



Data for Decisions Patron Databook 2.0

Department of General Practice
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CATEGORY	DESCRIPTION	EXAMPLE DATA AVAILABLE
PATIENT DETAILS		
Patient Details	This category stores the main demographic information about the patient	<ul style="list-style-type: none"> • Birth Year • Death Year (if applicable) • Gender • ATSI status • Ethnicity
SEIFA	Socio-Economic Indexes for Areas	<ul style="list-style-type: none"> • Indexes based on postcode
CLINICAL INFORMATION		
General	General clinical information	<ul style="list-style-type: none"> • Marital status • Sexuality • NKA (no known allergies) • Alcohol non-drinker flag
Alcohol	Alcohol Consumption (AUDIT-C)	<ul style="list-style-type: none"> • Assessment Date • AUDIT-C score • Alcohol frequency • Standard drinks per day • Binge drinks flag
Allergies/Reactions	Allergy and adverse reaction records	<ul style="list-style-type: none"> • Allergy /reaction type • Allergy reaction name • Allergy/reaction severity
Cervical screening	Result of Papanicolaou test or cervical screening (HPV) tests	<ul style="list-style-type: none"> • Date • Result • HPV 16, 18 or other result • Pap Smear or Cervical Screen flag • Screening no longer required or patient screening opt out
Immunisations	Vaccination type and administration information	<ul style="list-style-type: none"> • Date administered • Immunisation name • Batch • Sequence • Administration site • Route • Vaccination provided at clinic or elsewhere

CLINICAL INFORMATION <i>continued</i>		
Observations	Observation information	<ul style="list-style-type: none"> • Observation Date • Observation name • Observation value
Smoking	Smoking information	<ul style="list-style-type: none"> • Assessment Date • Smoking status • Smoking frequency • Smoker per day • Smoking cessation (if applicable)

MEDICAL HISTORY		
Medical History	Medical conditions or symptoms which have been recorded in the patient medical history.	<ul style="list-style-type: none"> • Condition name/description • Condition code • Onset & Diagnosis date • Active/inactive condition • Provisional/Confirmed flag

ENCOUNTER CHARACTERISTICS		
Clinical encounter characteristics	Clinical characteristics of encounters	<ul style="list-style-type: none"> • Visit Date • Visit Type • Duration • Worker type who recorded the encounter • Non visit flag (if encounter is a non-clinical encounter)
Encounter Reason	Reason for encounter	<ul style="list-style-type: none"> • Visit Date • Visit Reason • Visit Reason Code

MEDICATIONS		
Active Prescription List	List of currently prescribed medications.	<ul style="list-style-type: none"> • Date first prescribed • Date last Prescribed • Deleted/ceased date and reason • Medication prescribed details <ul style="list-style-type: none"> ○ Generic, Trade, Brand names ○ Strength ○ Quantity ○ Dose ○ Frequency ○ Formulation ○ Route • Repeats • Instructions • Reason for prescription • Reason Code

MEDICATIONS <i>continued</i>		
Prescriptions Issued	Record of all prescriptions that have been printed.	<ul style="list-style-type: none"> • Prescription Date • Printed status • Age at Prescription • Medication prescribed details <ul style="list-style-type: none"> ○ Generic, Trade, Brand names ○ Strength ○ Quantity ○ Dose ○ Frequency ○ Formulation ○ Route • Repeats • Instructions • Reason for prescription • Reason Code

INVESTIGATIONS		
Returned Test Names	Test Names and dates that have been imported from pathology organisations.	<ul style="list-style-type: none"> • Test name or grouped Test name (e.g. Lipid Panel) • Request date • Collected date • Report Date
Returned Test results	Pathology results that have been imported from pathology companies or have been manually added.	<ul style="list-style-type: none"> • Individual result name (e.g. HDL/LDL/Sodium) • Report Date • Result value • LOINC Code • Unit • Range
Investigations Requested	Requested pathology and imaging results	<ul style="list-style-type: none"> • Request date • Request type i.e. Pathology or Imaging • Name(s) of tests requested • Fasting Flag

DOCUMENTS		
Documents In	Documents received by the practice such as referrals in, letters and discharge summaries	<ul style="list-style-type: none"> • Document Date • Document Type, Category, Subject
Documents Out	Documents that have been sent by the practice such as Referrals out, Care plans, and Medical Certificates	<ul style="list-style-type: none"> • Document Date • Document Type, Category, Subject
Document MyHR	Shared health summaries and event summaries that have been uploaded to MyHealthRecord	<ul style="list-style-type: none"> • Document Date • Document Type, Category, Subject

FAMILY HISTORY		
Family History	Family information	<ul style="list-style-type: none"> • Maternal & Paternal death details • Family condition history

MBS BILLING		
MBS Billing items	Record of the MBS item numbers billed by a health professional working at the clinic.	<ul style="list-style-type: none"> • Date of Service • MBS Item Number • MBS Item Description • Service Status (e.g. Paid, Cancelled)

PRACTICE WORKER TYPE		
Clinic Worker	De-identified information about clinic workers, including role	<ul style="list-style-type: none"> • Worker type (e.g. GP, Practice nurse) • Provider flags (if worker has a provider number, prescriber number and/or registration number)

MATERNAL OBSTETRICS		
Pregnancies	Current and historical pregnancy information	<ul style="list-style-type: none"> • Pregnancy Number • LMP • EDC • Delivery Date • Delivery Outcome • Baby birth gender • Baby birth weight

PATIENT ADJUNCT		
Patient pre-mapped data	The Adjunct table implements clinical phenotype mapping that will lead to consistency in research and time saving for researchers in leveraging existing work.	Phenotypes include <ul style="list-style-type: none"> • Conditions • Pathology • Observations • Medications <i>New phenotypes are continuously being added</i>