

Ambulance Care Summary Standard Draft

HISO 10052:2026

Te Kāwanatanga o Aotearoa
New Zealand Government

hiso

Health Information Standards Organisation
PAEREWA PĀRONGO HAUORA

Health New Zealand
Te Whatu Ora

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1. Introduction

1.1 Background

To provide high-quality ambulance care in New Zealand we need to underpin ambulance clinical practice with information that supports

- the care of patients, family and whānau
- continuity of care
- best practice
- analytics

This standard presents a minimum data set specification for the collection, representation, and sharing of patient information in an ambulance setting. The standard is designed to ensure that information related to ambulance care is consistently recorded. It is intended to support transfer of patient care between an ambulance operator and another health care provider and to form part of a patient's permanent shared clinical record.

1.2 Purpose

HISO 10052 Ambulance Care Summary Standard was first released in 2015 as an interim standard to support road ambulance services' transition from paper to electronic clinical records, and to guide electronic transfer of care records between ambulance and hospital systems.

This second release supersedes the original and brings the standard up to date by:

- including a wider scope of practice of paramedicine (eg, community-based care, telephone consultations, aeromedical cases)
- updating the range of skills held by ambulance clinicians
- allowing exchange of electronic referrals with both health care and social service providers
- conforming to [HISO 10099:2022 New Zealand Patient Summary](#)

1.3 Definitions of key terms

Term	Description
Ambulance operator	An organisation that provides road or air ambulance services in New Zealand.
Clinician	A practitioner who provides clinical services to a patient on behalf of an ambulance operator; either: <ul style="list-style-type: none">• A person registered as a paramedic with Te Kaunihera Manapou Paramedic Council under the Health Practitioners Competence Assurance Act 2003 (HPCA Act)• Somebody other than a paramedic (eg, a doctor or nurse) registered under the HPCA Act

	<ul style="list-style-type: none"> An unregistered person with authority to practice (ATP) delegated by an ambulance operator's Medical Director
Incident	An occurrence requiring delivery of an ambulance service to one or more patients. When more than one patient is involved in an incident an ambulance care summary is completed for each of them. May be referred to informally as a "job" or "case".
Patient	Ambulance operators refer to any person receiving care from an ambulance operator as a "patient".

1.4 Scope

Ambulance operators collect patient information when responding to a request for help. A record is created for any clinical contact between a patient and a clinician. This includes providing telephone advice when the clinician does not see the patient in person.

This standard describes the subset of information made available to other health care providers (including other ambulance operators) involved in the care of a particular patient, providing the data set specification for sharing ambulance care summary information, ie, **what** information is to be shared. The standard will be supported by other specifications that describe **how** information sharing is to occur electronically by various methods, eg, via HL7® FHIR® interfaces or database schemas.

The ambulance care summary information has two purposes:

- to brief the person taking responsibility at transfer of care time (eg, when a patient is handed over at a hospital emergency department or from a road to an air ambulance operator) and to then form part of the patient's permanent shared clinical record.
- to advise an enrolled patient's GP that they had a clinical contact with the ambulance service when they were not transported to a health care facility (the assumption being that if the patient was transported then the receiving facility will advise their GP).

No record is created for incidents not requiring ambulance response (eg, nuisance 111 calls), or where the ambulance operator is providing transportation only and does not treat the patient (eg, an inter-hospital transfer with a nurse escort present).

The following is additional information collected by ambulance operators but is not covered by this standard:

- for administrative purposes.
- to record non-clinical contacts such as patient transfers.
- to help to improve ambulance operators' service.
- to contribute to an understanding of the population's ambulance service needs.
- to analyse the efficacy of care contributed by the ambulance operators.

1.5 Relevant New Zealand legislation and regulations

Accident Compensation Act 2001

Health Act 1956

[Health and Disability Commissioner \(Code of Health and Disability Services Consumers' Rights\) Regulations 1996](#)

[Health Information Privacy Code 2020](#)

[Health Practitioners Competence Assurance Act 2003](#)

[New Zealand Public Health and Disability Act 2000](#)

[Pae Ora \(Health Futures\) Act 2022](#)

[Privacy Act 2020](#)

[Public Records Act 2005](#)

[Retention of Health Information Regulations 1996](#)

1.6 Related specifications

[HISO 10099:2022 NZ Patient Summary](#)

[HISO 10046:2024 Consumer Health Identity Standard](#)

[HISO 10048 Emergency Care Data Standard](#)

[HISO 10005:2008 Health Practitioner Index \(HPI\) Data Set](#)

[HISO 10006:2008 Health Practitioner Index \(HPI\) Code Set](#)

[HISO 10033 SNOMED CT Endorsement](#)

[ISO/IEC 11179-1:2023 Information technology Metadata registries \(MDR\)](#)

[NZ Government Customer Information Quality \(CIQ\) Profiles](#)

[Common code tables for use with the national collections](#)

[New Zealand Universal List of Medicines \(NZULM\)](#)

[HISO 10042 Medication Charting and Medicine Reconciliation Standards](#)

[Design and trial of a new ambulance-to-emergency department handover protocol: 'IMIST-AMBO'](#)

1.7 Acknowledgement of gender diversity

Health NZ acknowledges that not all patients identify with the gender they were assigned at birth. Gender neutral terms are included alongside gendered terms where possible in this standard to ensure greater inclusion and representation. Health NZ is working to ensure our standards are more inclusive for the people they are relevant to. Further information regarding this work can be found on the [Health NZ website](#).

Health professionals and those involved in the care of patients should ensure they know the pronouns and name each person uses so that these are used correctly and documented in their records.

1.8 Data element templates

1.8.1 Data element format

Data element specifications are presented in the following templated form based on publicly available standard **ISO/IEC 11179 Information Technology – Metadata Registries (MDR)**.

Name	Data element name				
Definition	A statement that expresses the essential nature of the data element				
Source standards	Established standards or guidelines pertaining to the data element				
Value domain	<p>The named, enumerated or bounded set of valid values or codes that are acceptable for the data element</p> <p>Each coded data element has a specified code set</p> <p>The value domain may simply be a data type, with or without bound constraints</p> <p>Can add table:</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Preferred term</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> </tbody> </table>	Code	Preferred term		
Code	Preferred term				
Data type	<p>Data type and precision associated with the value domain:</p> <ul style="list-style-type: none"> • Alphabetic (A) • Boolean • String (X) • Date • Date/time • Numeric (N) • Decimal • SNOMED CT identifier (SCTID) 				
Layout	<p>The formatted arrangement of characters with 'A' for alpha, N for numeric and X for alphanumeric, eg:</p> <ul style="list-style-type: none"> • X(50) for a 50-character alphanumeric string • NNN for a 3-digit number 				
Unit of measure	<p>Unit of measure for the value domain</p> <p>The unit of measure is appropriate to the dimensionality of the conceptual domain associated with the value domain – eg, the choice of metre (m) as the unit of measure of a length data element</p>				

Obligation	<p>Indicates if the data element is mandatory, recommended, optional or conditional</p> <p>A recommended data element is not a mandatory requirement</p> <p>Conditional means use of the data element depends on the context</p>
Guide for use	<p>Additional guidance to inform the use of the data element, including verification rules</p>

In addition to the above-named data types, any of the data types listed in publicly available standard **ISO/IEC 11404:2007 Information technology – General purpose data types** may be used in data element specifications.

The data element name should be prefixed with a representation class term, for example: Code, Count, Currency, Identifier, Text, Date, Date/time, Indicator, Graphic, Picture, Icon, Quantity.

1.8.2 Clinical terminology standard

SNOMED CT is the standard clinical terminology for use in New Zealand. Accordingly, this standard uses SNOMED CT in relevant data elements.

See the [SNOMED pages on our website](#) for information about SNOMED releases and terminology services.

Where a data element in this standard uses SNOMED CT, the implementing application is to display the agreed SNOMED preferred term to the user and record the correct SNOMED concept identifier in the database. Active SNOMED CT concepts must be selected when determining values for data elements.

Most coded data elements use by default the SNOMED CT terminology for clinical information. The concepts making up each value domain are denoted by preferred term and linked to entries in the **SNOMED CT lookup tool**. The SNOMED CT concept identifier can be viewed by hovering over the link.

Some data elements are restricted to a definite set of SNOMED CT concepts, while others are more open-ended and allow the user to select from a wider set of concepts, usually within a certain hierarchy or sub-hierarchy – eg, the set of all disease concepts. See the **SNOMED CT Search and Data Entry Guide** for a guide to building a user-friendly search across the terminology.

The **SNOMED CT NZ Edition**, incorporating the SNOMED CT International Edition and released in April and October every year, is the standard distribution.

1.8.3 Character sets

Text data elements must accommodate macrons for te reo Māori and diacritic characters for other commonly used languages. By default, this means using the Unicode Basic Latin, Latin-1 Supplement and Latin Extended A character sets.

ISO/IEC 10646:2017 Information technology – Universal Coded Character Set (UCS) is the recognised standard. UTF-8 is the recommended character encoding.

Alphabetic and alphanumeric codes and identifiers are restricted to printable Basic Latin characters and may be restricted further.

1.8.4 Date and time value domain

As the date/time value domain is used many times in this document, its specification is stated once here.

Name	Date/time
Definition	The date and time for the associated data element
Source standards	ISO 8601-1:2019 Date and time. Representations for information interchange – Part 1: Basic rules
Value domain	Valid date and/or time where full date and/or time is specified
Data type	Date/time
Layout	YYYYMMDD:[HH:MM]

1.8.5 Health care provider information

This section specifies the health care provider information that is related to the care summary. References to health care provider information are included many times in this document, the specification of these elements is stated once here.

- General practice
- Ambulance service provider
- Receiving facility
- Third-party provider

The information should be obtained from the HPI system. This is available to registered health care providers and includes demographic and other generic information. The format and content of available fields is documented in

- [HISO 10005:2008 Health Practitioner Index \(HPI\) Data Set](#)
- [HISO 10006:2008 Health Practitioner Index \(HPI\) Code Set](#)

An update of these standards (HISO 10045 Health Provider Identity Standard) is currently underway and has been referred to in this document. A copy of the revised draft standard can be requested from standards@health.govt.nz.

'Provider person' is information related to the ambulance service provider and a third-party provider. 'Provider organisation' is information related to the patient's general practice, the ambulance service provider and a third-party provider. 'Provider facility' is information related to the receiving facility.

Data element
Provider person: Name Common Person Number (CPN) Address Language Contact Qualifications Registration and related information
Provider organisation:

Identifier and Identifier Check Digit

Name

Address

Contact

Provider facility:

Identifier and Identifier Check Digit

Name

Address

Contact

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2 Data set specification

This section presents the ambulance care summary data set specification.

Many sections of the ambulance care summary are based on **HISO 10099:2022 NZ Patient Summary**, our fully conforming adaptation of the International Patient Summary (IPS) standard to New Zealand requirements.

These are namely the following sections that are used to summarise care given to one patient involved in an ambulance incident.

