

# My Health Record

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My Health Record (MHR) provides a secure online summary of a patient's health information, which authorised Healthcare providers can view and update.

Zedmed can upload **Prescriptions** and **CDA letters** to My Health Record during a clinical encounter and an **Event Summary** at the end of an encounter. A **Share Health Summary** can be created at any time.

My Health Record (MHR) has a Practice Incentives Program (PIP), and only Shared Health Summary uploads count towards the quarterly requirements. For more information, visit digitalhealth.gov.au.

To learn how patients can manage their MHR and notifications, see the My Health Record FAQ.

### Requirements

To update and access a patient's MHR information in Zedmed, the following is required:

- The practice must have its HPI-O loaded in Zedmed and a NASH certificate.
- The practitioner needs an HPI-I number.
- For referrals (CDA letters), Clinical Address Book addressees must have an HPI-I number and an HPI-O for their practice.
- The patient must be registered for MHR and have a valid IHI Number.
- To learn more, see the Zedmed My Health Record setup guide.

### Practice Incentives Program (PIP)

There is a Practice Incentives Program (PIP) for Shared Health Summary uploads based on quarterly requirements. To meet the PIP requirements, a Shared Health Summary must be uploaded in full with all sections included.

The Shared Health Summary is manually run, and it is important to ensure that doctors meet their upload quota and follow the upload steps detailed in the Shared Health Summary section below.

To monitor the uploads, we recommend using the **My Health Record Uploads** report on a regular basis. This report shows how many Shared Health Summaries were successfully uploaded per doctor in a given time frame and is explained in the **My Health Record reporting** section below.

### Authority to access MHR

A healthcare provider providing patient care does not need to seek prior permission before accessing the patient's MHR. My Health Record participation transitioned to opt-out in 2018, as per the MHR Act Schedule 1, Clause 9. Patients can opt-out and manage access to their MHR information. They can also hide or remove specific documents. To learn more, see Digitalhealth.gov.au>Privacy and Access.

Important: When a patient is opened in Clinical, Zedmed accesses their MHR, and patients with notifications on

will receive an alert if it's the first time (or first time in 3 years) the organisation has accessed their record. To learn more, see the MHR FAQ.

#### **Upload Consent**

If a patient has not opted out of MHR, they can still prevent MHR uploads from Zedmed using the **My Health Record Upload Consent** tick box in Clinical's **Patient Details** (screenshot below). The box is ticked by default. If it is not ticked, no information will be uploaded from Zedmed. The tick box is reflected in the **MHR Status** shown in the demographic section (screenshot below), which must display **Consent to Upload** before information can be uploaded to MHR.

Removing the consent to upload is not the same as opting out of MHR. It does not prevent Zedmed Summary and History views from accessing MHR to update and display information already uploaded. The consultation is still added to the Past Consultations list, which can be used to upload an Event Summary if the Upload Consent box is ticked at a later date.

#### Upload Consent for a specific encounter

If a patient's status is **Consent to Upload**, BUT they don't want anything uploaded from the current encounter, select the **MHR Automatic Uploading** icon above the **Summary View** to toggle off uploads. Toggling off uploads stops any information from being uploaded from the Current Encounter.

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	MCINTYRE, Goldie	Patient - MCINTYRE, Goldie	×
Address: DOB: Age: Medicare No: File No: Referrer: MHR Status :	46 Hiram Cir, BOCOBRA 2865 25/04/1959 Home: 62 years Work: 29532965711 Mobile: 0409359466 65 Occupation: Hosp UR No: Consent to Upload	Patient Details       NOK and Emergency Contact       Family, Social & Past History       Smoking       Alcohol       Other Clinicians         Personal       Practice       File Number       65       p1D       65         Given Name       Goldie       Initial       Popular Name       ACIR       ACIR         Date of Birth       25/04/1959       Gender       File       Next Appointment         ATSI Status       CTG PBS Co-Payment Relief       Next Appointment       None scheduled	
Problems	Summary Views Sort By: Problem Text v Int Problems	EHealthID - Individual Healthcare Identifier (IHI) IHI Number Number Status Active Record Status Verified Last Updated	t

You can tell the status of a patient's participation by the type of icon shown for MHR above the **Summary View** section of the patient's clinical record.

lcon	Status
MHR	<ul> <li>Patient has a My Health Record and the Provider (Doctor) has open access.</li> <li>Access has been obtained to a protected/non-advertised My Health Record by entering the access code.</li> <li>An emergency access has been gained to a protected/non-advertised My Health Record.</li> </ul>
MHR	• Patient has a My Health Record which is protected with an access code and to which the provider has not yet accessed
MHR	<ul> <li>The Provider is on the patient's revoked list/they have removed the provider from the Provider Access List and revoked access.</li> <li>Patient has a non-advertised My Health Record which the provider has not accessed, which may or may not have an access code</li> <li>There is no My Health Record for the patient</li> </ul>
× MHR	• The call the the My Health Record system has failed for some reason.
? MHR	<ul><li>HPI-O not recorded (or) Invalid HPI-O</li><li>IHI not recorded</li></ul>
	Visible beside items in the various Summary Views, denotes that the item has been sourced from the patient's My Health Record.
	Visible on buttons that enable or disable automatic uploading to the patient's My Health Record during the encounter.

