



# Data for Decisions Patron Databook 3.0

Department of General Practice  
Melbourne Medical School  
Faculty of Medicine, Dentistry and Health Sciences

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

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

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

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

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

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

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

<b>DOCUMENTS</b>		
Documents In	Documents received by the practice such as referrals in, letters and discharge summaries	<ul style="list-style-type: none"> <li>• Document Date</li> <li>• Document Type, Category, Subject</li> </ul>
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"> <li>• Document Date</li> <li>• Document Type, Category, Subject</li> </ul>
Document MyHR	Shared health summaries and event summaries that have been uploaded to MyHealthRecord	<ul style="list-style-type: none"> <li>• Document Date</li> <li>• Document Type, Category, Subject</li> </ul>

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

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"> <li>• Date of Service</li> <li>• MBS Item Number</li> <li>• MBS Item Description</li> <li>• Service Status (e.g. Paid, Cancelled)</li> </ul>

PRACTICE		
Practice Profile	An overview profile of the practice data.	<ul style="list-style-type: none"> <li>• Latest Exported Date</li> <li>• Source System</li> <li>• MMM classification</li> <li>• PHN Code</li> <li>• Active patient counts</li> </ul>
Clinic Worker	De-identified information about clinic workers, including role	<ul style="list-style-type: none"> <li>• Worker type (e.g. GP, Practice nurse)</li> <li>• Provider flags (if worker has a provider number, prescriber number and/or registration number)</li> </ul>

MATERNAL OBSTETRICS		
Pregnancies	Current and historical pregnancy information	<ul style="list-style-type: none"> <li>• Pregnancy Number</li> <li>• LMP</li> <li>• EDC</li> <li>• Delivery Date</li> <li>• Delivery Outcome</li> <li>• Baby birth gender</li> <li>• Baby birth weight</li> </ul>
Antenatal Visits	Pregnancy observation details that are recorded at each antenatal visit.	<ul style="list-style-type: none"> <li>• Antenatal observations (eg. BP, weight, foetal size and presentation)</li> </ul>

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"> <li>• Conditions</li> <li>• Pathology</li> <li>• Observations</li> <li>• Medications</li> <li>• MBS item categories</li> </ul> <i>New phenotypes are continuously being added</i>