- Demographics - the patient's personal data (ambulance operators use the term "patient" to refer to any person to whom they provide services)
- Smoking and vaping – the patient's smoking/vaping status at the time of this incident
- Encounter – information about this incident, ambulance response and the patient outcome (ambulance operators use the term "incident" to describe information referred to as an "encounter" in the NZ Patient Summary)
- Problems – details of the patient's current complaint and any relevant medical history
- Measurements and vital signs – clinical observations of the patient made while responding to this incident
- Medications - drugs administered or dispensed to the patient during this incident
- Interventions – procedures carried out to treat the patient during this incident
- Care plan – recommendations for continuing care of the patient after this incident

2.1. Demographics

This section describes the data elements that identify and characterise a patient – that is, a person who has clinical contact with a clinician.

2.1.1. Personal information

The following table outlines the identity data elements required for a patient. When a patient is positively identified, personal information can be retrieved from the National Health Index (NHI) system, which provides registered health care providers with demographic and other general details. If the patient cannot be positively identified, information should be recorded in accordance with the **HISO 10046:2024 Consumer Health Identity Standard**.

Required data element
NHI Number
Person name
Date of Birth
Gender
Ethnicity
New Zealand residency and citizenship
Person death information

Person address
Language
Contact information

2.1.2. Additional personal information

The following data elements not defined in HISO 10046 Consumer Health Identity Standard may also be collected:

(a) Patient age

Name	<u>Patient age</u>
Definition	Patient's current age
Source standards	
Value domain	
Data type	Numeric
Layout	N(3)
Obligation	Mandatory
Guide for use	<p>Calculated automatically from birth date if entered, otherwise an estimated value can be recorded; calculate in days if age is less than one month, calculate in months if age is less than one year; set 'Error! Reference source not found.' accordingly</p> <p>Greater than zero; if 'Error! Reference source not found.' is "Day" then warning if age > 31; if 'Error! Reference source not found.' is "Month" then warning if > 12; if 'Error! Reference source not found.' is "Year" then warning if > 100</p>

(b) Unit of measure

Name	Unit of measure				
Definition	Unit of measure of patient's age				
Source standards					
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>Day</u></td> </tr> <tr> <td><u>Month</u></td> </tr> <tr> <td><u>Year</u></td> </tr> </table>	Preferred term	<u>Day</u>	<u>Month</u>	<u>Year</u>
Preferred term					
<u>Day</u>					
<u>Month</u>					
<u>Year</u>					
Data type	SNOMED CT identifier				
Layout	N(18)				
Obligation	Mandatory				
Guide for use	Valid code set value				

(c) *Age estimated*

Name	Age estimated			
Definition	The patient's age as estimated by the clinician			
Source standards				
Value domain	<table border="1"><thead><tr><th>Preferred term</th></tr></thead><tbody><tr><td><u>True</u></td></tr><tr><td><u>False</u></td></tr></tbody></table>	Preferred term	<u>True</u>	<u>False</u>
Preferred term				
<u>True</u>				
<u>False</u>				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Optional			
Guide for use	Valid code set value Value 'True' if the ambulance clinician estimated the patient's age.			

(d) *Sex at birth*

Name	<u>Sex at birth</u>										
Definition	The biological sex assigned at birth. Collected to determine sex specific treatment.										
Source standards											
Value domain	<table border="1"><thead><tr><th>Code</th><th>Preferred term</th></tr></thead><tbody><tr><td>M</td><td><u>Male</u> Tāne</td></tr><tr><td>F</td><td><u>Female</u> Wahine</td></tr><tr><td>U</td><td><u>Unknown</u></td></tr><tr><td>I</td><td><u>Indeterminate</u></td></tr></tbody></table>	Code	Preferred term	M	<u>Male</u> Tāne	F	<u>Female</u> Wahine	U	<u>Unknown</u>	I	<u>Indeterminate</u>
Code	Preferred term										
M	<u>Male</u> Tāne										
F	<u>Female</u> Wahine										
U	<u>Unknown</u>										
I	<u>Indeterminate</u>										
Data type	Code										
Layout	A										
Obligation	Optional										
Guide for use	Valid code set value. Only collected if it is clinically relevant for this case. This data should only be visible to people who need to know this information. 'I' codes are for use in cases, usually new-borns, where it is not possible to determine the patient's sex.										

(e) General practice

This element details the general practice the patient is enrolled with. If the patient is enrolled with a primary health organisation (PHO) then this is the HPI organisation identifier (which includes a check digit) (see '[Health care provider information](#)') of the PHO. Value is optional.

2.2. Smoking and vaping

This section describes the data elements that state the patient's smoking and vaping status at the time of the ambulance encounter.

2.2.1. Smoking status

Name	Smoking status					
Definition	Current smoking status					
Source standards						
Value domain	The following SNOMED CT terms are from the <u>New Zealand smoking status reference set</u> (72741000210106) <table border="1" data-bbox="582 891 1008 1218"><tr><td>Preferred term</td></tr><tr><td><u>Current smoker</u></td></tr><tr><td><u>Ex-smoker for less than 1 year</u></td></tr><tr><td><u>Ex-smoker for more than 1 year</u></td></tr><tr><td><u>Never smoked</u></td></tr></table>	Preferred term	<u>Current smoker</u>	<u>Ex-smoker for less than 1 year</u>	<u>Ex-smoker for more than 1 year</u>	<u>Never smoked</u>
Preferred term						
<u>Current smoker</u>						
<u>Ex-smoker for less than 1 year</u>						
<u>Ex-smoker for more than 1 year</u>						
<u>Never smoked</u>						
Data type	SNOMED CT identifier					
Layout	N(18)					
Obligation	Optional					
Guide for use	Valid code					

2.2.2. Smoking status recorded date

This element represents the date/time that the patient's smoking status was recorded. The format is set out in the common Date and time value domain specification. The data element is mandatory. The value must not be in the future.

2.2.3. Vaping status

Name	Vaping status
Definition	Current vaping status
Source standards	

Value domain	<p>The following SNOMED CT terms are from the <u>New Zealand vaping status reference set</u> (72721000210100)</p> <table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>Currently vaping</u></td> </tr> <tr> <td><u>Currently vaping with nicotine</u></td> </tr> <tr> <td><u>Currently vaping without nicotine</u></td> </tr> <tr> <td><u>Ex-vaping for less than 1 year</u></td> </tr> <tr> <td><u>Ex-vaping for more than 1 year</u></td> </tr> <tr> <td><u>Trying to give up using electronic cigarette</u></td> </tr> <tr> <td><u>Never used electronic cigarette</u></td> </tr> </table>	Preferred term	<u>Currently vaping</u>	<u>Currently vaping with nicotine</u>	<u>Currently vaping without nicotine</u>	<u>Ex-vaping for less than 1 year</u>	<u>Ex-vaping for more than 1 year</u>	<u>Trying to give up using electronic cigarette</u>	<u>Never used electronic cigarette</u>
Preferred term									
<u>Currently vaping</u>									
<u>Currently vaping with nicotine</u>									
<u>Currently vaping without nicotine</u>									
<u>Ex-vaping for less than 1 year</u>									
<u>Ex-vaping for more than 1 year</u>									
<u>Trying to give up using electronic cigarette</u>									
<u>Never used electronic cigarette</u>									
Data type	SNOMED CT identifier								
Layout	N(18)								
Obligation	Optional								
Guide for use	Valid code								

2.2.4. Vaping status recorded date

This element represents the date/time that the patient's vaping status was recorded. The format is set out in the common Date and time value domain specification. The data element is mandatory. The value must not be in the future.

2.3. Encounter

This section describes the data elements that summarise an ambulance encounter with a patient.

An encounter is initiated by:

- an emergency call to 111 reporting an incident.
- advice from Police or Fire and Emergency New Zealand (FENZ) of an incident.
- a non-emergency request for transport of an individual patient made by a health care provider (eg, a GP).
- a patient presenting themselves to a clinician, for example at an event, or at a community-based clinic.

Note that an incident may involve one or more patients, so there could be multiple encounters (one per patient) referencing a single incident.

2.3.1. Encounter type code

Name	Encounter type code
-------------	---------------------

Definition	Code for the type of encounter					
Source standards						
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>Air ambulance</u></td> </tr> <tr> <td><u>Land ambulance</u></td> </tr> <tr> <td><u>Community clinic</u></td> </tr> <tr> <td><u>Telehealth consultation</u></td> </tr> </table>	Preferred term	<u>Air ambulance</u>	<u>Land ambulance</u>	<u>Community clinic</u>	<u>Telehealth consultation</u>
Preferred term						
<u>Air ambulance</u>						
<u>Land ambulance</u>						
<u>Community clinic</u>						
<u>Telehealth consultation</u>						
Data type	SNOMED CT identifier					
Layout	N(18)					
Obligation	Mandatory					
Guide for use	Valid code					

2.3.2. Encounter date/time

This element defines when the ambulance operator first became aware of the incident. For an incident reported through a 111 call this is the date/time the call was received. The format is set out in the common Date and time value domain specification. The data element is mandatory. The element must not be in the future.

2.3.3. Ambulance service provider

This element defines the ambulance operator's provider persons details or, if unavailable, the provider organisation details of the ambulance operator providing care (see Health care provider information). The data element is mandatory.

2.3.4. Encounter disposition code

Name	Encounter disposition code						
Definition	What the clinician decided to do with the patient to allow the incident to be completed						
Source standards							
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>No action required</u></td> </tr> <tr> <td><u>Hear and advise</u></td> </tr> <tr> <td><u>See and advise</u></td> </tr> <tr> <td><u>See and treat</u></td> </tr> <tr> <td><u>Treat and transport</u></td> </tr> </table>	Preferred term	<u>No action required</u>	<u>Hear and advise</u>	<u>See and advise</u>	<u>See and treat</u>	<u>Treat and transport</u>
Preferred term							
<u>No action required</u>							
<u>Hear and advise</u>							
<u>See and advise</u>							
<u>See and treat</u>							
<u>Treat and transport</u>							
Data type	SNOMED CT identifier						

Layout	N(18)
Obligation	Mandatory
Guide for use	Valid code

2.3.5. Encounter diagnosis code

This element defines any diagnoses made at the encounter; these are the clinician's clinical impressions of the patient. The clinician records their clinical impressions by selecting SNOMED coded medical conditions from the New Zealand Emergency Care Reference Set. At least one value must be recorded. The element may repeat.

2.3.6. Additional encounter information

(a) Master incident number

Name	Master incident number
Definition	A unique identifier for the encounter assigned by the Computer Aided Dispatch (CAD) system.
Source standards	Generated by CAD
Value domain	
Data type	Alphanumeric
Layout	NNNN-N-ccyy/mm/dd
Obligation	Mandatory
Guide for use	<p>Each encounter is uniquely identified by its "Master Incident Number", consisting of case number (left zero filled) "-" CAD identifier (1, 2, or 3 for North, Central or South) "-" date (yyyy/mm/dd).</p> <p>For example, the Master Incident Number for case number 27 managed by the Central communications centre on 25th December 2024 is "0027-2-2024/12/25".</p> <p>CAD is the Ambulance Operators' Computer Aided Dispatch system, which is operated at three communications centres located in Auckland, Wellington, and Christchurch.</p>

(b) Receiving facility (destination)

If the patient was transported, then this is the Organisation Identifier plus Organisation Identifier Check Digit of the facility (eg, a hospital emergency department) they were taken to (see [Health care provider information](#)). The data element is conditional, mandatory if a patient was transported.