# How information is uploaded

With Zedmed's default settings, CDA letters and prescriptions are uploaded during an encounter, and you are prompted to approve the Event Summary upload at the end of the encounter. A Shared Health Summary is created manually as required.

### Upload settings

The MHR upload settings are configured in the Clinical Records menu: **Tools** > **My Options** > **My Health Record** tab. To learn more, see the **My Health Record setup guide**.

eneral	Drug Options	Document Handling	Function Selections	My Health Record		
My Hea	Ith Record Uplo	ad				
() /	Auto Upload	O Prompt		pload		
Refe	errals Default to send	as CDA / e-Letter			The default settings	
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History	View					
Dis En	splay My Health abling this chec	Record Entries kbox would then inclu	de all My Health record	d entries to display within	the History View.	
	10000					

### Upload options

This table shows how each upload option functions, and the dedicated sections below explain each data type.

Data type	Setting	How it works					
	<b>Auto upload</b> (Default)	When you select <b>Prescribe /Prescribe Electronically</b> , the script information is automatically uploaded to MHR					
Medications	Prompt	When you select Prescribe /Prescribe Electronically, there is a confirmation prompt to upload the script to MHR.  Confirm Upload this prescription to My Health Record?  Yes No					
Referrals (CDA)	Send as CDA/eLetter	When you use select Write Letter in the referrals module, a CDA form will open to fill in and then Send.          Actions         Back       Confirm Content Without Sending    Confirm Content and Send					
	Auto upload	When you end an encounter, an Event Summary will be automatically uploaded. A yellow banner will display during the encounter so you can review or modify the information. All items are selected by default.          MCINTYRE, Goldie         Based on today's interaction(s) an Event Summary will be generated. Click here to modify.         MCINTYRE, Goldie					
Event Summary							

	<b>Prompt</b> (Default)	When you end an encounter, a prompt will ask you to confirm the Event Summary upload. If you select No, you can still create an Event Summary from Quick Documents>My Health Record Summaries at a later date. All items are unticked by default.						
History View	<b>Ticked</b> (Default)	MHR information is added to the History View and can be toggled on and off by the Include MHR button.						
Shared Health Summary	Manually created as required.	The form is opened from the Quick Documents menu then reviewed and submitted to MHR						

### Medications

Prescriptions are uploaded during an encounter when you select **Prescribe** or **Prescribe Electronically**. By default, the upload happens automatically in the background. You can also enable a **Yes / No** prompt in the upload settings.

- When you create an **Event Summary**, you can tick the medication to add it to the content of the Event Summary.
- When you create a **Shared Health Summary**, all prescribed medications will be added and ticked, including those not uploaded during an encounter. They can be unticked as required.

When you upload a medication from the prescriptions module, it will appear in the Medication Summary in MHR.



All medications uploaded with the **Event Summary** or **Shared Health Summary** will appear under their respective category in **All Documents.** The **Medicines View** collates allergy and medicine information from different sources and providers, but the **Summary Views > Medications** tab may provide a better option to view this information.

		All Documents	Medications Summary	Pathology Report	Diagnostic Imaging Report					
My Health Record Do	cuments	This is not a con	mplete view of the individ	lual's health informa	ation. For more information ab	out the individual's health	h record or data, please	consult the individual or other hea	althcare	professionals as needed
Include Documents from		Document dat	e 🔻					Service d	ate	Document
Date Custom Date	*	■ No ne ■ Shar	ew document(s red Health Summa	) since the l	last Shared Healt	h Summary				
From 20 Feb 2021		Ever e-Re	nt Summary eferral							
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# Referrals, Specialist Letters and Results

### **GP** Referrals and Specialist Letters

Referrals & Specialist Letters are uploaded to MHR whenever the CDA letter format is used, as explained in the Write a CDA letter guide.

- In the Referrals module, the CDA document is called a Specialist Letter or eReferral (GP), depending on the practitioner.
- The batch writer and Letter writer in quick documents cannot create CDA letters for MHR.
- For Write Letter to open a CDA format letter, the addressee must have their HPI-I number in the practice's Address Book.
- The Summary Views Referrals tab does not show the referrals uploaded to MHR by other organizations.
- When the CDA letter is uploaded, you canview it in the patient's MHR under the Specialist Letter or eReferral group.

Enabling CDA Referrals and Letters:

- The CDA format is enabled by the **Send as CDA/eReferral** tick box in the Referrals module (screenshot below).
- This box is ticked by default if the Default to send as CDA/eLetter tick box in the upload settings (Tools > My Options).



