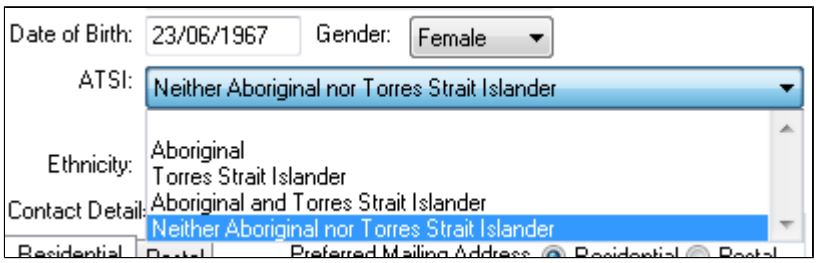
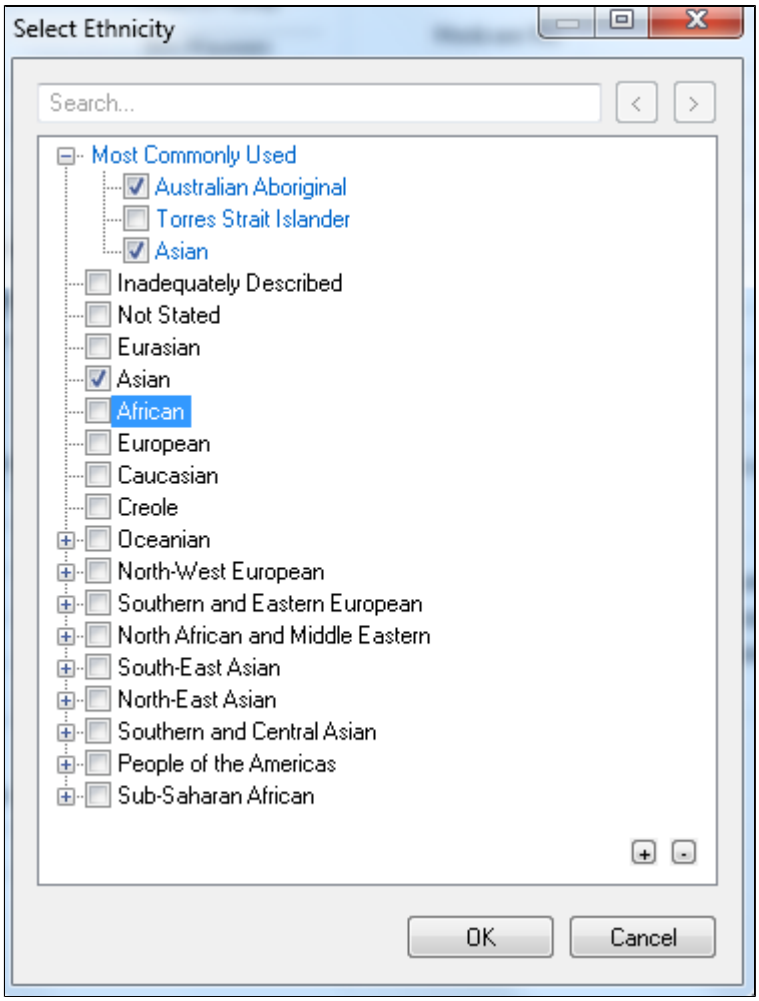
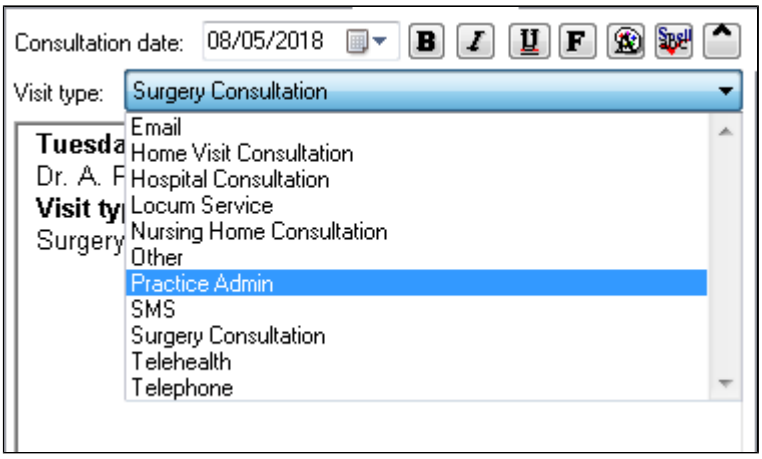
General Data Category Mappings MD3