2.4. Problems

This section describes the data elements that summarise what happened before the ambulance operator became involved.

2.4.1. Presenting complaint

The presenting complaint data element is represented by the Medical Priority Dispatch System (MPDS) codes. See [Appendix A](#) for details regarding the MPDS code system.

Name	<u>Presenting complaint</u>
Definition	The reason the ambulance was called
Source standards	
Value domain	Medical Priority Dispatch System (MPDS) code. See Appendix A
Data type	code
Layout	[N]NAN[N]
Obligation	Mandatory for a valid Medical Priority Dispatch System (MPDS) code
Guide for use	Valid code. The MPDS is a way of categorising and prioritising EMS incidents. The code system assigns a number-letter-number format code to each type of incident. The first number indicates the category of the incident. The letter denotes the priority of the incident, and the second number indicates the subcategory of the incident. Where a code is not available the information should be captured in 'Other presenting complaint'

2.4.2. Other presenting complaint

Name	Other presenting complaint
Definition	The other reason the ambulance was called if not covered by 'Presenting complaint'
Source standards	
Value domain	Free text
Data type	Alphabetic
Layout	A(30)
Obligation	Mandatory on no response for 'Presenting complaint'
Guide for use	

2.4.3. Date/time of onset

This element defines when the patient's condition became apparent. The format is set out in the common [1.8.4 Date and time value domain](#) specification. The data element is optional; if entered it must not be in the future.

2.4.4. Onset time unknown

Name	Onset unknown
Definition	Onset date/time of the patient's condition is unknown
Source standards	

Value domain	Preferred term
	<u>True</u>
	<u>False</u>
Data type	SNOMED CT identifier
Layout	N(18)
Obligation	Optional
Guide for use	Valid code set value Value 'True' if 'Date/time of onset' is not recorded

2.4.5. History of incident

Name	History of incident
Definition	A summary of history relating to this complaint
Source standards	
Value domain	Free text
Data type	Alphanumeric
Layout	X(255)
Obligation	Optional
Guide for use	The patient's description of events

2.4.6. Accident details

This section describes the data elements that summarise what led to an injury. The data is only collected for incidents where an ACC claim applies.

(a) Mechanism of injury

Name	<u>Mechanism of injury</u>						
Definition	The event that caused any injuries						
Source standards							
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>Road traffic accident (RTA)</u></td> </tr> <tr> <td><u>Work accident</u></td> </tr> <tr> <td><u>Sports accident</u></td> </tr> <tr> <td><u>Assault</u></td> </tr> <tr> <td><u>Accident due to excessive cold</u></td> </tr> </table>	Preferred term	<u>Road traffic accident (RTA)</u>	<u>Work accident</u>	<u>Sports accident</u>	<u>Assault</u>	<u>Accident due to excessive cold</u>
Preferred term							
<u>Road traffic accident (RTA)</u>							
<u>Work accident</u>							
<u>Sports accident</u>							
<u>Assault</u>							
<u>Accident due to excessive cold</u>							

	<table border="1"> <tr><td><u>Accident due to excessive heat</u></td></tr> <tr><td><u>Accident caused by machinery</u></td></tr> <tr><td><u>Accident caused by electric current</u></td></tr> <tr><td><u>Accidental physical contact with animal</u></td></tr> <tr><td><u>Accident caused by fire and flames</u></td></tr> <tr><td><u>Accidental exposure to corrosive or caustic chemical</u></td></tr> <tr><td><u>Exposure to potentially hazardous substance</u></td></tr> <tr><td><u>Fall</u></td></tr> <tr><td><u>Other</u></td></tr> </table>	<u>Accident due to excessive heat</u>	<u>Accident caused by machinery</u>	<u>Accident caused by electric current</u>	<u>Accidental physical contact with animal</u>	<u>Accident caused by fire and flames</u>	<u>Accidental exposure to corrosive or caustic chemical</u>	<u>Exposure to potentially hazardous substance</u>	<u>Fall</u>	<u>Other</u>
<u>Accident due to excessive heat</u>										
<u>Accident caused by machinery</u>										
<u>Accident caused by electric current</u>										
<u>Accidental physical contact with animal</u>										
<u>Accident caused by fire and flames</u>										
<u>Accidental exposure to corrosive or caustic chemical</u>										
<u>Exposure to potentially hazardous substance</u>										
<u>Fall</u>										
<u>Other</u>										
Data type	SNOMED CT identifier									
Layout	N(18)									
Obligation	Optional									
Guide for use	Valid code. The most common mechanisms are coded as described above. For less common mechanisms, select “Other” and enter in the element ‘Other mechanism of injury’									

(b) Other mechanism of injury

Name	<u>Other mechanism of injury</u>
Definition	The event that caused any injuries if not covered by ‘Mechanism of injury’.
Source standards	
Value domain	Free text
Data type	Alphanumeric
Layout	X(30)
Obligation	Mandatory on response of “Other” for ‘Mechanism of injury’
Guide for use	

(c) Sports activity

Name	<u>Sports activity</u>
Definition	Code representing the sport or activity that the patient was participating in at the time of injury
Source standards	Subset of SNOMED CT: < 390736008 Physical activity (qualifier value)
Value domain	

Data type	SNOMED CT identifier
Layout	N(18)
Obligation	Mandatory on response of "Sports accident" for 'Mechanism of injury'
Guide for use	Valid code set value

(d) *Road traffic accident injury details*

Vehicle type

Name	<u>Vehicle type</u>																	
Definition	Type of vehicle that the patient was travelling in																	
Source standards																		
Value domain	<table border="1"> <thead> <tr> <th>Preferred term</th> </tr> </thead> <tbody> <tr><td><u>Bicycle</u></td></tr> <tr><td><u>E-bike</u></td></tr> <tr><td><u>Foot-propelled scooter</u></td></tr> <tr><td><u>Electric scooter</u></td></tr> <tr><td><u>Motor scooter</u></td></tr> <tr><td><u>Motorcycle</u></td></tr> <tr><td><u>Car</u></td></tr> <tr><td><u>Van</u></td></tr> <tr><td><u>Railway vehicle</u></td></tr> <tr><td><u>Recreational vehicle (RV)</u></td></tr> <tr><td><u>Trailer</u></td></tr> <tr><td><u>Bus</u></td></tr> <tr><td><u>All-terrain vehicle</u></td></tr> <tr><td><u>Light truck</u></td></tr> <tr><td><u>Heavy truck</u></td></tr> <tr><td><u>Animal drawn vehicle</u></td></tr> </tbody> </table>	Preferred term	<u>Bicycle</u>	<u>E-bike</u>	<u>Foot-propelled scooter</u>	<u>Electric scooter</u>	<u>Motor scooter</u>	<u>Motorcycle</u>	<u>Car</u>	<u>Van</u>	<u>Railway vehicle</u>	<u>Recreational vehicle (RV)</u>	<u>Trailer</u>	<u>Bus</u>	<u>All-terrain vehicle</u>	<u>Light truck</u>	<u>Heavy truck</u>	<u>Animal drawn vehicle</u>
Preferred term																		
<u>Bicycle</u>																		
<u>E-bike</u>																		
<u>Foot-propelled scooter</u>																		
<u>Electric scooter</u>																		
<u>Motor scooter</u>																		
<u>Motorcycle</u>																		
<u>Car</u>																		
<u>Van</u>																		
<u>Railway vehicle</u>																		
<u>Recreational vehicle (RV)</u>																		
<u>Trailer</u>																		
<u>Bus</u>																		
<u>All-terrain vehicle</u>																		
<u>Light truck</u>																		
<u>Heavy truck</u>																		
<u>Animal drawn vehicle</u>																		
Data type	SNOMED CT identifier																	
Layout	N(18)																	

Obligation	Optional on response of "Road traffic accident (RTA)" for 'Mechanism of injury'
Guide for use	Valid code set value

Vehicle diagram

Name	Vehicle diagram
Definition	Sketch of vehicle and scene
Source standards	
Value domain	Diagram based on vehicle type
Data type	Raw
Layout	Picture (256KB)
Obligation	Optional on response of "Road traffic accident (RTA)" for 'Mechanism of injury'
Guide for use	Mark position of patient, direction of travel, point and direction of impact, damaged area.

Patient characteristics

Name	Patient characteristics								
Definition	The patient characteristic of role in the road traffic accident								
Source standards									
Value domain	<table border="1"> <thead> <tr> <th>Preferred term</th> </tr> </thead> <tbody> <tr> <td><u>Pedestrian</u></td> </tr> <tr> <td><u>Cyclist</u></td> </tr> <tr> <td><u>Motorcycle rider</u></td> </tr> <tr> <td><u>Pillion</u></td> </tr> <tr> <td><u>Driver</u></td> </tr> <tr> <td><u>Passenger</u></td> </tr> <tr> <td><u>Other</u></td> </tr> </tbody> </table>	Preferred term	<u>Pedestrian</u>	<u>Cyclist</u>	<u>Motorcycle rider</u>	<u>Pillion</u>	<u>Driver</u>	<u>Passenger</u>	<u>Other</u>
Preferred term									
<u>Pedestrian</u>									
<u>Cyclist</u>									
<u>Motorcycle rider</u>									
<u>Pillion</u>									
<u>Driver</u>									
<u>Passenger</u>									
<u>Other</u>									
Data type	SNOMED CT identifier								
Layout	N(18)								
Obligation	Optional on response of "Road traffic accident (RTA)" for 'Mechanism of injury'								
Guide for use	Valid code set value								

Estimated impact speed

Name	<u>Estimated impact speed</u>								
Definition	The estimated impact speed for the road traffic accident								
Source standards									
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td>0-20 km/h</td> </tr> <tr> <td>20-40 km/h</td> </tr> <tr> <td>40-60 km/h</td> </tr> <tr> <td>60-80 km/h</td> </tr> <tr> <td>80-100 km/h</td> </tr> <tr> <td>100-150 km/h</td> </tr> <tr> <td>>150 km/h</td> </tr> </table>	Preferred term	0-20 km/h	20-40 km/h	40-60 km/h	60-80 km/h	80-100 km/h	100-150 km/h	>150 km/h
Preferred term									
0-20 km/h									
20-40 km/h									
40-60 km/h									
60-80 km/h									
80-100 km/h									
100-150 km/h									
>150 km/h									
Data type	Alphanumeric								
Layout	X(12)								
Obligation	Optional on response of "Road traffic accident (RTA)" for 'Mechanism of injury'								
Guide for use	Valid code set value								

Passenger compartment intrusion

Name	Passenger compartment intrusion			
Definition	Whether passenger compartment intrusion occurred			
Source standards				
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>True</u></td> </tr> <tr> <td><u>False</u></td> </tr> </table>	Preferred term	<u>True</u>	<u>False</u>
Preferred term				
<u>True</u>				
<u>False</u>				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Optional on response of "Road traffic accident (RTA)" for 'Mechanism of injury'			
Guide for use	Valid code set value			

