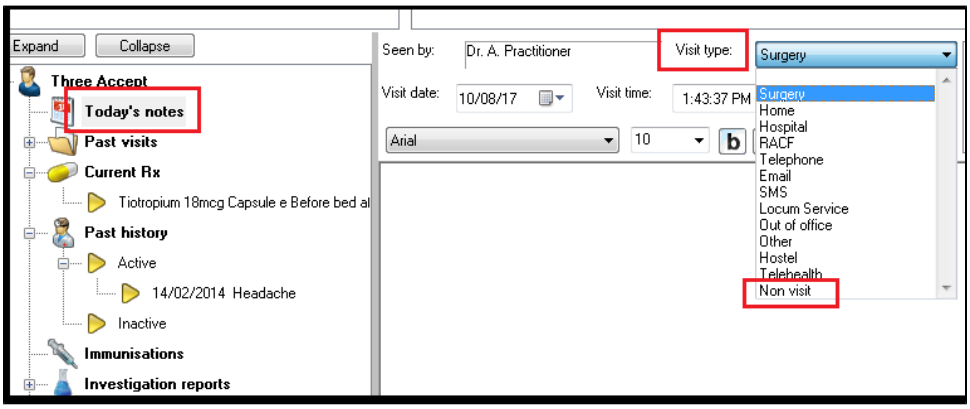
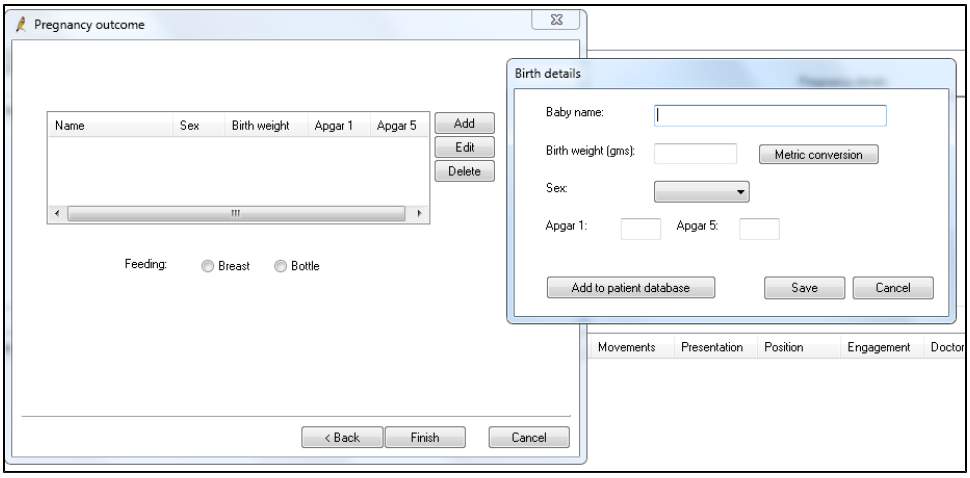
General Data Category Mappings BP

Demographic	Best Practice Data Mapping
Gender	Open > Demographics screen > Sex
Ethnicity	Open > Demographics screen >Drop down list for Aboriginal / TSI  When 'Other' is chosen, BP gives additional options for ethnicity. Only one option can be chosen: 

DVA	Open > Demographics screen > DVA No. has a value
Age	Open > Demographics screen > DOB
Last Visit / Activity	After entering notes on the 'Today's notes' tab, the visit will appear on the 'Past Visits' tab CAT will check the most recent date in the list **Visits flagged as Type = Non Visit are excluded.** Last Visit = the most recent date recorded Active = 3 or more visits recorded in the last 2 years Note: The past visits screen in Best Practice can be used by practices to record non clinical contacts, for example, when a recall letter is sent. T must be flagged a type **Non Visit** to be excluded by CAT. 
Postcode	Open > Demographics screen > Postcode
Family History	Main Patient Screen > Family & Social History any information entered on this form will be counted as family history information
Allergy	Main Patient Screen > Allergies / Adverse Drug Reactions Box
Allergy Recorded	An Allergy Item is present