Demographic	Medical Director Mapping
Gender	Patient Details screen > Sex

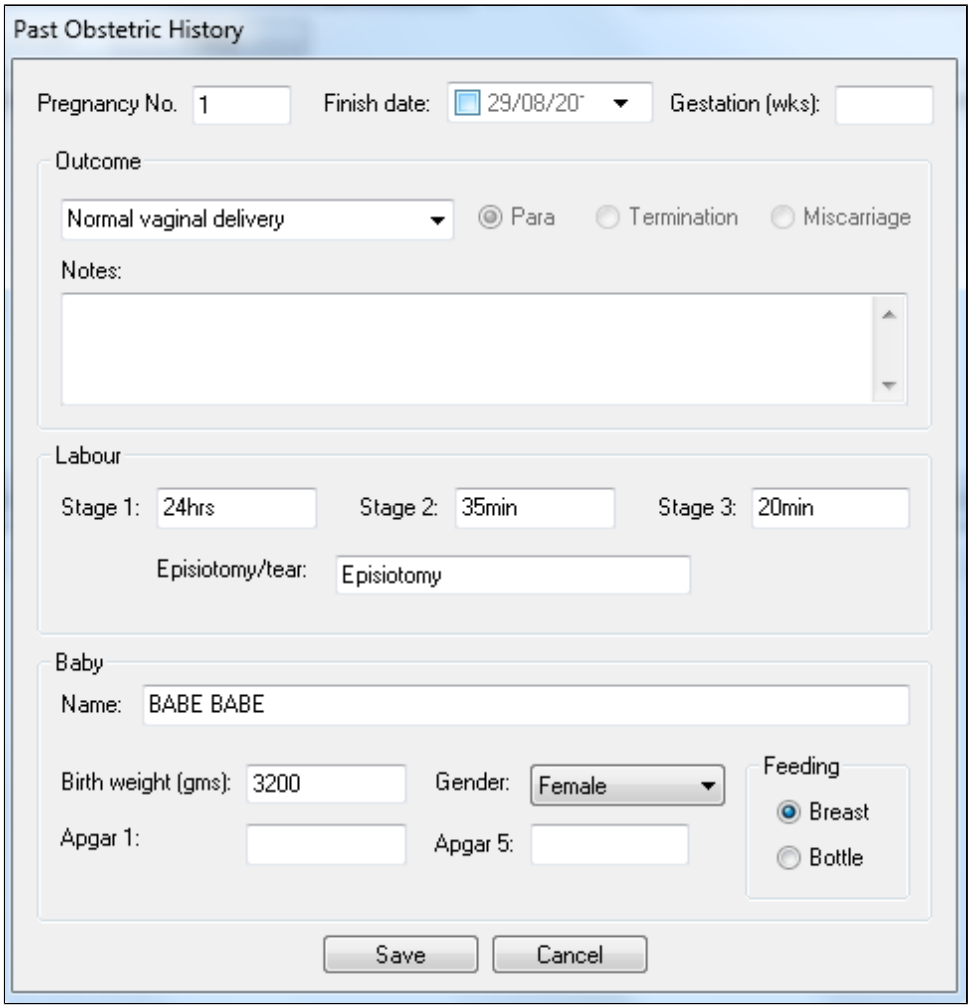
Ethnicity	Patient Details screen > ATSI > Drop down list for Aboriginal and/or TSI, non ATSI, Not Recorded  Patient Details screen > Ethnicity > ... button will open up a list of countries/ethnicities. Multiple selections can be made 
DVA	Patient Details Screen > the Pension Status set to 'Full DVA' or 'Limited DVA' or the DVA No. field has a value
Age	Patient Details screen > DOB

Last Visit/Activity	Progress screen > Checks entries on previous visits list Last Visit = the most recent 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. 
Postcode	Patient Details screen > Postcode
Allergy	Patient Details > Allergies tab
AllergyRecorded	An Allergy Item is present
NoKnownAllergies	The 'No Known Allergies' check box is checked
NothingRecorded	No Allergy Items are present and the 'No Known Allergies' check box is unchecked

FamilyHistory	Family/Social Hx tab - any entry (free text) in the Family History box will be counted
Smoking	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.]
DailySmoker	Smoker = Smoker is selected and frequency is daily
IregularSmoker	Smoker = Smoker is selected and frequency is not daily
ExSmoker	Smoker = Ex-Smoker is selected
NeverSmoked	Smoker = Never smoked is selected
NothingRecorded	Smoker has nothing selected

StateofChangeAssessment	Not ready = not ready Unsure = Intends to quit Ready = Ready Recent quitter = Other
ReviewDate	Date of Assessment [Note that this date only gets updated if something on the screen is changed]
Alcohol	Patient Details > Alcohol tab > Frequency = days a week patient usually drinks alcohol
Drinker	Frequency = any except Never
NonDrinker	Frequency = Never
NothingRecorded	Alcohol tab has nothing selected
ReviewDate	Date of Assessment [Note that this date only gets updated if something on the screen is changed]

Measurements/Pathology*	
BMI	Clinical > Diabetes Record > Add Values or Assessment OR Tools > Weight Calculator
Waist	Tools > Weight Calculator