	Value 'True' if patient was ejected from the vehicle
--	--

Patient ejected

Name	Patient ejected			
Definition	Whether patient was ejected from the vehicle			
Source standards				
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>True</u></td> </tr> <tr> <td><u>False</u></td> </tr> </table>	Preferred term	<u>True</u>	<u>False</u>
Preferred term				
<u>True</u>				
<u>False</u>				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Optional on response of "Road traffic accident (RTA)" for 'Mechanism of injury'			
Guide for use	Valid code set value Value 'True' if patient was ejected from the vehicle			

Rollover

Name	Rollover			
Definition	Whether the vehicle rolled over			
Source standards				
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>True</u></td> </tr> <tr> <td><u>False</u></td> </tr> </table>	Preferred term	<u>True</u>	<u>False</u>
Preferred term				
<u>True</u>				
<u>False</u>				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Optional on response of "Road traffic accident (RTA)" for 'Mechanism of injury'			
Guide for use	Valid code set value Value 'True' if vehicle rolled-over			

End over end

Name	End over end			
Definition	Whether the vehicle tumbled end over end			
Source standards				
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>True</u></td> </tr> <tr> <td><u>False</u></td> </tr> </table>	Preferred term	<u>True</u>	<u>False</u>
Preferred term				
<u>True</u>				
<u>False</u>				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Optional on response of "Road traffic accident (RTA)" for 'Mechanism of injury'			
Guide for use	Valid code set value Value 'True' if vehicle rolled end-over-end			

Air bag deployed

Name	Air bag deployed			
Definition	Whether the air bag deployed in the accident			
Source standards				
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>True</u></td> </tr> <tr> <td><u>False</u></td> </tr> </table>	Preferred term	<u>True</u>	<u>False</u>
Preferred term				
<u>True</u>				
<u>False</u>				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Optional on response of "Road traffic accident (RTA)" for 'Mechanism of injury'			
Guide for use	Valid code set value Value 'True' if patient's air bag was deployed			

Seatbelt worn

Name	Seatbelt worn
Definition	Whether the patient was wearing a seat belt or appropriate child restraint
Source standards	

Value domain	Preferred term
	<u>True</u>
	<u>False</u>
Data type	SNOMED CT identifier
Layout	N(18)
Obligation	Optional on response of "Road traffic accident (RTA)" for 'Mechanism of injury'
Guide for use	Valid code set value Value 'True' if patient was wearing a seatbelt

Helmet worn

Name	Helmet worn
Definition	Whether the patient was wearing a helmet
Source standards	
Value domain	Preferred term
	<u>True</u>
	<u>False</u>
Data type	SNOMED CT identifier
Layout	N(18)
Obligation	Optional on response of "Road traffic accident (RTA)" for 'Mechanism of injury'
Guide for use	Valid code set value Value 'True' if patient was wearing a helmet

Self-extricated

Name	Self-extricated
Definition	Whether the patient extricated themselves from the vehicle
Source standards	
Value domain	Preferred term
	<u>True</u>

	False
Data type	SNOMED CT identifier
Layout	N(18)
Obligation	Optional on response of "Road traffic accident (RTA)" for 'Mechanism of injury'
Guide for use	Valid code set value Value 'True' if patient extricated themselves from the vehicle

Patient trapped

Name	Patient trapped			
Definition	Whether the patient was trapped in the vehicle			
Source standards				
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td>True</td> </tr> <tr> <td>False</td> </tr> </table>	Preferred term	True	False
Preferred term				
True				
False				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Optional on response of "Road traffic accident (RTA)" for 'Mechanism of injury'			
Guide for use	Valid code set value Value 'True' if patient was trapped in the vehicle Trapped means that the patient is entangled, or their injuries are preventing them from exiting, not that they are encased (eg, by a locked or non-opening door)			

2.5. Patient History

This section describes the data elements that summarise what happened before the ambulance operator became involved.

2.5.1. Patient history

This section describes the data elements collected about the Patient's medical history and any current medical problems or injuries that are relevant to the current incident.

(a) Past medical history

Name	Past medical history
-------------	----------------------

Definition	Overview of the patient's (relevant) medical history
Source standards	
Value domain	Free text
Data type	Alphanumeric
Layout	X(255)
Obligation	Optional
Guide for use	The clinician may specifically record "None" or "Unknown"

(b) Medications

Name	<u>Medications</u>
Definition	Self-reported list of medications currently taken by the patient
Source standards	
Value domain	
Data type	Alphanumeric
Layout	X(255)
Obligation	Optional
Guide for use	The use of NZMT or ATC codes is preferred where possible. Each of the medicine classes may appear once and only once, or not at all. The clinician may enter either "None" or "Unknown" in which case there will be no other entries.

(c) Allergies

Name	<u>Allergies</u>
Definition	Self-reported list of allergies the patient suffers from
Source standards	
Value domain	Free text
Data type	Alphanumeric
Layout	X(255)
Obligation	Optional
Guide for use	The clinician may specifically record "None" or "Unknown"

(d) Last oral intake date and time

This element describes when the patient last ate or drank something. The format is set out in the common Date and time value domain specification. The data element is optional; if entered it must not be in the future.

(e) *Last oral intake unknown*

Name	Last oral intake unknown		
Definition	Time of last oral intake is not known		
Source standards			
Value domain	<table border="1"><tr><td>Preferred term</td></tr><tr><td><u>Unknown</u></td></tr></table>	Preferred term	<u>Unknown</u>
Preferred term			
<u>Unknown</u>			
Data type	SNOMED CT identifier		
Layout	N(18)		
Obligation	Mandatory on no response to 'Last oral intake date and time'		
Guide for use	Valid code set value Value 'Unknown' on no response to 'Last oral intake date and time'		

(e) *Pregnant*

Name	<u>Pregnant</u>			
Definition	Is the patient pregnant?			
Source standards				
Value domain	<table border="1"><tr><td>Preferred term</td></tr><tr><td><u>Yes</u></td></tr><tr><td><u>Unknown</u></td></tr></table>	Preferred term	<u>Yes</u>	<u>Unknown</u>
Preferred term				
<u>Yes</u>				
<u>Unknown</u>				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Optional			
Guide for use	Valid code set value Unknown means that the patient was asked and does not know, not that the clinician did not ask			

(f) *Length of gestation*

Name	<u>Length of gestation</u>
Definition	Number of weeks pregnant
Source standards	
Value domain	Valid integer
Data type	Numeric

Layout	N(2)
Obligation	Optional on a response of “Yes” to ‘Pregnant’
Guide for use	Between 1 and 50; warning if > 40

(g) *Estimated weight*

Name	<u>Estimated weight</u>
Definition	Estimate of the patient’s weight in kilograms
Source standards	
Value domain	Valid number
Data type	Decimal
Layout	NNN.N
Obligation	Optional
Guide for use	Greater than zero; warning if > 200

(h) *Current mental health crisis*

Name	<u>Current mental health crisis</u>			
Definition	The clinician believes that a mental health problem may have contributed to the patient’s presentation			
Source standards				
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>True</u></td> </tr> <tr> <td><u>False</u></td> </tr> </table>	Preferred term	<u>True</u>	<u>False</u>
Preferred term				
<u>True</u>				
<u>False</u>				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Optional			
Guide for use	Valid code set value Value ‘True’ if a mental health problem is believed to have contributed			

(i) *Alcohol contributed*

Name	<u>Alcohol contributed</u>
Definition	The clinician believes that consumption of alcohol may have contributed to the patient’s presentation
Source standards	

Value domain	Preferred term
	<u>True</u>
	<u>False</u>
	<u>Uncertain</u>
	<u>Third party</u>
Data type	SNOMED CT identifier
Layout	N(18)
Obligation	Optional
Guide for use	Valid code set value 'Third party' is to be used when alcohol consumption by someone other than the patient is relevant eg, patient was assaulted by someone who had consumed alcohol

(j) *Patient took recreational drugs*

Name	<u>Patient took recreational drugs</u>
Definition	The clinician believes that consumption of recreational drugs may have contributed to the patient's presentation
Source standards	
Value domain	Preferred term
	<u>True</u>
	<u>False</u>
Data type	SNOMED CT identifier
Layout	N(18)
Obligation	Optional
Guide for use	Valid code set value

(k) *Estimated level of impairment*

Name	Estimated level of impairment
Definition	Estimated description of the patient's presentation
Source standards	
Value domain	Preferred term
	<u>Uninhibited</u>

	<table border="1"> <tr><td><u>Slurring</u></td></tr> <tr><td><u>Unable to mobilise</u></td></tr> <tr><td><u>Overly talkative</u></td></tr> <tr><td><u>Unintelligible words</u></td></tr> <tr><td><u>Unresponsive</u></td></tr> <tr><td><u>Other impairment finding</u></td></tr> </table>	<u>Slurring</u>	<u>Unable to mobilise</u>	<u>Overly talkative</u>	<u>Unintelligible words</u>	<u>Unresponsive</u>	<u>Other impairment finding</u>
<u>Slurring</u>							
<u>Unable to mobilise</u>							
<u>Overly talkative</u>							
<u>Unintelligible words</u>							
<u>Unresponsive</u>							
<u>Other impairment finding</u>							
Data type	SNOMED CT identifier						
Layout	N(18)						
Obligation	Mandatory on response of “Yes” to ‘Alcohol contributed’ or to ‘Patient took recreational drugs’						
Guide for use	Valid code set value						

(l) *Other estimated level of impairment*

Name	Other estimated level of impairment
Definition	An estimated description of the patient’s presentation if not covered by ‘Estimated level of impairment’
Source standards	
Value domain	Free text
Data type	Alphanumeric
Layout	X(255)
Obligation	Mandatory on response of “Other” to ‘Estimated level of impairment’
Guide for use	

2.5.2. Clinical documents

Name	Clinical documents
Definition	List of relevant clinical documents sighted by the clinician
Source standards	
Value domain	Free text
Data type	Alphanumeric
Layout	X(255)
Obligation	Optional
Guide for use	Photos of the documents may be attached in ‘Images’

2.6. Measurements and vital signs

This section describes a set of observations made at a particular time. All observations are coded using SNOMED CT.

When an ambulance care summary report is created (see [Ambulance Care Summary representation](#)) the entries in this section are interleaved, based on [Observation date and time](#), with the entries in sections [Medications](#) and [Procedures](#).

2.6.1. Observation date and time

This element defines the date and time this set of observations were made. The format is set out in the common [Date and time value domain](#) specification. The data element is mandatory. The element must not be in the future.

2.6.2. Observable entities

This is the set of observations made at [Observation date and time](#). Each of the following observable entities may appear once and only once, or not at all.

