



Medications : Submitting your **Prescribing** & **Dispensing** Records

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Medication

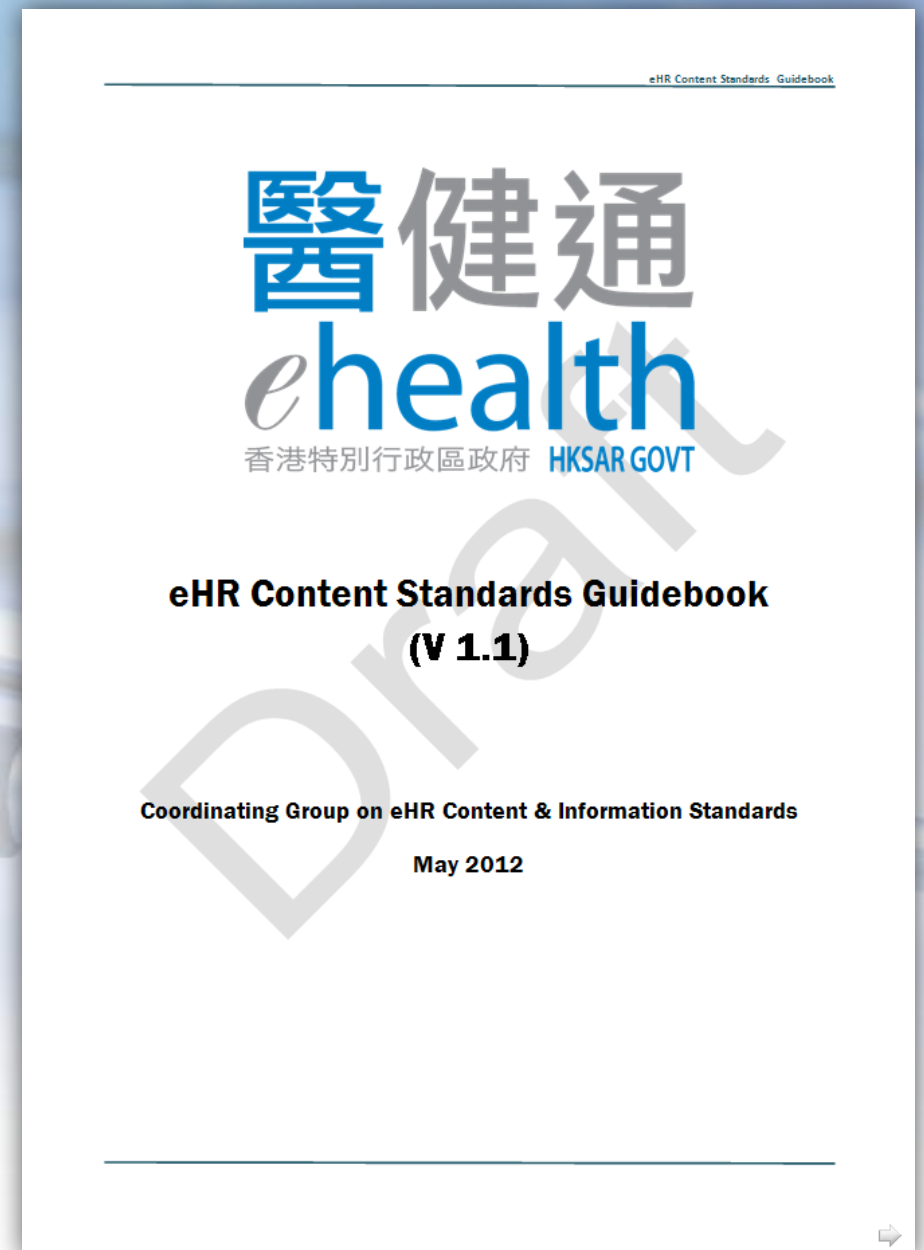
eHR Content Standards Guidebook (v1.1)

Coordinating Group on eHR Content & Information Standards

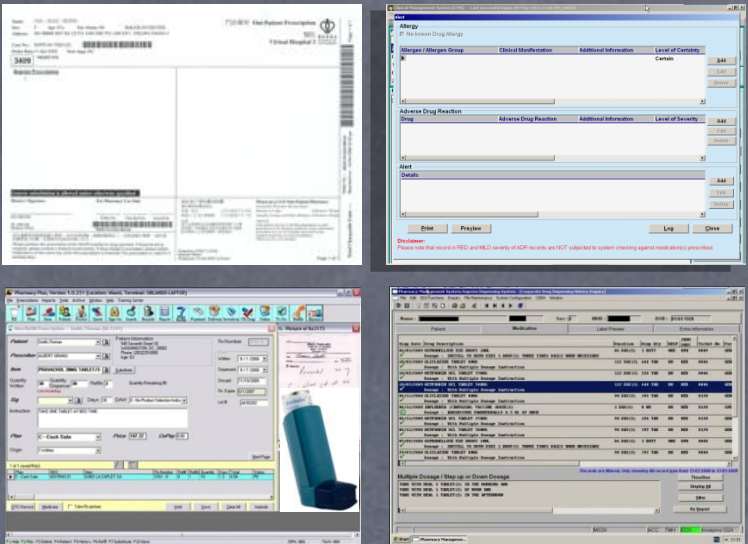
7.14 Medication

7.14.1 This includes medication **ordered** and/or **dispensed/administered** during the healthcare process. Where the medication is ordered, information on whether it is dispensed and/or administered should also be included