#### Results

Pathology and Radiology results are uploaded to MHR by the laboratory. Next to **Order Test** in the **Referrals** module is a tick box **Do Not Send Report to MyHealth Record**. This should be selected if you do not want the laboratory to upload the results.



## **Event Summary**

Event Summaries capture information about healthcare events that are relevant to the ongoing care of an individual. An Event Summary may contain allergies and adverse reactions, medications, diagnoses, interventions, immunisations and diagnostic investigations. To learn more, see Digitalhealth.gov.au>what's in a record.

With the default setting, you will be prompted to create an Event Summary at the end of an encounter. Selecting **Yes** will open the Event Summary form so you can review and select the items you want to include. Once you are happy with the information, select **Next** to view the final form, then select **Confirm Content and Upload** to upload the information to My Health Record.

If the Event Summary is changed from **Prompt** to **Auto Upload** in the **upload settings**, there will be no prompt, and all items will be selected by default and uploaded when the encounter is stopped. There will also be a clickable yellow banner during the encounter if you record information using a clinical module, and selecting the banner will open the Event Summary with nothing selected, so you can select the items to be uploaded. You can also select **Confirm Content and upload** the Event Summary manually, even if the default was for an auto upload.

Please be aware of the following scenarios:

- If no information is recorded using the clinical modules, an Event Summary will not be created (you will not be prompted).
- Any modifications to an existing Event Summary will be uploaded with a different version number.
- The tick boxes for items in the Event Summary only determine if that information will be included within the Event Summary.
- Having no tick next to a referral will not undo the uploading of that referral (CDA letter) during the encounter.
- Having no tick next to a medication will not undo the uploading of a prescription during the encounter.

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DOB:     250/474       Medicare Card     DVA       Medicare Card     DVA       Medicare Card     DVA       Jump to> Source     Allergies       Medicare Card     Dotor Name       Dotor Name     Devis, DP Philip (PD)       Problems     Feerrer:       Problems     Event Details       Problems     Res       Agent     Reaction Description       Allergies:     Medical Processor       Medications:     Medical Processor       Medications:     Medical Processor       Medications:     Medical Fiscation is deselected so that it is not uploaded       Medical Pressing     Medical Fiscation is deselected so that it is not uploaded       Medical Fiscations     Save the Event Summary as a draft. Each ndvidual, it is not a complete health summary as a draft. Each ndvidual, it is not a complete health summary as a draft. Each ndvidual, it is not a complete health summary as a draft. Each ndvidual, it is not a complete health summary as a draft. Each ndvidual, it is not a complete health summary as a draft. Each ndvidual, it is not a complete health summary as a draft. Each ndvidual, it is not a complete health summary as a draft. Each ndvidual, it is not a complete health summary as a draft. Each ndvidual, it is not a complete health summary as a draft. Each ndvidual, it is not a complete health	Address: 46 Hiram	Name MiLini Net, Golde IIII III HI MO 63 Phone 0403339400 Alisi Mot Reduided
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**Important**: When you select **Click here to modify**, all items in the Event Summary will be<u>deselected</u> when the summary opens, and only information that is selected will be uploaded. If you do not select **Click here to modify**, <u>all information</u> will stay selected and be uploaded when the encounter is ended.

### Manually uploading at a later date

If you select **Yes** (using the prompt setting) to upload an Event Summary and then select **Save draft** when reviewing it, the Event Summary will be saved in the **Summary Views** > **Documents** under **My Health Record Summaries** with a red D icon. You can right-click edit the draft Event Summary to update and upload it.

r	Summary Views	
Problems		
Referrals	14/09/2022 Ref Letter - Standard - Fred Tester2     09/09/2022 Ref Letter - Standard - Mack Tester1	^
Results	<ul> <li>My Health Record Summaries</li> <li>24/10/2022 Event Summary v1</li> </ul>	
Immunisations	28/09/2022 Event Summary v1 14/09/2022 Event Summary v1	
Allergies	09/09/2022 Event Summary v1     08/09/2022 Event Summary v1     08/09/2022 Event Summary v1     06/09/2022 Event Summary v1	
Images/ECG	06/09/2022 Event Summary v1	
Documents	4	
Measurements	f	

If you select **No** to upload an Event Summary at the end of an encounter or **Cancel** after selecting **Yes**, the consultation will be saved in the **Past Consultation** screen under **Quick documents** > **My Health Record Summaries** > **Event Summary**. Select the consultation and click OK to create an Event Summary. You can then review and upload it.

Image: A start and a start and a start a st												
Summary Views												
	Past Consultations X											
	Select a Consultation											
	Start Date/Time	End Date/Time	Duration									
	17/01/2023 14:08	17/01/2023 14:25	00:17									
	16/01/2023 15:50	17/01/2023 12:49	20:58									
	16/01/2023 12:15	05/02/2146 04:14	01:36									
	09/01/2023 10:14	22/01/2146 01:32	23:48									
	06/01/2023 08:59	13/01/2146 23:47	00:52									
	22/12/2022 16:22	03/01/2023 12:51	00:11									
	21/12/2022 15:53	21/12/2022 16:00	00:06									
	19/12/2022 14:45	19/12/2022 14:56	00:11									
	15/12/2022 13:08	15/12/2022 13:58	00:49									
	08/12/2022 11:34	08/12/2022 12:01	00:20									
In												
	Ch				× c							
	Show All			✓ <u>u</u> K	X Lanc	el						

# Shared Health Summary

This is a summary of a patient's health status at a point in time, which can include problems, medications, allergies and adverse reactions, and immunisations. To learn more, see Digitalhealth.gov.au>what's in a record.