(a) *Blood glucose level (BGL)*

Name	Blood glucose level (BGL)
Definition	The amount of glucose (sugar) present in the patient's blood
Source standards	
Value domain	Valid decimal
Data type	Decimal
Layout	NN.N mmol/L
Obligation	Optional
Guide for use	

(b) *Blood pressure (BP) - systolic*

Name	Blood pressure (BP) - systolic
Definition	Systolic blood pressure
Source standards	
Value domain	Valid integer
Data type	Numeric
Layout	N(3) mmHg
Obligation	Optional
Guide for use	

(c) *Blood pressure (BP) - diastolic*

Name	Blood pressure (BP) - diastolic
Definition	Diastolic blood pressure

Source standards	
Value domain	Valid integer
Data type	Numeric
Layout	N(3) mmHg
Obligation	Optional
Guide for use	

(d) Capillary (Cap) refill time

Name	Capillary (Cap) refill time value
Definition	Capillary refill time in seconds
Source standards	
Value domain	Valid integer
Data type	Numeric
Layout	N(2) sec
Obligation	Optional
Guide for use	

(e) Capillary (Cap) refill time location

Name	Capillary (Cap) refill time location			
Definition	Position on the patient's body where the cap refill time was measured			
Source standards				
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td>Peripheral</td> </tr> <tr> <td>Central</td> </tr> </table>	Preferred term	Peripheral	Central
Preferred term				
Peripheral				
Central				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Mandatory on a response to 'Capillary (Cap) refill time'			
Guide for use	Valid code set value			

(f) ECG interpretation

Name	ECG interpretation
Definition	Initial presenting rhythm of the heart
Source standards	

Value domain	Preferred term
	<u>Sinus rhythm</u>
	<u>Atrial fibrillation</u>
	<u>Atrial flutter</u>
	<u>Supraventricular tachycardia (SVT)</u>
	<u>Ventricular fibrillation (VF)</u>
	<u>Ventricular tachycardia (VT)</u>
	<u>Sinus tachycardia</u>
	<u>Sinus bradycardia</u>
	<u>Junctional</u>
	<u>Premature ventricular contractions (PVC)</u>
	<u>Premature atrial contractions (PAC)</u>
	<u>Premature junctional contractions (PJC)</u>
	<u>1st degree heart block</u>
	<u>2nd degree heart block; Mobitz type 1</u>
	<u>2nd degree heart block; Mobitz type 2</u>
	<u>Complete heart block</u>
	<u>Left bundle branch block (LBBB)</u>
	<u>Right bundle branch block (RBBB)</u>
	<u>Asystole</u>
<u>Unknown</u>	
<u>Other</u>	
Data type	SNOMED CT identifier
Layout	N(18)
Obligation	Optional
Guide for use	Valid code set value

(g) *End-tidal carbon dioxide (ETCO₂)*

Name	End-tidal carbon dioxide (ETCO ₂)
-------------	---

Definition	The partial pressure of carbon dioxide (CO ₂) at the end of a patient's exhaled breath
Source standards	
Value domain	Valid integer
Data type	Numeric
Layout	N(2) mmHg
Obligation	Optional
Guide for use	

(h) Glasgow coma scale (GCS) Score

Name	Glasgow coma scale (GCS) Score
Definition	Measure of a patient's motor, verbal and eye responses
Source standards	
Value domain	Valid integer
Data type	Numeric
Layout	N(2)
Obligation	Optional
Guide for use	Value between 3 and 15

(i) Heart rate

Name	Heart rate
Definition	Heart rate in beats per minute
Source standards	
Value domain	Valid integer
Data type	Numeric
Layout	N(3) BPM
Obligation	Optional
Guide for use	

(j) Oxygen saturation (SPO₂)

Name	Oxygen saturation (SPO ₂)
Definition	The ratio of oxyhemoglobin to the total concentration of hemoglobin present in the blood
Source standards	
Value domain	Valid integer
Data type	Numeric

Layout	N(3) %
Obligation	Optional
Guide for use	

(k) *Pain score*

Name	Pain score
Definition	Patient's self-reported level of pain
Source standards	Numerical Pain Rating Scale (NPRS)
Value domain	Valid integer
Data type	Numeric
Layout	N(2)
Obligation	Optional
Guide for use	<p>Range 0 to 10, where:</p> <p>0 = no pain</p> <p>1-3 = mild pain</p> <p>4-6 = moderate pain</p> <p>7-9 = severe pain</p> <p>10 = very severe pain</p> <p>Refer https://www.acc.co.nz/assets/provider/outcome-measures-guide.doc</p>

(l) *Patient status*

Name	<u>Patient status</u>						
Definition	Status of the patient						
Source standards							
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>Deceased</u></td> </tr> <tr> <td><u>Immediate threat to life</u></td> </tr> <tr> <td><u>Potential threat to life</u></td> </tr> <tr> <td><u>Unlikely threat to life</u></td> </tr> <tr> <td><u>No threat to life</u></td> </tr> </table>	Preferred term	<u>Deceased</u>	<u>Immediate threat to life</u>	<u>Potential threat to life</u>	<u>Unlikely threat to life</u>	<u>No threat to life</u>
Preferred term							
<u>Deceased</u>							
<u>Immediate threat to life</u>							
<u>Potential threat to life</u>							
<u>Unlikely threat to life</u>							
<u>No threat to life</u>							
Data type	SNOMED CT identifier						
Layout	N(18)						

Obligation	Conditional: must be recorded at least once
Guide for use	Valid code set value

(m) Peak Expiratory Flow Rate (PEFR)

Name	Peak Expiratory Flow Rate (PEFR)
Definition	The volume of air forcefully expelled from the lungs in one quick exhalation
Source standards	
Value domain	Valid integer
Data type	Numeric
Layout	N(3) L/min
Obligation	Optional
Guide for use	Range 1 to 800

(n) Pupil size

Name	Pupil size
Definition	Pupil size of the eye
Source standards	
Value domain	Valid integer
Data type	Numeric
Layout	N(1)
Obligation	Optional
Guide for use	Range 0 to 9

Name	Eye side			
Definition	Which eye the pupil size refers to			
Source standards				
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>Left</u></td> </tr> <tr> <td><u>Right</u></td> </tr> </table>	Preferred term	<u>Left</u>	<u>Right</u>
Preferred term				
<u>Left</u>				
<u>Right</u>				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Mandatory on a response to 'Pupil size'			
Guide for use	Valid code set value			

(o) *Pupil reaction*

Name	<u>Pupil reaction</u>			
Definition	Pupil reaction to light			
Source standards				
Value domain	<table border="1"><tr><td>Preferred term</td></tr><tr><td><u>True</u></td></tr><tr><td><u>False</u></td></tr></table>	Preferred term	<u>True</u>	<u>False</u>
Preferred term				
<u>True</u>				
<u>False</u>				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Optional			
Guide for use	Valid code set value Value 'True' if pupil responds to light			

Name	Eye side			
Definition	Which eye the pupil reaction refers to			
Source standards				
Value domain	<table border="1"><tr><td>Preferred term</td></tr><tr><td><u>Left</u></td></tr><tr><td><u>Right</u></td></tr></table>	Preferred term	<u>Left</u>	<u>Right</u>
Preferred term				
<u>Left</u>				
<u>Right</u>				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Mandatory on a response to 'Pupil reaction'			
Guide for use	Valid code set value			

(p) *Respiratory rate*

Name	<u>Respiratory rate</u>
Definition	Respiratory rate (breaths per minute)
Source standards	
Value domain	Valid integer
Data type	Numeric
Layout	N(3) /min

Obligation	Optional
Guide for use	

(q) *Skin condition*

Name	Skin condition						
Definition	The observed skin condition						
Source standards							
Value domain	<table border="1"> <thead> <tr> <th>Preferred term</th> </tr> </thead> <tbody> <tr> <td><u>Normal</u></td> </tr> <tr> <td><u>Diaphoretic (sweaty)</u></td> </tr> <tr> <td><u>Pallor (Pale)</u></td> </tr> <tr> <td><u>Flushed</u></td> </tr> <tr> <td><u>Cyanosed (Bluish discolouration)</u></td> </tr> </tbody> </table>	Preferred term	<u>Normal</u>	<u>Diaphoretic (sweaty)</u>	<u>Pallor (Pale)</u>	<u>Flushed</u>	<u>Cyanosed (Bluish discolouration)</u>
Preferred term							
<u>Normal</u>							
<u>Diaphoretic (sweaty)</u>							
<u>Pallor (Pale)</u>							
<u>Flushed</u>							
<u>Cyanosed (Bluish discolouration)</u>							
Data type	SNOMED CT identifier						
Layout	N(18)						
Obligation	Optional						
Guide for use	Valid code set value						

(r) *Temperature*

Name	Temperature
Definition	The patient's body temperature
Source standards	
Value domain	Valid decimal
Data type	Decimal
Layout	NN.N °C
Obligation	Optional
Guide for use	

2.6.3. Notes

Name	<u>Notes</u>
Definition	Any other observations of or comments on the patient's condition
Source standards	
Value domain	Free text

Data type	Alphanumeric
Layout	X(255)
Obligation	Optional
Guide for use	

2.6.4. Images

Name	<u>Images</u>
Definition	A relevant graphic or picture
Source standards	
Value domain	Photograph saved as JPEG or HEIC
Data type	Graphic or Picture
Layout	
Obligation	Optional
Guide for use	Up to 1024KB Examples: <ul style="list-style-type: none"> • Photos of relevant documentation (eg, handover from PRIME, Hospital clinic letter) • Photos of an accident scene to show injury mechanism • Photos of limbs before splinting

2.7. Medications

A record of medication (drugs and fluids) administered or supplied to the patient.

When an ACS report is created (see Ambulance Care Summary representation) the entries in this section are interleaved, based on Supply time, with the entries in sections Measurements and vital signs and Procedures.

2.7.1. Supply method

Name	Supply method			
Definition	The method by which a medication is provided to a patient			
Source standards				
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>Administration of medication</u></td> </tr> <tr> <td><u>Dispensing medication</u></td> </tr> </table>	Preferred term	<u>Administration of medication</u>	<u>Dispensing medication</u>
Preferred term				
<u>Administration of medication</u>				
<u>Dispensing medication</u>				
Data type	SNOMED CT identifier			

Layout	N(18)
Obligation	Mandatory on a medication being administered or dispensed
Guide for use	Valid code set value “Administered” means the clinician oversaw the medicine being given to/taken by the patient “Dispensed” means the clinician supplied the medicine for the patient to take later

2.7.2. Supply time

This element defines the date/time the medicine was administered or supplied. The format is set out in the common Date and time value domain specification. The data element is mandatory. The element must not be in the future.

2.7.3. Medicinal product code

Name	<u>Medicinal product code</u>
Definition	NZMT code for the medicine
Source standards	
Value domain	Valid integer
Data type	Numeric
Layout	N(18)
Obligation	Optional
Guide for use	Valid NZMT code. Clinicians can administer the patient’s own medicines and certain medicines from the New Zealand Universal List of Medicines (NZULM). The medicinal product administered is recorded using its New Zealand Medicines Terminology (NZMT) “medicinal product” (MP) code whenever possible, otherwise the name of the medicine is recorded in the Medicinal product name and this field is left empty.

