## **General Data Category Mappings MD3**

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 Medical Director Mapping

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 Patient Details screen > Sex

E th ni ci	Patient Details screen > ATSI > Drop down list for Aboriginal and/or TSI, non ATSI, Not Recorded
ty	Date of Birth: 23/06/1967 Gender: Female 🔻
	ATSI: Neither Aboriginal nor Torres Strait Islander
	Ethnicity: Aboriginal Torres Strait Islander Contact Detail: Aboriginal and Torres Strait Islander Neither Aboriginal nor Torres Strait Islander
	Residential Deviat Preferred Mailing Address @ Residential Postal
	Select Ethnicity
	Search < >
	- Most Commonly Used
	Torres Strait Islander
	Asian
	Inadequately Described      Not Stated
	- Vilasian
	African

		Indeclarity Prescribed		
		Not Stated		
		Eurasian		
		- African		
		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		
		🔠 🔚 Sub-Saharan African		
		•		
		OK Cancel		
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D		Patient Details Screen >		
VA		he Pension Status set to 'Full DVA' or 'Limited DVA' or the DVA No. field has a value		
	-			
A	F	Patient Details screen > DOB		
ge				

selections can be made

L a st i si t / A ct iv ity	Progress screen > Checks entries on previous visits list Last Visit = the most record date recorded Active = 3 or more entries recorded in the last 2 years Note: The progress screen in Medical Director is used by some practices to record non clinical contacts, for example, when a recall letter is sent. These contacts cannot be distinguished from clinical contacts by CAT. To correctly record a non clinical visit please use the 'Practice Admin' visit type in MD3.
P o st c o de	Patient Details screen > Postcode
Al le rgy	Patient Details > Allergies tab
Al le rg y R e c or d ed	An Allergy Item is present
N o K n w n Al le rg ies	The 'No Known Allergies' check box is checked
N ot n g R e c or d ed	No Allergy Items are present and the 'No Known Allergies' check box is unchecked

F a il y H is to ry	Family/Social Hx tab - any entry (free text) in the Family History box will be counted
S m o ki ng	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 ai ly S m o k er	Smoker = Smoker is selected and frequency is daily
lr g ul ar S m o k er	Smoker = Smoker is selected and frequency is not daily
E x S m k er	Smoker = Ex-Smoker is selected
N e v er S m o k ed	Smoker = Never smoked is selected
N ot hi n g R e c or d ed	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 vi 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 ri n k er	Frequency = any except Never
N o D ri k er	Frequency = Never
N ot hi n g R e c or d ed	Alcohol tab has nothing selected
R e vi 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 ur e m e nt s / P at h o o g y *	
B MI	Clinical > Diabetes Record > Add Values or Assessment OR Tools > Weight Calculator
W ai st	Tools > Weight Calculator

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' Bi

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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.

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ast Obstetric History	
Pregnancy No. 1	Finish date: 29/08/20     Gestation (wks):
Normal vaginal delivery	👻 💿 Para 💿 Termination 💿 Miscarriage
Notes:	*
Labour Stage 1: 24hrs Episiotomy/tear:	Stage 2: 35min Stage 3: 20min
Baby Name: BABE BABE	
Birth weight (gms): 3200 Apgar 1:	Gender: Female Feeding Apgar 5: OB Bottle
	Save Cancel
inical > Diabetes Record > Add \ R thology HL7 results with LOINC	
inical > Diabetes Record > Add \ R thology HL7 results	/alues or Assessment
nical > Diabetes Record > Add \ २ thology HL7 results	/alues or Assessment
inical > Diabetes Record > Asses ? thology HL7 results	sment

T gl y c er id es	Clinical > Diabetes Record > Add Values or Assessment OR Pathology HL7 results
C re at in ine	Clinical > Diabetes Record > Add Values or Assessment OR Pathology HL7 results
U ri n ar y cr e at in ine	Pathology HL7 results with LOINC code 14683-7
M ic ro al b u m in	Clinical > Diabetes Record > Assessment (Microalbumin in units mg/L) OR Pathology HL7 results
A C R ( M ic ro al b u m in C re at in e R at io)	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

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R e s	Tools > Toolbox > Respiratory Calculator > FEV1 and FVC post values (entered manually or collected via a device)		
pi ra to	Please note that currently only POST results are extracted by CAT4		
ry – S pi ro m et ry			
l NR	Tools > Toolbox > INR Record > INR		
P h y si c al A ct iv ity	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 BT	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 FR	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 ar	Female Patient Record > Smears tab		
R e c or d ed	An entry is present on the tab		
D o n e D ate	Date of most recent entry		
	Pathology HL7 Results		

R e	True if a result exists
c	
or	
d	
ed	
D o	Date of test result
n	
е	
D	
ate	

T e

CAT checks for the test names in the list below:

st CCSR N

a CERVICAL CONVENTIONAL SMEAR

me 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.

P a p S m e ar In e i g i b le	<ol> <li>Smear tab – ticked to exclude OR</li> <li>Coded condition of Hysterectomy:</li> </ol>
M a	
m m o g r am	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:
	Add Investigation Result
	Start Patient : Andrews, Sally       21 Best St, Pill Land         Birthdate : 12/05/98 Age: 19 yrs       Sex: F         Your Reference: 8       Date Requested:         Tuesday , 13       June         2017
	Result

	Imm.     Pap Test     Imm.     Pap Test     Imm.     Pap Test     Imm.     MDExchange       Correspondence     Imm.     Pap Test     Imm.     Pap Test     Imm.     Imm.     MDExchange       Correspondence     Imm.     Pap Test     Imm.     Pap Test     Imm.     Imm.     Imm.       Correspondence     Imm.     Imm.     Pap Test     Imm.     Imm.     Imm.     Imm.       Correspondence     Imm.     Imm.     Pap Test     Imm.     Imm.     Imm.     Imm.       Correspondence     Imm.     Imm.     Imm.     Imm.     Imm.       Correspondence     Imm.     Imm.     Imm.     Imm.     Imm.       Imm.     Imm.     Imm.     Imm.     Imm.     Imm.       Im
	Preview - Full 👻 Hide Preview   Clear Filters   Move Location   Document Details   Scan 👻 Import 👻 Print 👻 Add   Delete   Search
	1 of 1 Records Select All
	Date Checked IV       Image: Checked IV       Imag
	Image: Stat Patient : Andrews, Sally     BREAST MAMMOGRAM SCREENING       21 Best St, Pil Land     BREAST MAMMOGRAM SCREENING       Brithdate     12 /05 /9 Age: 13 yrs       Sex. F     Lab. Reference:
	Your Reference: 8 Requested: 13/06/17 Complete: Performed: 13/06/17
	n/a
D is e a s es	
C o n di ti on	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.
M e di c at io ns	
M e di	Current Rx screen > Checks the Drugs listed, where Drugs are selected from a coded list
c at ion	Refer to the Appendices for a list of medications mapping to each CAT medication.
M e di c at io n C o u nt	Current Rx screen > Counts All Drugs listed as current medications

\* Refer to pathology note at the start of this manual