My Health Record (MHR) has a Practice Incentives Program (PIP), and only Shared Health Summary uploads count towards the quarterly requirements. If you upload a Shared Health Summary, it needs to be uploaded in full, with all four sections of the document included ( patient's current condition, medications, etc. at that point in time ), as this summary serves as a complete health snapshot for other clinicians.

For more information, visit digitalhealth.gov.au.

Each time a Shared Health Summary is run it includes the information of past Shared Health Summaries and any new clinical information up to the time the Summary is created. A Shared Health Summary cannot be modified once it's been uploaded. You can only delete and redo it.

To upload a Shared Health Summary:

1. Open the patient's clinical record.

To learn more, see the find a patient article.

2. Select the Quick Documents icon shown below the red arrow in the screenshot below.

MCINTYRE,	Goldie 🗵		
		MCINTYRE, Goldie	
Address:	46 Hiram Cir,		
	BOCOBRA 2865		
DOB:	25/04/1959	Home:	
Age:	62 years	Work:	
Medicare No:	29532965711	Mobile: 0409359466	
File No:	65	Occupation:	
Referrer:		Hosp UR No:	
MHR Status :	Consent to Upload		
			×
•	<ul> <li>(a) (a)</li> </ul>		
<b>F</b>	Patient Drug Sheets	Summary Views	
	New Letter		
N	My Health Record Summaries	Shared Health Summary	~
4	15-49 Health Check 717	Event Summary	

3. Select My Health Record Summaries > Shared Health Summary.

The screen will open (screenshot below) and load a Zedmed form populated with data from the patient's Zedmed record.

- 4. Review the data to be uploaded:
  - a. Review the items that have been selected.

Review items that we deselected in past encounters with the patient.

Removing a tick removes that item from the upload.

- b. Check that the **Allergies and Adverse Reactions** section has an Agent selected or **None Supplied** is selected from the drop-down.
- c. Check that the **Immunisations** section has a selection or that **None Known** is selected from the dropdown.
- 5. Select Next (preview).

**If you receive an error**, it will often be because not all the fields are complete or information is missing from the encounter. Until an error is resolved, the Shared Health Summary will not be uploaded or counted for the PIP.