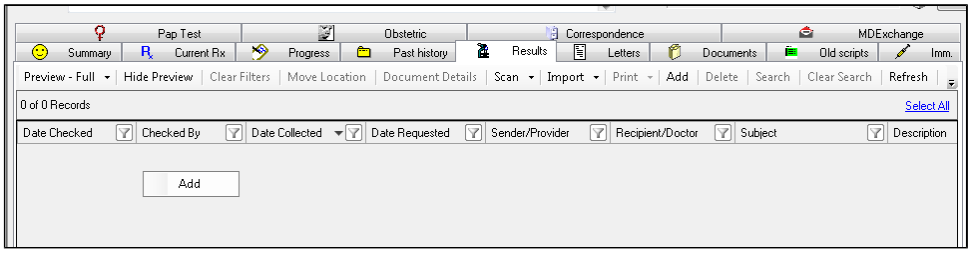
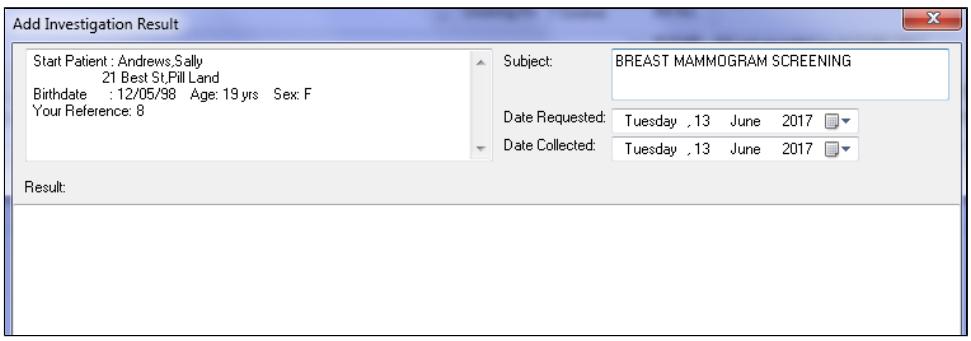
Birth weight	For the Maternal Health Care report, CAT can extract the birth weight of the child from two sources. One is the child's record, which needs the weight entered and the date backdated to the child's birthday - this will be picked up under the 'Patient Record' report. For the Mother's Antenatal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

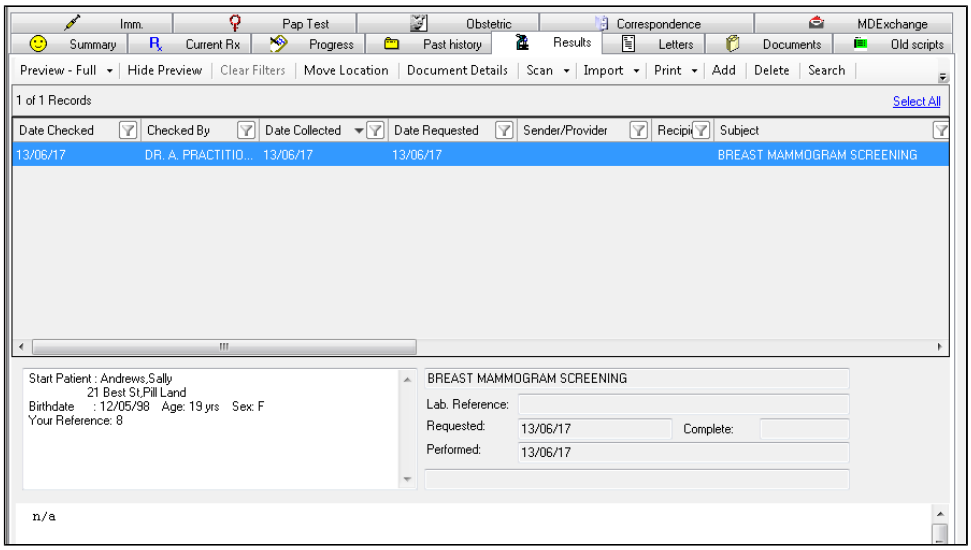
Triglycerides	Clinical > Diabetes Record > Add Values or Assessment OR Pathology HL7 results
Creatinine	Clinical > Diabetes Record > Add Values or Assessment OR Pathology HL7 results
Urinary creatinine	Pathology HL7 results with LOINC code 14683-7
Microalbumin	Clinical > Diabetes Record > Assessment (Microalbumin in units mg/L) OR Pathology HL7 results
ACR (Microalbumin Creatinine Ratio)	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
HbA1c	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

Respiratory – Spirometry	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
INR	Tools > Toolbox > INR Record > INR
Physical Activity	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
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, 57905-2,56490-6,56491-4,29771-3 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
eGFR	Pathology HL7 results with LOINC code 33914-3 OR Renal Function Calculator OR Calculation (Refer Clinical Audit User Guide – Part 2 Functionality)
PapSmear	**Female Patient Record > Smears tab**
Recorded	An entry is present on the tab
DoneDate	Date of most recent entry
	Pathology HL7 Results

Recorded	True if a result exists
DoneDate	Date of test result

TestName	CAT checks for the test names in the list below: 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 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	1) Smear tab – ticked to exclude OR 2) Coded condition of Hysterectomy:
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 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: 

	
Diseases	
Condition	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.
Medications	
Medication	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.
MedicationCount	Current Rx screen > Counts All Drugs listed as current medications

* Refer to pathology note at the start of this manual