2.7.4. Medicinal product name

Name	Medicinal product name
Definition	Name of the medicine
Source standards	
Value domain	Free text
Data type	Alphabetic
Layout	A(200)
Obligation	Mandatory on a medication being administered or dispensed

Guide for use	Use the NZMT name for the medicine if 'Medicinal product code' is not NULL; otherwise as entered by the clinician
----------------------	---

2.7.5. Dose supplied

(a) Dose

Name	<u>Dose</u>
Definition	The dose of medication administered to the patient by the clinician, or dispensed to the patient for them to take later
Source standards	
Value domain	Valid numeric
Data type	Numeric
Layout	NNNNNNN.NNN
Obligation	Mandatory on a medication being administered or dispensed
Guide for use	Depending on the product, dose can be expressed as either: <ul style="list-style-type: none"> • a <u>counted quantity</u> in terms of a unit of use (such as capsule) – which works for any Medicinal Product Unit of Use (MPUU) or Trade Product Unit of Use (TPUU) in a discrete dose form • a <u>measured quantity</u> in terms of a unit of measure (for mass, volume, flow rate etc) – which is used when (a) the product is in a continuous dose form or (b) a measured quantity is more informational than a counted quantity

(b) Unit

Name	<u>Unit</u>							
Definition	Unit of measure of the dose administered/dispensed							
Source standards								
Value domain	<table border="1"> <thead> <tr> <th>Preferred term</th> </tr> </thead> <tbody> <tr> <td>g</td> </tr> <tr> <td>L/min</td> </tr> <tr> <td>ug</td> </tr> <tr> <td>mg</td> </tr> <tr> <td>mL</td> </tr> <tr> <td>mmol</td> </tr> </tbody> </table>	Preferred term	g	L/min	ug	mg	mL	mmol
Preferred term								
g								
L/min								
ug								
mg								
mL								
mmol								

	<table border="1"> <tr><td>F</td></tr> <tr><td>%</td></tr> <tr><td>units</td></tr> </table>	F	%	units
F				
%				
units				
Data type	UCUM code			
Layout	X(30)			
Obligation	Mandatory on a medication being administered or dispensed			
Guide for use	Valid code set value. Use “units” for a counted quantity.			

2.7.6. Route

Name	Route																	
Definition	Route by which the dose is administered																	
Source standards																		
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr><td><u>Infusion</u></td></tr> <tr><td><u>Inhalation route</u></td></tr> <tr><td><u>Intramuscular route</u></td></tr> <tr><td><u>Nasal route</u></td></tr> <tr><td><u>Intraosseous route</u></td></tr> <tr><td><u>Intravenous route</u></td></tr> <tr><td><u>Manual hyperinflation</u></td></tr> <tr><td><u>Oxygen administration via nasal cannula</u></td></tr> <tr><td><u>Nebuliser mask</u></td></tr> <tr><td><u>Per oral route</u></td></tr> <tr><td><u>Per rectum</u></td></tr> <tr><td><u>Reservoir mask</u></td></tr> <tr><td><u>Simple face mask</u></td></tr> <tr><td><u>Subcutaneous route</u></td></tr> <tr><td><u>Sublingual route</u></td></tr> <tr><td><u>Topical route</u></td></tr> </table>	Preferred term	<u>Infusion</u>	<u>Inhalation route</u>	<u>Intramuscular route</u>	<u>Nasal route</u>	<u>Intraosseous route</u>	<u>Intravenous route</u>	<u>Manual hyperinflation</u>	<u>Oxygen administration via nasal cannula</u>	<u>Nebuliser mask</u>	<u>Per oral route</u>	<u>Per rectum</u>	<u>Reservoir mask</u>	<u>Simple face mask</u>	<u>Subcutaneous route</u>	<u>Sublingual route</u>	<u>Topical route</u>
Preferred term																		
<u>Infusion</u>																		
<u>Inhalation route</u>																		
<u>Intramuscular route</u>																		
<u>Nasal route</u>																		
<u>Intraosseous route</u>																		
<u>Intravenous route</u>																		
<u>Manual hyperinflation</u>																		
<u>Oxygen administration via nasal cannula</u>																		
<u>Nebuliser mask</u>																		
<u>Per oral route</u>																		
<u>Per rectum</u>																		
<u>Reservoir mask</u>																		
<u>Simple face mask</u>																		
<u>Subcutaneous route</u>																		
<u>Sublingual route</u>																		
<u>Topical route</u>																		

	<u>Transdermal route</u>
Data type	SNOMED CT identifier
Layout	N(18)
Obligation	Mandatory on a medication being administered or dispensed
Guide for use	Valid code set value

2.7.7. Administered PRN

Name	Administered PRN			
Definition	Medication was administered as necessary			
Source standards				
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>True</u></td> </tr> <tr> <td><u>False</u></td> </tr> </table>	Preferred term	<u>True</u>	<u>False</u>
Preferred term				
<u>True</u>				
<u>False</u>				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Optional on response of "Administration of medication" to 'Supply method'			
Guide for use	<p>Valid code set value</p> <p>Value 'True' if the medicine was administered as required. PRN is an abbreviation of the Latin "pro re nata".</p>			

2.7.8. Count of doses dispensed

Name	Count of doses dispensed
Definition	Number of doses supplied
Source standards	
Value domain	Valid integer
Data type	Numeric
Layout	N(3)
Obligation	Mandatory on response of "Dispensing medication" to 'Supply method'
Guide for use	Greater than zero

2.7.9. Notes

Name	Notes
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Definition	Additional information related to medications
Source standards	
Value domain	Free text
Data type	Alphanumeric
Layout	X(255)
Obligation	Optional
Guide for use	

2.8. Procedures

A record of interventions made, or procedures performed, on the patient.

When an ACS report is created (see [Ambulance Care Summary representation](#)) the entries in this section are interleaved, based on [Intervention time](#), with the entries in sections [Measurements and vital signs](#) and [Medications](#).

2.8.1. Intervention time

This element defines the start time of the procedure. The format is set out in the common [Date and time value domain](#) specification. The data element is mandatory. The element must not be in the future.

2.8.2. Procedure type

Name	Procedure type								
Definition	The type of procedure or intervention performed								
Source standards									
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td>Abscess management</td> </tr> <tr> <td>Airway – manual clear</td> </tr> <tr> <td>Airway – suction</td> </tr> <tr> <td>Airway jaw thrust</td> </tr> <tr> <td>Airway – OPA (SNOMED preferred term: Insertion of oropharyngeal airway)</td> </tr> <tr> <td>Airway – NPA (SNOMED preferred term: Nasopharyngeal airway insertion)</td> </tr> <tr> <td>Airway – LMA</td> </tr> </table>	Preferred term	Abscess management	Airway – manual clear	Airway – suction	Airway jaw thrust	Airway – OPA (SNOMED preferred term: Insertion of oropharyngeal airway)	Airway – NPA (SNOMED preferred term: Nasopharyngeal airway insertion)	Airway – LMA
Preferred term									
Abscess management									
Airway – manual clear									
Airway – suction									
Airway jaw thrust									
Airway – OPA (SNOMED preferred term: Insertion of oropharyngeal airway)									
Airway – NPA (SNOMED preferred term: Nasopharyngeal airway insertion)									
Airway – LMA									

	(SNOMED preferred term: Laryngeal mask airway insertion)
	<u>Intubation</u>
	<u>Cricothyroidotomy</u>
	<u>Airway – laryngoscopy</u>
	<u>Airway other device</u>
	<u>Cardioversion</u>
	<u>Catheter troubleshooting</u>
	<u>Chest decompression</u>
	<u>CPAP</u> (SNOMED preferred term: Continuous positive airway pressure to nonventilated lung)
	<u>CPR</u> (SNOMED preferred term: Cardiopulmonary resuscitation)
	<u>Defibrillation</u>
	<u>Epistaxis management</u>
	<u>Epley manoeuvre</u>
	<u>Intraosseous infusion (IO)</u>
	<u>IV cannulation</u>
	<u>Limb reduction – wrist</u>
	<u>Limb reduction – elbow</u>
	<u>Limb reduction – shoulder</u>
	<u>Limb reduction – ankle</u>
	<u>Limb reduction – other</u>
	<u>Nasal tamponade</u>
	<u>Manual disimpaction</u>
	<u>Fascia iliac block</u>
	<u>Ring block – thumb</u>
	<u>Ring block – index finger</u>

<u>Ring block – middle finger</u>
<u>Ring block – ring finger</u>
<u>Ring block – little finger</u>
<u>Ring block – great toe</u>
<u>Ring block – second toe</u>
<u>Ring block – third toe</u>
<u>Ring block – fourth toe</u>
<u>Ring block – fifth toe</u>
<u>Dental block</u>
<u>Field block</u>
<u>Edge infiltration</u>
<u>Pacing</u>
<u>PEEP</u> (SNOMED preferred term: Positive end expiratory pressure reduced)
<u>PEG troubleshooting</u> (SNOMED preferred term: Maintenance of percutaneous endoscopic gastrostomy tube)
<u>Positioning – recovery</u>
<u>Positioning – supine</u>
<u>Positioning – seated</u>
<u>Positioning – lateral</u>
<u>Positioning – semi-recumbent</u>
<u>Positioning – prone</u>
<u>Positioning – other</u>
<u>Rectal prolapse reduction</u>
<u>RSI</u> (SNOMED preferred term: Rapid sequence induction)
<u>SC cannulation</u>

	<p>(SNOMED preferred term: Cannulation of subcutaneous reservoir)</p> <p><u>Splint/dressing/tag – dressing</u></p> <p><u>Splint/dressing/tag – bandage</u></p> <p><u>Splint/dressing/tag – cardboard splint</u></p> <p><u>Splint/dressing/tag – traction splint</u></p> <p><u>Splint/dressing/tag – KED or similar</u> (SNOMED preferred term: Immobilization using extrication splint)</p> <p><u>Splint/dressing/tag – cervical collar</u></p> <p><u>Splint/dressing/tag – cervical lanyard</u></p> <p><u>Splint/dressing/tag – other</u></p> <p><u>Stomach decompression</u></p> <p><u>Thrombosed haemorrhoid management</u></p> <p><u>Tourniquet</u></p> <p><u>Urinary catheter placement</u></p> <p><u>Valsalva manoeuvre</u></p> <p><u>Ventillation – manual</u></p> <p><u>Ventillation – mechanical</u></p> <p><u>Wound management</u></p>
Data type	SNOMED CT identifier
Layout	N(18)
Obligation	Mandatory
Guide for use	Valid code set value. The type of procedure or intervention performed is recorded with reference to a SNOMED concept

2.8.3. Body structure

Name	<u>Body structure</u>	
Definition	Details where the procedure was performed	
Source standards		
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> </table>	Preferred term
Preferred term		

	<u>ACF</u> (SNOMED preferred term: Entire cubital fossa)
	<u>Arm</u>
	<u>EJV</u> (SNOMED preferred term: Entire external jugular vein)
	<u>Forearm</u>
	<u>Fourth intercostal</u>
	<u>Hand</u>
	<u>Humeral</u>
	<u>Left ankle</u>
	<u>Left elbow</u>
	<u>Left shoulder</u>
	<u>Left wrist</u>
	<u>Leg</u>
	<u>Right ankle</u>
	<u>Right elbow</u>
	<u>Right shoulder</u>
	<u>Right wrist</u>
	<u>Second intercostal</u>
	<u>Tibial</u>
Data type	SNOMED CT identifier
Layout	N(18)
Obligation	Optional
Guide for use	Valid code set value <ul style="list-style-type: none"> • Second and Fourth intercostal only apply to Chest decompression • Tibial Humeral only apply to intraosseous (IO) access • Hand, Forearm, ACF and EJV only apply to IV cannulation • Arm and Leg only apply to Tourniquet • Left and right ankle, elbow, shoulder and wrist only apply to Limb reduction