					S	hared Health Sumr	mary			_ □
Patient Details										
Name Holla	away, Mr K	Inut		IHI		File No 4	Phone	0478701007	ATSI Both Aborigin	al and Torres Strait
DOB 19/0	5/1995		Sex Male	Address	5 Jacob Pl	BUGLE RANGES, 5251			Email	
Medicare Car	d	1		DVA						
						Jump to> So	urce Allergies	Medicine Hi	story Immunisation	
ealth Summa	ary Sourc	ce								
Doctor Name	Davis D	r Phillin (PD)	5		Пнры		Healthcare Br	le General Me	dical Practitioner	~
linia Noma	Propole 1	( C)					Clinic Address		Albert Board, SOUTH &	
unic Name	branch				- HEPO		Clinic Address	03 9284 33		
							Clinic Frione	03 3204 330		
llergies and	d Advers	e Reaction	s							3
		$\checkmark$								
ason for nothi	ing	Agent						Reacti	ion Description	
ed / selected		Penicillin	ns					Unable to brea	athe Adverse reaction	
	~	Mixed n	iuts					Ache A	dverse reaction	
		1								
										>
ledicine										
Aedicine ason for nothi	ing	Medication	15			Directions	Clinic	al Indication	Comments	
<b>fedicine</b> ason for nothi ed / selected	ing	Medication	is tide 250mcg (	perm Linjecta 24 mi [1]	able	Directions ONCE A DAY ONCE A AFTER MEALS	Clinic. DAY	al Indication	Comments	
fedicine ason for nothi ed / selected	ing	Medication Teriparal Solution	is tide 250mcg p 250mcg/mL 3 line 10mg Ora	per mL Injecta 2.4 mL [1] al Tablet 10mg	able g (50)	Directions ONCE A DAY ONCE A AFTER MEALS TAKE 1 BID NOCTE	Clinic DAY	al Indication	Comments	
fedicine ason for nothi ed / selected	ng	Medication Teriparal Solution Nortriptyl	is tide 250mcg p 250mcg/mL ; line 10mg Ora an 10mg Waf	perm L Injecta 2.4 mL [1] al Tablet 10mg er 10mg [2]	able g (50)	Directions ONCE A DAY ONCE A AFTER MEALS TAKE 1 BID NOCTE TAKE 1 PRN	Clinic DAY Vinsc	al Indication omnia omnia	Comments	
ledicine ason for nothi ed / selected	ng	Medication Teriparal Solution Nortripty Rizatripta Adapalet Topical (	is tide 250mcg r 250mcg/mL : Jine 10mg Waf na 0.1% - Ber Gel 30 g(0.1%	per mL Injecta 2.4 mL [1] al Tablet 10mg ier 10mg [2] nzoyl peroxide \$/2.5% tube) [	able g (50) e 2.5% (1)	Directions ONCE A DAY ONCE A AFTER MEALS TAKE 1 BID NOCTE TAKE 1 PRN TAKE 1 BID AS DIREC	Clinic DAY Vinse TED	al Indication omnia omnia	Comments	
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<b>4edicine</b> eason for nothi ed / selected	ng	Medication Teriparal Solution Nortripty Rizatripta Adapate Ada	is tide 250mcg r 250mcg/mL iline 10mg Waf ne 0.1% - Ber Gel 30 g(0.1% amol 500mg C nic acid 70mg Jet (70 mg/70 zole 10mg Ga 20le 10mg Ga	per mL Injecta 2.4 mL [1] al Tablet 10mg er 10mg [2] rzoyl peroxide ;/2.5% tube) [ Coated Tablet - Colecalcifer 0 mcg) [4] stro-resistant	able 9 [50] 2 2.5% 11] 500mg [12 500mg [12 Tablet	Directions ONCE A DAY ONCE A AFTER MEALS TAKE 1 BID NOCTE TAKE 1 BID AS DIREC TAKE 1 TAB AS DIREC TAKE 1 TAB WEEKLY MEALS TAKE 1 CAP AS DIREC	Clinic DAY Vinsc TED BEFORE VPyn	al Indication omnia omnia	Comments	
<b>dedicine</b> eason for nothi ed / selected	ng	Medication Teriparal Solution Nortripty Rizatripta Adapater Topical ( Paraceta Calandror Oregraz Unang (33) Metformi Metformi	is tide 250mcg r 250mcg/mL iline 10mg Waf ne 0.1% - Ber Gel 30 g(0.1% amol 500mg C nic acid 70mg Jet (70 mg/70 zole 10mg Ga 0) in hydrochlorid	per mL Injecta 2.4 mL [1] al Tablet 10mg r 10mg [2] rzoyl peroxide (72.5% tube) [ Coated Tablet Coated Tablet - Colecalcifer 0 mcg) [4] stro-resistant de 500mg Mo	able g [50] g 2.5% 1] 500mg [12 rol 70mcg Tablet udified	Directions ONCE A DAY ONCE A AFTER MEALS TAKE 1 BID NOCTE TAKE 1 BID AS DIREC TAKE 1 TAB WEEKLY MEALS TAKE 1 CAP AS DIREC	Clinic DAY Vinsc TED BEFORE VPyn	al Indication omnia omnia exia, with rash	Comments	
<b>dedicine</b> eason for nothi ed / selected	ing	Medication Teriparal Solution Nortriptyl Rizatripta Adapalei Adapalei Paraceta Qual Tab Omepraz 10mg [30] Metformi Release Outpool	is tide 250mcg r 250mcg/mL ine 10mg Waf ne 0.1% - Ber Gel 30 g(0.1% amol 500mg C amol 500mg C tole 170 mg/70 zole 10mg Ga 0) in hydrochloric T ablet 500m T ablet 500m	per mL Injecta 2.4 mL [1] al Tablet 10mg r10mg [2] nzoyl peroxide (?2.5% tube) [ Coated Tablet - Colecalcifer 0 mcg) [4] stro-resistant de 500mg Mo g [120] wide 2 Emg Jo	able g (50) g (25% 1) 500mg (12 500mg (12 rol 70mcg Tablet dified	Directions ONCE A DAY ONCE A AFTER MEALS TAKE 1 BID NOCTE TAKE 1 BID AS DIREC TAKE 1 BID AS DIREC TAKE 1 TAB WEEKLY MEALS TAKE 1 CAP AS DIREC TAKE 1 CAP MANE	Clinic DAY Vinsc TED BEFORE Pyn CTED	al Indication minia minia exia;with rash	Comments	
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Aedicine ason for nothi	ng	Medication Teriparal Solution Nortripty Rizatipta Adapate Topical ( Paraceta Alendror Oral Tab Omepraz 10mg (30 Refease Oxycode Vhydroch (25 mg/	is tide 250mcg p 250mcg/mL 3 ine 10mg Waf ne 0.1% - Ber Gel 30 g(0.1% amol 500mg C nic acid 70mg olet (70 mg/7C) zole 100mg Ca 0] in hydrochloric T ablet 500mg one hydrochlori 1.25 mg) [28] lax 100mg Ca	per mL Injecta 2.4 mL [1] al Tablet 10mg er 10mg [2] rooyl peroxide (/2.5% tube) [ Coated Tablet - Colecalcifer 0 mg] [4] stro-resistant de 500mg Mo g [120] vide 2.5mg - N Modified Rele bated Tablet	able 9 [50] 9 2.5% 11] 500mg [12 rol 70mcg Tablet rolfied Valoxone ease Table	Directions ONCE A DAY ONCE A AFTER MEALS TAKE 1 BID NOCTE TAKE 1 PRN TAKE 1 BID AS DIREC TAKE 2 TID TID PRN TAKE 1 TAB WEEKLY MEALS TAKE 1 CAP AS DIREC TAKE 1 CAP MANE TAKE 1 TAKE 1	Clinic DAY Vinso TED BEFORE Pyn TED	al Indication minia minia exia;with rash	Comments	
<b>dedicine</b> eason for nothind is a selected	ng	Medication Teriparal Solution Nortripty Rizatipta Adapater Topical ( Paraceta Alendror Oral Tab Omepraz 10mg (30 Refease Oxycode Vhydroch (25 mg/ Venetoc Di0mg(8 Paraceta	is tide 250mcg p 250mcg/mL 3 ine 10mg Waf ne 0.1% - Ber Gel 30 g(0.1% amol 500mg C nic acid 70mg cole 10mg Ga 0] in hydrochloric T ablet 500mg one hydrochloric 1.25mg] [28] lax 100mg Co 3ottle] [120] mol 500mg -	per mL Injecta 2.4 mL [1] al Tablet 10mg [2] rooyl peroxide (/2.5% tube) [ Coated Tablet - Colecalcifer 0 mg] [4] stro-resistant de 500mg Mo g [120] ride 2.5mg - N Modified Rele bated Tablet Codeine pho:	able 9 [50] 9 2.5% 11] 500mg [12 rol 70mcg Tablet ndified Valoxone ease Table sphate	Directions ONCE A DAY ONCE A AFTER MEALS TAKE 1 BID NOCTE TAKE 1 PRN TAKE 1 BID AS DIREC TAKE 2 TID TID PRN TAKE 1 TAB WEEKLY MEALS TAKE 1 CAP AS DIREC TAKE 1 CAP MANE TAKE 1 CAP MANE	Clinic DAY Vinso TED BEFORE Pyn TED	al Indication minia minia exia;with rash	Comments	
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An example of an error that is known to prevent the **Shared Health Summary** from uploading is the **Problem** definition missing an **Onset Date.** If ICPC was used, this will appear in the **Problem/Diagnosis** section. If Free Text was used, it will appear under **Other Medical History**. The screenshot below shows where the Onset Date is set in the Problems module.