No Known Allergies	The ‘Nil Known’ check box is checked
Nothing Recorded	No Allergy Items are present and the ‘Nil Known’ check box is unchecked
Smoking	Main Patient screen > Open > Alcohol and Smoking History > Tobacco
Smoking Cessation	Patient would like cessation advice yes/no will be mapped to: • Yes = Ready to Quit • No = Not Ready to quit
Daily Smoker	Smoker = Smoker is selected
Irregular Smoker	This option is not captured in Best Practice
Ex Smoker	Smoker = Ex-Smoker is selected

NeverSmoked	Smoker = Never smoked is selected
NothingRecorded	Smoker has nothing selected
ReviewDate	This will be the date something in the ‘Family & Social History’ section is changed. It is not possible to isolate Smoking changes.
Alcohol	Main Patient screen > Open > Alcohol and Smoking History > Alcohol Frequency = days a week patient usually drinks alcohol
Drinker	Frequency = any except Never
NonDrinker	Frequency = Never
NothingRecorded	Alcohol tab has nothing selected
ReviewDate	This will be the date something in the ‘Family & Social History’ section is changed. It is not possible to isolate Alcohol changes.

Measurements / Pathology *	Best Practice Mapping
BMI	Patient Record >Main Patient Screen > Observations screen
Waist	Patient Record >Main Patient Screen > Observations screen
Birthweight	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 w 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 'Past Pregnancy' on the 'Obs tab after adding the pregnancy outcome, BP will show a field for the birth weight of the child born. 
BSLF	Patient Record >Main Patient Screen > Observations screen OR Patient Record > Main Patient screen > Enhanced Primary Care > Diabetes Cycle of Care screen. OR Pathology HL7 results with LOINC codes 14771-0, 14996-3
Cholesterol	Lipids data : Patient Record > Main Patient screen > Enhanced Primary Care > Diabetes Cycle of Care screen. OR Pathology HL7 results

HDL	OR manually entered result
LDL	
Triglycerides	
Creatinine	Patient Record > Main Patient screen > Enhanced Primary Care > Diabetes Cycle of Care screen. OR Pathology HL7 results OR manually entered result
Urinary creatinine	Pathology HL7 results with LOINC code 14683-7
Microalbumin	Patient Record > Main Patient screen > Enhanced Primary Care > Diabetes Cycle of Care screen. OR Pathology HL7 results
ACR (Microalbumin Creatinine Ratio)	Listed in the BP database as an ACR result (with the BP pathology code 17) OR one of these LOINC codes: 32294-1,30000-4,9318-7,14959-1 OR one of these result names: Alb/Cre, Alb/Creat, Albumin/Creatinine, Albumin/Creatinine Ratio, Urinary Albumin/Creatinine Ratio, Urinary Albu Ratio, Microalbumin Ratio OR manually entered result

HbA1c	Patient Record > Main Patient screen > Enhanced Primary Care > Diabetes Cycle of Care screen. OR Pathology HL7 results OR manually entered result OR Additional test name 'Blood haemoglobin A 1 c'
BP	Patient Record > Main Patient screen either - opening the Observations screen, or - opening the Enhanced Primary Care > Diabetes Cycle of Care screen.
Respiratory - Spirometry	Clinical > Respiratory function OR Today's Notes >History and Examination > Respiratory > Calculator > FEV1 and FVC Please note that currently only POST results are extracted by CAT4
INR	Clinical > INR Manager
Physical Activity	Clinical > Physical Activity Prescription The prescription must be printed for it to be saved. A selected 'current physical activity level' of moderate or active meets the physical activity guidelines, otherwise they do not meet the guidelines We report Inactive as sedentary, Moderate and Active as sufficient.
FOBT	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, 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 occ OCCULT BLOOD, faecal human haemoglobin, Insure FOBT, FOBT1, FOBT2, FOBT3, FOB1, FOB2, FOB3, Faecal Occult Blood1, Faecal Occu Faecal Occult Blood3, BOW, IFOBT, OCCULT BLOOD (OCB-0), OCCULT BLOOD (OCB-1), OCCULT BLOOD (OCB-2), OCB NATIONAL SCF 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 FOB in the name.
eGFR	Pathology HL7 results with LOINC code 33914-3 OR Calculation (Refer Clinical Audit User Guide – Part 2 Functionality)