	Value is NULL for all other Procedure types
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2.8.4. Laterality

Name	<u>Laterality</u>				
Definition	The distinction between whether a body structure is left, right or bilateral				
Source standards					
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>Left</u></td> </tr> <tr> <td><u>Right</u></td> </tr> <tr> <td><u>Bilateral</u></td> </tr> </table>	Preferred term	<u>Left</u>	<u>Right</u>	<u>Bilateral</u>
Preferred term					
<u>Left</u>					
<u>Right</u>					
<u>Bilateral</u>					
Data type	SNOMED CT identifier				
Layout	N(18)				
Obligation	Optional				
Guide for use	Valid code set value. Conditional on response of “Chest decompression”, “Intraosseous infusion (IO)”, “IV cannulation”, “Limb reduction” or “Tourniquet”				

2.8.5. Anatomical relationship

Name	<u>Anatomical relationship</u>			
Definition	A further distinction of the body structure positioning			
Source standards				
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>Lateral</u></td> </tr> <tr> <td><u>Midclavicular</u></td> </tr> </table>	Preferred term	<u>Lateral</u>	<u>Midclavicular</u>
Preferred term				
<u>Lateral</u>				
<u>Midclavicular</u>				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Optional			
Guide for use	Valid code set value. Conditional on response of “Chest decompression” to ‘Procedure type’			

2.8.6. Intervention success

Name	Intervention success
Definition	The success of the applicable intervention

Source standards				
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>Successful</u></td> </tr> <tr> <td><u>Unsuccessful</u></td> </tr> </table>	Preferred term	<u>Successful</u>	<u>Unsuccessful</u>
Preferred term				
<u>Successful</u>				
<u>Unsuccessful</u>				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Optional			
Guide for use	<p>Valid code set value.</p> <p>Conditional on response of</p> <ul style="list-style-type: none"> • Airway management (OPA, NPA, LMA, Intubation, Cricothyroidotomy, Laryngoscopy) • Catheter troubleshooting • Chest decompression • Intraosseous infusion (IO) • IV cannulation • Limb reduction • Pacing • RSI • Stomach decompression • Tourniquet • Valsalva manoeuvre <p>To 'Procedure type'</p>			

2.8.7. Notes

Name	Notes
Definition	Any additional material related to this intervention
Source standards	
Value domain	Free text
Data type	Alphanumeric
Layout	X(255)
Obligation	Optional
Guide for use	

2.9. Care Plan

A record of ongoing patient care recommended by the clinician.

2.9.1. Advice to patient

Name	<u>Advice to patient</u>
Definition	Self-care advice given to a patient that is not transported to a health care facility
Source standards	
Value domain	Subset of SNOMED CT: < 420227002 Recommendation to (procedure)
Data type	SNOMED CT identifier
Layout	N(18)
Obligation	Optional on a response of “Hear and advise”, “See and advise”, “See and treat” to ‘Encounter disposition code’
Guide for use	Patients who are not transported can receive leaflets and other advice. In many cases this can be coded (eg, <u>Advice to rest</u>); the code is recorded here.

2.9.2. Other advice to patient

Name	<u>Other advice to patient</u>
Definition	Additional advice given to a patient that is not transported to a health care facility
Source standards	
Value domain	Free text
Data type	Alphanumeric
Layout	X(255)
Obligation	Optional on a response of “Hear and advise”, “See and advise”, “See and treat” to ‘Encounter disposition code’
Guide for use	When there is no suitable SCTID for the advice provided then a summary is recorded here

2.9.3. Advice to patient’s GP

Name	<u>Advice to patient’s GP</u>
Definition	Note from the ambulance clinician to a patient’s GP
Source standards	
Value domain	Free text
Data type	Alphanumeric
Layout	X(255)
Obligation	Optional on a response of “Hear and advise”, “See and advise”, “See and treat” to ‘Encounter disposition code’
Guide for use	

2.9.4. Appointment made

The clinician may make an appointment on the patient's behalf with a third-party provider. The provider may or may not be a health care provider (eg, could be a social service or government department). The ambulance service would not normally transport the patient to the appointment.

(a) Appointment date/time

The format is set out in the common Date and time value domain specification. The data element is mandatory.

(b) Third-party provider

For a third-party provider who is also a health care provider, this is the Provider person or the Provider organisation (see Health care provider information). For third-party providers that are not health care providers or do not hold an HPI-ORG or HPI-CPN; this information is recorded under 'Other third-party provider'. Value is optional.

(c) Other third-party provider

Name	Other third-party provider
Definition	Name of the third-party provider if they are not a health care provider or hold an HPI-ORG or HPI-CPN.
Source standards	
Value domain	Free text
Data type	Alphanumeric
Layout	X(255)
Obligation	Mandatory on an appointment being made and no response to 'Third-party provider'
Guide for use	

(d) Patient consent obtained

Name	Patient consent obtained			
Definition	The patient consented to their personal information being shared with the third-party			
Source standards				
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>True</u></td> </tr> <tr> <td><u>False</u></td> </tr> </table>	Preferred term	<u>True</u>	<u>False</u>
Preferred term				
<u>True</u>				
<u>False</u>				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Mandatory on an appointment being made			

Guide for use	Valid code set value Value 'True' if the patient consented
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2.9.5. Referral initiated

The clinician may refer a patient to a pathway (eg, falls prevention, smoking cessation) that will be provided by a third-party. The provider is not known to the clinician at the time of making the referral.

(a) Referral pathway

Name	Referral pathway
Definition	The onward referral pathway
Source standards	
Value domain	Subset of SNOMED CT: < 169443000 Preventive procedure (procedure) or < 243120004 Regimes and therapies (regime/therapy)
Data type	SNOMED CT identifier
Layout	N(18)
Obligation	Mandatory on a referral being made
Guide for use	Records the SCTID for the pathway (eg, smoking cessation , falls prevention)

(b) Reason for referral

Name	Reason for referral
Definition	The reason for referral
Source standards	
Value domain	Free text
Data type	Alphanumeric
Layout	X(1024)
Obligation	Mandatory on a referral being made
Guide for use	

(c) Urgent referral

Name	<u>Urgent referral</u>		
Definition	This referral should be actioned as soon as possible		
Source standards			
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>True</u></td> </tr> </table>	Preferred term	<u>True</u>
Preferred term			
<u>True</u>			

	False
Data type	SNOMED CT identifier
Layout	N(18)
Obligation	Mandatory on a referral being made
Guide for use	Valid code set value Value 'True' if the referral is considered urgent

(d) *Patient consent obtained*

Name	<u>Patient consent obtained</u>			
Definition	The patient consented to their personal information being shared with the third-party			
Source standards				
Value domain	<table border="1"> <tr> <td>Preferred term</td> </tr> <tr> <td><u>True</u></td> </tr> <tr> <td><u>False</u></td> </tr> </table>	Preferred term	<u>True</u>	<u>False</u>
Preferred term				
<u>True</u>				
<u>False</u>				
Data type	SNOMED CT identifier			
Layout	N(18)			
Obligation	Mandatory on a referral being made			
Guide for use	Valid code set value Value 'True' if the patient consented to the sharing of their information with the third-party			

2.10. Metadata elements

The following table lists relevant clinical document metadata elements useful in the ambulance care summary context.

These elements are documented, with relevant HL7 FHIR mappings in:

- **HISO 10040.4:2015 Clinical Document Metadata Interim Standard**

Clinical document metadata elements
Creation datetime
Document identifier
Document URI
Availability status

3 Ambulance Care Summary representation

The Ambulance Operators offer two readable views (ie, reports) of the ambulance care summary in PDF format; each containing the same information but structured according to the requirements of the intended recipients.

These reports are accurate at the time of their creation but must not be considered themselves as part of the patient's permanent clinical record as the ambulance care summary may later be changed.

3.1. Transfer of care view

Transfer of care view is used to share information with the receiving health care provider when a transported patient is handed over. It is the basis for a clinical conversation between the ambulance clinician and receiving clinician (eg, an emergency department triage nurse) and may be recreated at any time later by an authorised health care provider.

The transfer of care view follows the structure defined in Design and trial of a new ambulance-to-emergency department handover protocol: 'IMIST-AMBO', interpreted as follows:

IMIST-AMBO	Transfer of Care View
Identification of Patient	Demographics; Encounter
Mechanism of injury / medical complaint	Problems
Injuries / information related to the complaint	Problems
Signs	Measurements and vital signs
Treatment and trends	Medications; Procedures
Allergies	Patient History
Medication	Patient History
Background history	Patient History
Other information	Care Plan

3.2. GP advice view

General practitioners (GPs) have overall responsibility for coordination of care provided to their patients, so should be informed whenever another clinician treats them.

GP advice view is used to advise an enrolled¹ patient's GP of an ambulance contact when the patient is not transported. This includes the patient being deceased at scene. GPs are not advised about transported patients; the assumption being that the receiving facility will advise them eg, through a discharge summary.

Every GP in New Zealand is set up to electronically receive hospital discharge summaries through the HealthLink service. Ambulance operators use this existing infrastructure to send the GP advice view.

¹ ie, a patient who is enrolled with a PHO

The GP advice view follows the structure of a discharge summary as follows:

eDischarge Summary	GP Advice View
Episode identification	Encounter
Discharge details	Encounter
Identification	Demographics
Advice to Patient	Advice to Patient
Advice to GP	Advice to patient's GP
Presenting complaint	Problems
Diagnosis	Encounter
Medications	Patient History
Allergies/reactions	Patient History
Other information	Clinical Summary Measurements and vital signs; Medications; Procedures

Appendix A

Medical Priority Dispatch System Codes

The MPDS system is a way of categorising and prioritising EMS incidents. The code system assigns a number-letter-number format code to each type of incident. The first number indicates the category of the incident. The letter denotes the priority of the incident, and the second number indicates the subcategory of the incident.