Problem Ringing in ear	Extra Text		1			
✓ Include in Correspondence Problem Details for - Ringing in ear	Left ear (Existin	Required for My Health Record - Shared Health Summary uploads		Select Problem	Add to History	Add to Common
Onset Date 15/03/2023	Accurate To: 🤇	Day O Month O Year O Other	Criticality Imp	portant	✓ Left	🗌 Right 🕑 Current

The Shared Health Summary report will open.

This provides a summary of the information to be uploaded into My Health Record.

- 6. Check the information.
- 7. Select Confirm Content and Upload.
- 8. If you check the **Documents** tab in **Summary Views**, you will see the upload under **My Health Record Summaries**. Once the information has been uploaded, the entry will turn from blue to black.

2	Shared Health Summary	-	D X
૨ <	Mousewheel zoom c	ontrol	
Mr Knut HOLLAWAY DoB 19 May 1	Shared Health Summary 27 Oct 2021 995 (26y*) SEX Male IHI		^
Branch 1 Author Dr Phillip Davis (General Me Phone 03 9284 3300 Adverse Reactions	edical Practitioner)		
Adverse Reactions			
Substance/Agent	Manifestations	Reaction Type	
Penicillins	Unable to breatne	Adverse reaction	
Mixed nuts	• Acne	Adverse reaction	
Cow's milk	Unspecified	Hypersensitivity reaction type I	
Medications			
Medications			
Medication	Directions	Clinical Indication	
Teriparatide 250mcg per mL Injectable Solution 250mcg/mL 2.4 mL [1]	ONCE A DAY ONCE A DAY AFTER MEALS		
Nortriptyline 10mg Oral Tablet 10mg [50]	TAKE 1 BID NOCTE	insomnia	
Rizatriptan 10mg Wafer 10mg [2]	TAKE 1 PRN	insomnia	
Adapalene 0 1% - Renzovl neroxide 2 5%	TAKE 1 RID AS DIRECTED		>
<ul> <li>I am the patient's nominated healthcare prov.</li> <li>I am providing ongoing care to this patient.</li> <li>I have prepared this Shared Health Summar Actions</li> </ul>	vider in accordance with the <i>My Health Record Act</i>	2012 .	Close
Back Confirm Content Without Upload Confirm Content a	nd Upload	L	

# Summary View & History View

Clinical information uploaded to MHR, including information from other providers, can be displayed in the Summary Views and History View

### **History View**

To view information added to the patient's My Health Record by other healthcare providers, toggle the **Include MHR** button on or off. Each MHR entry appears under a date, has a green tick next to it and can be selected to open the record.

