My Health Record
Rapid Reference Tools

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Shared Health Summary

What is it?

They are typically completed by a person's General Practitioner, a Registered Nurse or an Aboriginal or Torres Strait Islander Health Practitioner. It may include past medical history information, allergies, an immunisation history and any previous adverse medication reactions. It may include past medical history, current medicines list, allergy information, immunisation history and any previous adverse medicines reactions.

Considerations

- Shared health summaries are presented sequentially and may have been authored by different clinicians.
- Because a shared health summary can be uploaded by different healthcare providers, you may choose to view multiple summaries to gain a more complete clinical picture.

For more information:
myhealthrecord.gov.au

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Event Summary

What is it?

An Event Summary should reflect a single episode in a patient's health care.

Event summaries can be authored by a variety of healthcare professionals such as those staffing after-hours GP clinics, hospitals, community pharmacies or an allied health professional.

Considerations

- Due to the multi-purpose nature of event summaries, it is expected that the number of documents and the types of information appearing in this section of a patient's My Health Record will increase over time.
- If you are looking for particular details relating to a specific episode of care, it can be helpful to filter this list by 'date', 'document type' or 'registered healthcare provider organisation.
- In some states and territories, ED discharge summaries might be classified as event summaries.

For more information:
myhealthrecord.gov.au

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Advance Care Planning Information

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What is it?

This section of My Health Record is where consumers (or their authorised representative / full-access nominated representative) can upload documents referring to their end-of-life wishes in the form of a PDF file. Consumers can also add the contact details of their advance care document custodian.

Considerations

- At present, only consumers (or their authorised representative / full-access nominated representative) can upload to this section of the My Health Record. Documents should be used as a guide to assist clinical decision making.
- Since there is no standardised format around the source of these consumer initiated documents, their presence in My Health Record does not imply any legal integrity.
- Be aware that end-of-life documentation uploaded to My Health Record is by consumers themselves and not via their GP or a hospital.

For more information:
myhealthrecord.gov.au

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Pathology & Diagnostic Imaging Reports

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What is it?

This section contains pathology and diagnostic imaging results from any provider that is connected to the My Health Record.

Only results for investigations that have occurred after a consumer's record has been created will be uploaded – retrospective reports are not available for viewing. There may be some historical trending in pathology reports.

Considerations

- There is a 7-day delay before consumers can see results in their My Health Record. Clinicians can see any results as soon as a report is uploaded by a provider.
- Some states and territories prevent any uploading of sensitive results (e.g. HIV and other sexually transmitted / blood-borne disease results).
- Results are presented as the original PDFs from pathology and diagnostic imaging providers in reverse chronological order. These reports can be filtered by date range.
- Whilst My Health Record contains diagnostic imaging reports, some states and territories have their own repositories for directly viewing images.

For more information:
myhealthrecord.gov.au

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Prescription and Dispense Views

What is it?

The Prescription and Dispense views are two similar-looking documents that are produced when medications are prescribed and dispensed in the community. They are auto-generated by a GP or community pharmacist's conformant software respectively. Both should have the dosing instructions and cover PBS and non-PBS medications.

Considerations

- Since these documents refer only to medications prescribed and dispensed at any one time, they should not be taken as a full record of a consumer's current medication list.
- The prescription view will not include handwritten or private prescriptions.
- Both the prescription and dispense view might be presented to look like one document, depending on the viewing platform.
- You can see a cumulative view of medicines information in the Medicines View.

For more information:
myhealthrecord.gov.au

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Medicare and Pharmaceutical Benefits Scheme (PBS) Information

What is it?

As consumers interact with the Medicare system, a record of these interactions will be displayed in their My Health Record. When a consumer's My Health Record has been activated, the previous 2 years of their Medicare and PBS transactional data is automatically populated.