PapSmear	**Best Practice Mapping**
	Female Patient Record > Main Patient Screen > Cervical Smears tab (Manual entry or Pathology HL7 results)
Recorded	A smear test is listed
SmearDate	Date of most recent entry
BestPracticePapSmearHL7MapingTESTNAME	CCSR 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

Best Practice automatically recognises HL7 items as pap smear results if they are this list.	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.
Pap Smear Ineligible	**Best Practice Mapping**
	Cervical Smears screen - tick-box ‘Not Required’ checked Coded condition of Hysterectomy: see Diagnosis Codes Screening Tests

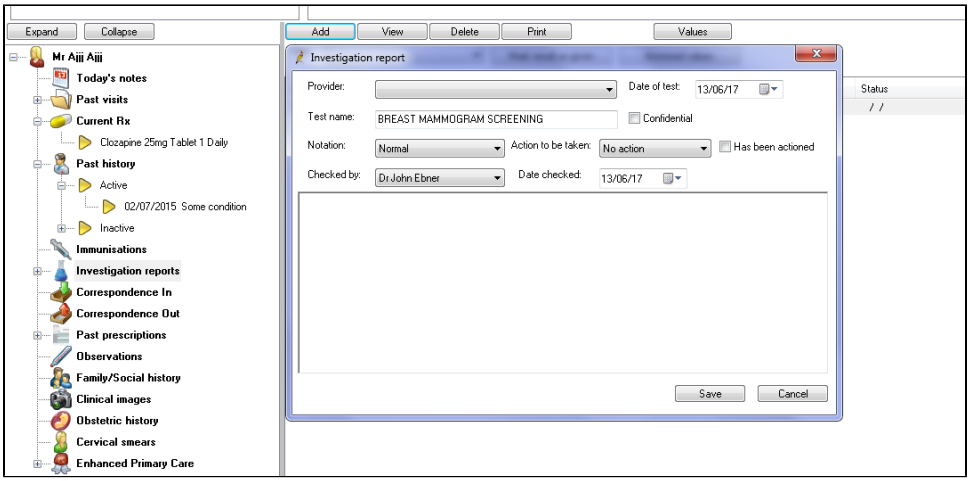
Mammogram

If you are not receiving your results electronically, you will have to enter the test results manually using one of the names specified in th guides. Please check the links below for details. Also please note that CAT4 can't pick up mammogram test from your conditions or pas - 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 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 manually add a mammogram result click on the 'Add' button under the 'Investigation report' tab, then enter one of the test names from above the other fields. CAT4 will only extract the test name and date but no outcome/result.



Disease

Best Practice Mapping

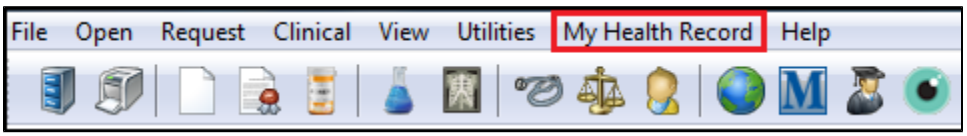
Condition

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

Refer to Appendix C-1 for a list of conditions mapping to each CAT condition.

Medications

Best Practice Mapping

Medication	Current Rx screen > Checks the Drugs listed as current medications, where Drugs are selected from a coded list. Refer to Appendix C-2 for a list of medications mapping to each CAT medication.
Medication Count	Current Rx screen > Counts All Drugs listed as current medications
My Health Record status	To update a patient's MHR status from unknown the 'My Health Record' menu needs to be accessed in BP. If no one has clicked on 'My Health CAT4 will list the status as 'unknown'. 

* Refer to pathology note at the start of this manual and Appendix