History View	
Image: 1 2 3       Image: 2 3<	
25/11/2021 (Thu) 9:37am with Dr Phillip Davis at MED, for 26m 13s No RFE Referral: Dr Vivian Mortier - eReferral	^
25/11/2021 (Thu) 4:24am V My Health Record from Dr Phillip Davisat Branch 1 Specialist Letter Specialist Letter	
24/11/2021 (Wed) 11:03pm VMy Health Record from Dr Phillip Davisat Branch 1 Event Summary	
24/11/2021 (Wed) 10:39pm V My Health Record from Dr Phillip Davisat Branch 1 Specialist Letter	
Specialist Letter 24/11/2021 (Wed) 4:14pm with Dr Phillip Davis at MED, 1d 21h 28m 09s No RFE	
24/11/2021 (Wed) 3:55pm with Dr Phillip Davis at MED, for 2m 53s No RFE	
Referral: Dr Vivian Mortier - eReferral 24/11/2021 (Wed) 1:27pm with Dr Phillip Davis at MED, for 2m 21s No RFF	~

#### MHR in Summary Views

The **Include MHR** icon in the **Results**, **Immunisations**, **Allergies** and **Medications** tabs toggle on and off to show any records uploaded by other healthcare providers. This important feature provides an easy way to get a comprehensive view of this clinical information.

- Each MHR entry appears by an Australia icon.
- Selecting an attachment link within a Diagnostic Imaging Report will open the scan or x-ray.
- When information from an encounter is uploaded to MHR, it will also appear in the usual Summary View tab.
- New entries in the Summary Views will appear as blue and turn black when they have uploaded to MHR.

To learn more, see the Results, Immunisations, Allergies and Medications Summary Views articles.



# Viewing a patient's My Health Record

A patient's MHR is displayed using the **My Health Record Documents** UI, which contains tabs and filters to manage the information available.

### Opening the MHR Documents UI

#### To view a patient's information:

1. Open the patient's record.

To learn more, see the find a patient article.

2. Select the My Health icon above the **Summary Views** section.

OR

If the encounter is running, select the MHR icon from the **Current Encounter** menu.

3. The My Health Record Documents screen will open.



### All Documents tab

The **All documents** tab with a 2-year date range is the default, and **Refresh** must be selected to download and display the records. The left pane contains the filters and search criteria used to locate specific information, and Refresh must also be used when applying these filters.

All **Shared Health Summary, Event Summary**, and CDA letters (Specialist Letter or eReferrals for GPs) are grouped here. There are also documents uploaded by other providers, such as discharge summaries from hospitals and records from pharmacists, and overviews of information from different sources. Pathology Overview and Diagnostic Imaging provide a useful way to see a patient's results.

A doctor can **Remove documents** they uploaded by selecting the document and then selecting the **Remove Document** button on the bottom right. In the screenshot below, it is greyed out as another provider's document is selected. A doctor can view removed documents by ticking the **Remove** box below the date (top left), then selecting **Refresh**. Only a patient can prevent their MHR documents from being viewed.

0	My Health Record Documents	s for MCINTYRE, Goldie		_ D X
	All Documents Medications Summary Pathology Report	Diagnostic Imaging Report		
My Health Record Documents	This is not a complete view of the individual's health informat individual or other healthcare professionals as needed.	tion. For more information about the	individual's health record or o	data, please consult the
Include Documents from	<ul> <li>Service date</li> <li>Document</li> </ul>	Organisation	Organisation Type	Saved Status
Date     Custom Date       From     21 Feb 2021       To     21 Feb 2023	<ul> <li>13 new document(s) since the lage</li> <li>Shared Health Summary</li> <li>Event Summary</li> <li>Discharge Summary</li> <li>Specialist Letter</li> <li>Referral</li> </ul>	ast Shared Health Sun	nma <b>ry</b>	
Include Document Status	6 Sep 2 e-Referral	Communicare	Specialist Medical Servi	. No
Removed Superseded	21 Jun e-Referral	Test Health Service 752	General Practice	No
	19 Jun e-Referral	Test Health Service 752	General Practice	No
Documents	eHealth Prescription Record			35.30
Show All	Medicare Overview			
	Medicines View			
Shared Health Summary	Diagnostic Imaging Overview			
Event Summary	Pathology Overview			
Discharge Summary	Immunisation Consolidated View			
Specialist Letter				
e-Referral	QQQ  <b>fGJ</b>  H 4 F H <b>B</b>	[	Mousewheel zoom control	l.
Additional Filters (none)				
Most Recent Shared Health Summary		e-Referral 6 Sep 2022		<b>^</b>
	Goldie MCINTYRE DoB 25 Apr 195	9 (63y*) SEX Female	IHI 8003 6086	5 6689 3235
Group By Document Type V				
		START OF DOCUMENT		*
	<			>
Refresh			Remove Documen	t View Document
Additional Access				Close

Viewing documents:

- Select a document, and a preview will appear in the lower pane.
- View Document opens the selected document with the Save Document option.
- SaveDocument saves a document to the patient's record under Summary Views > Incoming Documents.