MPDS Category codes			
1	Abdominal Pain	18	Headache
2	Allergic Reaction	19	Heart Problem
3	Animal Bites	20	Environmental Exposure
4	Assault	21	Haemorrhage
5	Back Pain	22	Industrial Accidents
6	Breathing Difficulty	23	Overdose
7	Burn Subject	24	Pregnancy
8	Hazardous Exposure	25	Psychiatric Problem
9	Cardiac Arrest	26	Sick Call
10	Chest Pain	27	Stab/Gunshot/Penetrating Trauma
11	Choking	28	Stroke
12	Seizures	29	Traffic Collision
13	Diabetic Problems	30	Traumatic Injuries

14	Drowning	31	Subject Unconscious
15	Electrocution	32	Medical Nature Unknown
16	Eye Problem	33	Transfer
17	Falls		
MPDS Priority System codes			
A	Low Priority		
B	Mid Priority		
C	Possibly Life Threatening		
D	Life Threatening		
E	Full Arrest or Imminent Death		
O	Lowest Priority		

Code	Sub Category
1 – Abdominal Pain	
1D1	Not alert
1C1	Fainting or near fainting >50 yrs
1C2	Females fainting o near fainting 12-50 yrs
1C3	Males with pain above navel >45 yrs
1C4	Females with pain above navel >45 yrs
1A1	Abdominal pain
2 – Allergic Reaction	
2E1	Ineffective breathing
2D1	Severe respiratory distress
2D2	Not alert
2D3	Condition worsening
2D4	Swarm attack
2D5	Snakebite
2C1	Difficulty breathing or swallowing
2C2	Special medications or injections used
2B1	Unknown status (3 rd party caller)
2A1	No difficulty breathing or swallowing
2A2	Spider bite
3 – Animal Bites	
3D1	Unconscious or arrest
3D2	Not alert
3D3	Dangerous body area

3D4	Large animal
3D5	Exotic animal
3D6	Attack or multiple attack
3B1	Possibly dangerous body part
3B2	Serious haemorrhage
3B3	Unknown status (3 rd party caller)
3A1	Not dangerous body area
3A2	Non-recent injuries >6 hours
3A3	Superficial bites
4 – Assault	
4D1	Unconscious or arrest
4D2	Not alert
4D3	Abnormal breathing
4D4	Dangerous body area
4D5	Multiple victims
4B1	Possibly dangerous body area
4B2	Serious haemorrhage
4B3	Unknown status (3 rd party caller)
4A1	Not dangerous body area
4A2	Non-recent injuries >6 hours
5 – Back Pain	
5D1	Not alert
5C1	Fainting or near fainting >50 yrs
5A1	Non-traumatic
5A2	Non-recent injuries >6 hrs
6 – Breathing Difficulty	
6E1	Ineffective breathing
6D1	Severe respiratory distress
6D2	Not alert
6D3	Clammy
6C1	Abnormal breathing
6C2	Cardiac history
7 – Burn Subject	
7D1	Unconscious or arrest
7D2	Severe respiratory distress
7D3	Not alert
7D4	Explosion

7D5	Multiple victims
7C1	Building fire with persons inside
7C2	Difficulty breathing
7C3	Burns >18% BSA
7B1	Unknown status (3 rd party caller)
7A1	Burns 35 yrs
7A2	Fire alarm unknown situation
7A3	Sunburn or minor burn
8 – Hazardous Exposure	
8D1	Unconscious or arrest
8D2	Severe respiratory distress
8D3	HAZMAT
8D4	Not alert
8D5	Multiple victims
8D6	Unknown status (3 rd party caller)
8C1	Alert with difficulty breathing
8B1	Alert with difficulty breathing
8A1	CO alarm – EMS requested
9 – Cardiac Arrest	
9E1	Not breathing at all
9E2	Breathing uncertain
9E3	Hanging
9E4	Strangulation
9E5	Suffocation
9E6	Underwater
9D1	Ineffective breathing
9B1	Obvious Death
10 – Chest Pain	
10D1	Severe respiratory distress
10D2	Not alert
10D3	Clammy
10C1	Abnormal breathing
10C2	Cardiac history
10C3	Cocaine
10C4	Breathing normally >35 yrs
10A1	Breathing normally <35 yrs
11 – Choking	

11E1	Choking verified/ineffective breathing
11D1	Not alert
11D2	Abnormal breathing
11A1	Not choking now
12 - Seizures	
12D1	Not breathing
12D2	Continuous or multiple seizures
12D3	Irregular breathing
12D4	Breathing regularly not verified >35 yrs
12C1	Pregnancy
12C2	Diabetic
12C3	Cardiac history
12B1	Breathing regularly not verified 6 feet
12A1	Not seizing now & breathing verified
13 – Diabetic Problems	
13D1	Unconscious
13C1	Not alert
13C2	Abnormal behaviour
13C3	Abnormal breathing
13A1	Alert
14 – Drowning	
14D1	Unconscious
14D2	Not alert
14D3	Diving or neck injury
14D4	SCUBA accident
14C1	Alert with abnormal breathing
14B1	Alert & breathing normally with injuries
14B2	Unknown status (3 rd party caller)
14A1	Alert & breathing normally without injuries
15 – Electrocutation	
15E1	Not breathing/ineffective breathing
15D1	Unconscious
15D2	Not disconnected from power
15D3	Power not off
15D4	Long fall >6 feet
15D5	Not alert
15D6	Abnormal breathing

15D7	Unknown status (3 rd party caller)
15C1	Alert & breathing normally
16 – Eye Problem	
16D1	Not alert
16B1	Severe eye injuries
16A1	Moderate eye injuries
16A2	Minor eye injuries
16A3	Medical eye problems
17 – Falls	
17D1	Dangerous body area
17D2	Long fall >6 feet
17D3	Not alert
17D4	Abnormal breathing
17B1	Possibly dangerous body area
17B2	Serious haemorrhage
17B3	Unknown status (3 rd party caller)
17A1	Not dangerous body area
17A2	Non-recent injuries >6 hrs
18 – Headache	
18C1	Not alert
18C2	Abnormal breathing
18C3	Speech problems
18C4	Sudden onset of severe pain
18C5	Numbness or paralysis
18C6	Change in behaviour
18B1	Unknown status (3 rd party caller)
18A1	Breathing normally
19 – Heart Problem	
19D1	Severe respiratory distress
19D2	Not alert
19D3	Clammy
19C1	Firing of AICD
19C2	Abnormal breathing
19C3	Chest pain >35 yrs
19C4	Cardiac history
19C5	Cocaine
19C6	Heart rate 130

19B1	Unknown status (3 rd party caller)
19A1	Heart rate >50 or 5 mths
19A2	Chest pain <35 yrs without symptoms
20 – Environmental Exposure	
20D1	Not alert
20C1	Cardiac history
20B1	Change in skin colour
20B2	Unknown status (3 rd party caller)
20A1	Alert
21 – Haemorrhage	
21D1	Dangerous haemorrhage
21D2	Not alert
21D3	Abnormal breathing
21C1	Haemorrhage through a tube
21B1	Possibly dangerous haemorrhage
21B2	Serious haemorrhage
21B3	Bleeding disorder or blood thinners
21A1	Non-dangerous haemorrhage
21A2	Minor haemorrhage
22 – Industrial Accidents	
22D1	Life status questionable
22D2	Caught in machinery
22D3	Multiple victims
22B1	Unknown status (3 rd party caller)
23 – Overdose	
23D1	Unconscious
23D2	Severe respiratory distress
23C1	Violent
23C2	Not alert
23C3	Abnormal breathing
23C4	Antidepressants
23C5	Cocaine
23C6	Narcotics
23C7	Acid or alkali
23C8	Unknown status (3 rd party caller)
23C9	Poison Control request for response
23B1	Overdose without symptoms

23O1	Poisoning without priority symptoms
24 – Pregnancy	
24D1	Breech or code
24D2	Head visible
24D3	Imminent delivery >5 mths
24D4	3 rd trimester bleeding
24D5	High risk complications
24D6	Baby born
24C1	2 nd trimester haemorrhage or miscarriage
24C2	1 st trimester serious haemorrhage
24B1	Labour >5 mths
24B2	Unknown status (3 rd party caller)
24A1	1 st trimester haemorrhage or miscarriage
25 – Psychiatric Problem	
25D1	Not alert
25B1	Violent
25B2	Threatening suicide
25B3	Near hanging
25B4	Unknown status (3 rd party caller)
25A1	Non-violent & non-suicidal
26 – Sick call	
26D1	Not alert
26C1	Cardiac History
26B1	Unknown status (3 rd party caller)
26A1	Non priority symptoms
26A2	Boils
26A3	Bumps
26A4	Cannot sleep
26A5	Cannot urinate
26A6	Catheter problems
26A7	Constipation
26A8	Cramps/spasms
26A9	Cut-off ring request
26A10	Deafness
26A11	Defecation/diarrhoea
26A12	Earache
26A13	Enema

26A14	Gout
26A15	Haemorrhoids/piles
26A16	Hepatitis
26A17	Hiccups
26A18	Hungry
26A19	Nervous
26A20	Object stuck
26A21	Object swallowed
26A22	Penis problems
26A23	Rash/skin disorder
26A24	STD
26A25	Sore throat
26A26	Toothache
26A27	Transport only
26A28	Wound infected
27 – Stab/Gunshot/Penetrating Trauma	
27D1	Unconscious or arrest
27D2	Not alert
27D3	Central wounds
27D4	Multiple wounds
27D5	Multiple victims
27B1	Non-recent injuries >6 hrs / central wounds
27B2	Known single peripheral wound
27B3	Serious haemorrhage
27B4	Unknown status (3 rd party caller)
27A1	Non-recent >6 hrs / peripheral wounds
28 – Stroke	
28C1	Not alert
28C2	Abnormal breathing
28C3	Speech or movement problems
28C4	Numbness or tingling
28C5	Stroke history
28C6	Breathing normally >35yrs
28B1	Unknown status (3 rd party caller)
28A1	Breathing normally 6 hrs
29 – Traffic Collision	
29D1A	Major incident (aircraft)

29D1B	Major incident (bus)
29D1D	Major incident (train)
29D1E	Major incident (watercraft)
29D2A	High mechanism (all-terrain)
29D2B	High mechanism (motorcycle)
29D2C	High mechanism (auto-pedestrian)
29D2D	High mechanism (ejection)
29D2E	High mechanism (personal watercraft)
29D2F	High mechanism (rollover)
29D2G	High mechanism (vehicle off bridge/height)
29D3	HAZMAT
29D4	Pinned
29D5	Not alert
29B1	Injuries
29B2	Multiple victims (one unit)
29B3	Multiple victims (additional units)
29B4	Serious haemorrhage
29B5	Unknown status (3 rd party caller)
29A1	1 st party caller with non-dangerous injury
30 – Traumatic injuries	
30D1	Dangerous body area
30D2	Not alert
30D3	Abnormal breathing
30B1	Possibly dangerous body area
30B2	Serious haemorrhage
30A1	Not dangerous body area
30A2	Non-recent injuries (≥6hrs)
31 – Subject Unconscious	
31E1	Ineffective breathing
31D1	Unconscious
31D2	Severe respiratory distress
31D3	Not alert
31C1	Alert with abnormal breathing
31C2	Cardiac history
31C3	Multiple fainting episodes
31C4	Single or near fainting episodes & alert
31C5	Female 12-50 yrs without abdominal pain

32 – Medical Nature Unknown	
32D1	Life status questionable
32B1	Standing, moving, sitting, or talking
32B2	Medical alert notification
32B3	Unknown status (3 rd party caller)
33 – Transfer	
33D1	Suspected cardiac or respiratory arrest
33C1	Not alert (acute change)
33C2	Abnormal breathing
33C3	Significant haemorrhage or shock
33C4	Possible acute heart problems or MI
33C5	Acute severe pain
33C6	Emergency response requested
33A1	No priority symptoms

DRAFT