This can include:

- Medicare Benefits Schedule (MBS) items
- Pharmaceutical Benefits Scheme (PBS) medication data
- Australian Organ Donor Registration (AODR) status
- Australian Immunisation Register (AIR) – including childhood immunisations

Considerations

- If consumers are activating their record for the first time, they will be given the option to have the past 2 years' MBS and PBS data populated into their record.
- Be aware that immunisation and organ donor information (if included) is listed at the end of the MBS and PBS section.
- Like with other aspects of My Health Record, consumers can restrict or remove Medicare and PBS data entries, so this may not be a complete record of all interactions.
- Medication listings are PBS-only and will not include medications dispensed that are not PBS-classified (e.g. private or NSW hospital scripts).
- Dosing instructions are not included in the PBS transactional data.

For more information:
myhealthrecord.gov.au

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Medicines Information View

What is it?

The Medicines Information View is a combination of several key My Health Record clinical documents integrated into one convenient summary.

Medicines and Allergy information may be drawn from:

- Recent **prescription** and **dispensing information** and data from PBS claims
- Recent **discharge** and **shared health summaries**
- **Specialist letters**, **event summaries** and notes from **eReferrals**
- Information from a **personal health summary** that may include allergies or previous adverse reactions

Considerations

- Like the other information in a consumer's My Health Record, the Medicines Information View might not be a fully comprehensive record of a patient's medication history.
- Other sources of medicines information may be required to support any clinical decisions you make.

For more information:
myhealthrecord.gov.au

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Discharge Summary

What is it?

A Discharge Summary is created from the hospital's Clinical Information System and is uploaded to the My Health Record. Whilst the appearance might look different from the original, the clinical content will be the same.

Considerations

- The majority of hospital inpatient discharge summaries are being uploaded to My Health Record. However, it is important to note that not all summaries or discharge letters are uploaded to a patient's record.
- Patients may request the discharge summary not be uploaded to My Health Record during their hospital stay.
- It is important to be familiar with local processes to withhold uploading clinical documents to My Health Record.

For more information:
myhealthrecord.gov.au

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Specialist Letters

What is it?

The My Health Record Specialist Letter is where communication following a specialist appointment will be documented. These letters may include clinical information about all aspects of a patient's history or information relevant to a particular consultation.

Considerations

- There is ongoing work to increase the number of Specialists practicing in private rooms who are connected to the My Health Record system.
- Currently, letters from hospital outpatient departments are not typically uploaded to My Health Record. However, some states and territories are working to enable this functionality.

For more information:
myhealthrecord.gov.au

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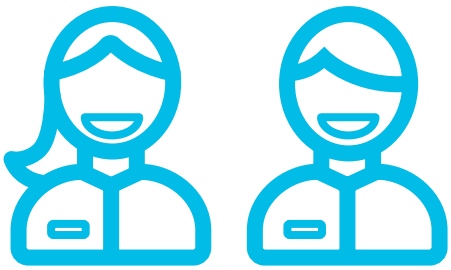
Child Development Information



What is it?

The Child Development section of My Health Record allows consumers to upload information relating to childhood health.

It includes the following sections:

- An Achievement Diary
- Personal Observations
- Immunisations
- Child Health Check Schedule
- Growth Charts
- Information for Parents

Considerations

This section is currently being reviewed by the National Children's Digital Health Collaborative and additional, integrated functionality may be available in the future.

For more information:
myhealthrecord.gov.au

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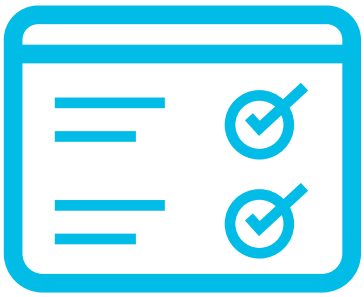
eReferrals



What is it?

The eReferral document is a tool designed for GPs to be able to refer a patient to a Specialist or other healthcare provider.

This structured document may contain information such as:

- Current and past medications
- Current medication
- Allergies and adverse reactions
- Diagnostic investigations performed

An optional 'reason for referral' free-text section is also included in the body of the document.

Considerations

- Ongoing work is being undertaken to increase the number of eReferrals in the My Health Record.
- Be aware that some states and territories are developing stand-alone electronic referral systems that may also be called eReferrals.

For more information:
myhealthrecord.gov.au

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