Summary Views				
Problems	0 Sort By Date	¥		
Referrals	Downloaded from My Health Record 21/02/2023 Pathology Overview, , 21/02/2023			
Results				

### Medications Summary | Pathology Report | Diagnostic Imaging Report

These tabs contain uploads of the patient's prescriptions and results. The results come from pathology and radiology providers, and the medications come from clinical encounters, as explained in the Medications section.

### Restricted records & emergency access

Patients can restrict access to their records or specific documents using an access code, which they can choose to share with healthcare providers. Section 64 of the My Health Records Act defines situations where it may be permissible for a treating healthcare provider to use the Emergency Access function to access a patient's record without entering an access code. It is important to understand when this function can lawfully be used. To learn more, see Digitalhealth.gov.au > privacy and access and the OAIC resource.

If you try to open a record with an access code, the **My Health Record Access Type** dialog will prompt you to make a selection.

If the patient wants to provide access to their record, select **Access Code** and enter the code provided by the patient.

In an emergency situation, you can select **Emergency Access** in accordance with the legislation. This will allow the treating healthcare provider to access information in a patient's record without entering an access code. If a patient has **enabled notifications** in MHR, they will receive an email or SMS if Emergency Access is used to access their information.

		Summary Views	
Proble	My Health Record	Access Type	5
Refer	Please, select pre input Access Cod	ferred access type for My Health Record and le if necessary	
Resu	Access type	Access Code	
Immunis	Access code	Access Code	
Allerg			
Transa			

### My Health Record reporting

### Tracking health record uploads

Zedmed's **My Health Record Uploads** report shows the number of Event Summaries and Shared Health Summaries uploaded to My Health Record.

To run the report:

- 1. Open Zedmed clinical.
- 2. From the menu, select **Reports** menu > **Tracking Health RecordUploads**.

The Tracking of My Health Record Uploads screen will open.

3. Select the settings for the information you want.

For a Shared Health Summary Report, the dates could capture the quarter being monitored for the Practice Incentives Program.

For Branch, use the report to monitor by Branch or by All branches.

4. If you selected Style Single line details: Select Screen to display the information or Print to print it out.

If you selected Style CSV File: Select Export.

Tracking	of My Health Record Uploads
Style	Report Criteria
● Single line details	From 15/09/2022 T To 14/12/2022 T
O CSV File Data	Branch All ~
Group By Branch 🗸	Document Type Shared Health Summary
Print Screen	Shared Health Summary Event Summary

The report shows the number of reports uploaded by each doctor.

My Health Shared Hea	n Record Uploads Ith Summaries Uploaded b	ov Practitioner.				
Branch: All						
For Period:	21/12/2022 to 22/03/2023					Page 1 of 1
Document	Type: Shared Health	n Summaries				
Clinic Name:	ALL					
User Name	Doctor Name	Dr Code	Staff ID	From Date	To Date	# Uploaded
PDAVIS	Davis ,Dr Phillip	PD	PD	21/12/2022	22/03/2023	4
				Total U	ploads for ALL:	4
		Total Shared	d Health	Summarie	s Uploads:	4
5	Total Nun	nber of Health Reco	ords Up	loaded for	this Period:	4

View health record uploads for a patient

You can view all **Event Summaries** and **Shared Health Summaries** uploaded to a patient's My Health Record in **Summary Views**.

To view a patient's uploaded records:

- 1. Go to Zedmed's **Reception** tab.
- 2. Select **Clinical Records**, locate the patient, and open the patient's record.
- 3. Select the **Summary Views > Documents** tab.
- 4. Scroll to the My Health Record Summaries.

You will see a list of all Event Summary and Shared Health Summary reports that have been uploaded to MHR with a green P icon.

The Red D means the record is a draft that can be edited and uploaded.

👁 🖹 🕸 🚍 🕼 🛐				
Summary Views				
Problems	0			
Referrals	Forms      Letters			
Results	Referral Letters			
Immunisations	0 01/12/2022 Event Summary v1			
Allergies	<ul> <li>24/10/2022 Event Summary v1</li> <li>11/10/2022 Shared Health Summary</li> </ul>			
Images/ECG	28/09/2022 Event Summary v1			
Documents	09/09/2022 Event Summary v1			
Measurements	06/09/2022 Shared Health Summary			
Medications	06/09/2022 Event Summary v1			
Incoming Documents				

# Lunch and Learn video

Zedmed has recorded a Lunch & Learn session to explain how My Health Record works and how to use it in Zedmed. We recommend watching this video to get a good understanding of the benefits and features available.