7.14.2 Medications acquired over the counter by the patient should also be included in the future when the patient portal is developed



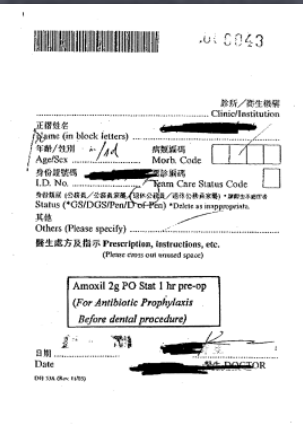
Local CPOE systems, Pharmacy Systems



Coded information with full HK and international interoperability

Level 3

Handwritten Prescriptions



non-coded text information

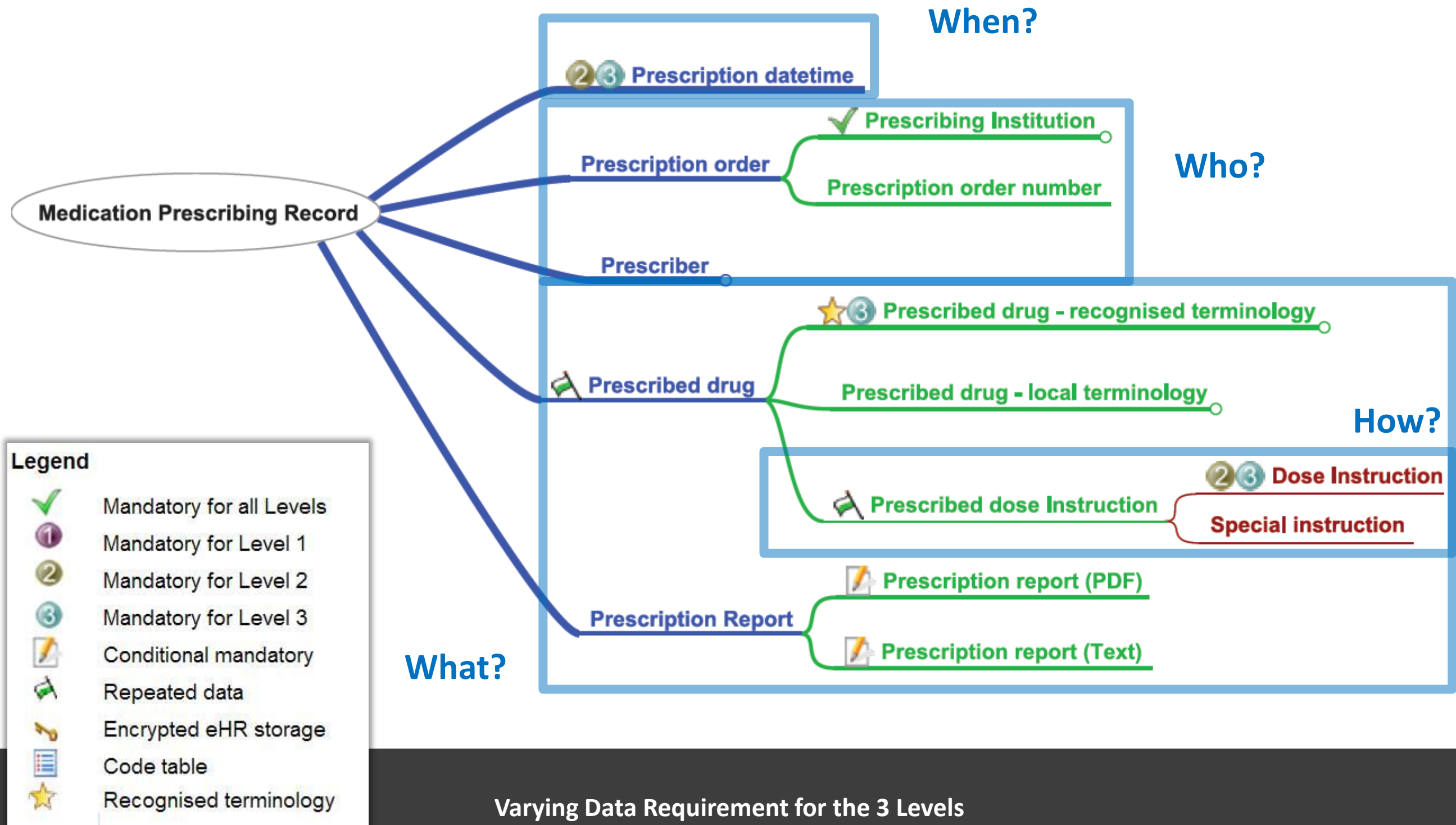
Level 2

no system what-so-ever

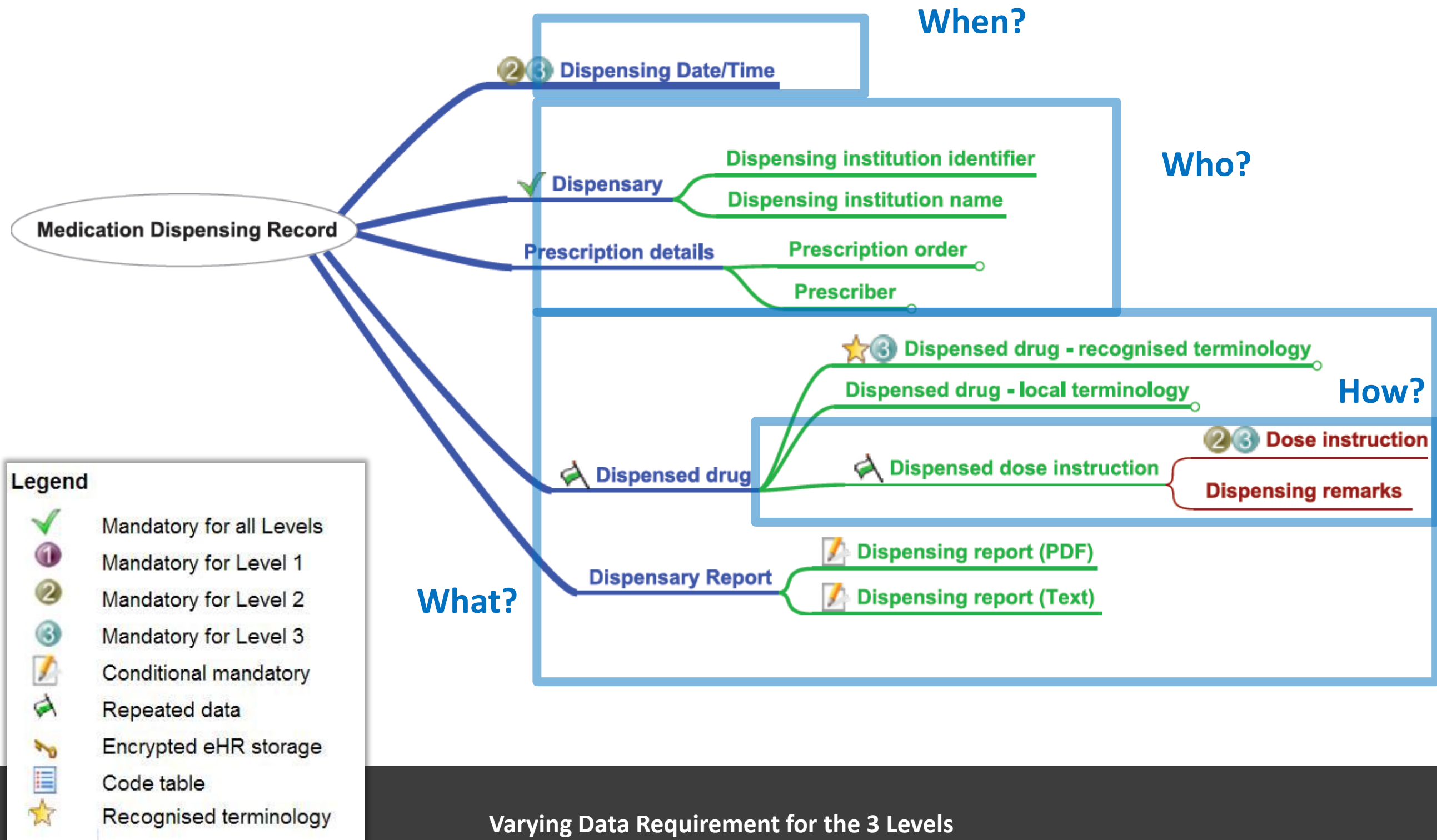
Level 1



What data can be submitted : The Prescribing Record Data Set



What data can be submitted : The **Dispensing Record** Data Set



Level 1

Submitting your Prescribing / Dispensing Record to eHR

1

010043

診所/衛生機構
Clinic/Institution

正體姓名
Name (in block letters)

年齡/性別
Age/Sex

病類碼
Morb. Code

身份證號碼
I.D. No.

團隊護理碼
Team Care Status Code

身份類別 (公務員/公務員家屬/退休公務員/退休公務員家屬) *刪除不適用者
Status (*GS/DGS/Pen/D-of-Pen) *Delete as inappropriate.

其他
Others (Please specify)

醫生處方及指示 Prescription, instructions, etc.
(Please cross out unused space)

Amoxil 2g PO Stat 1 hr pre-op
(For Antibiotic Prophylaxis
Before dental procedure)

日期
Date

醫生
DOCTOR

DH HA (Rev. 11/00)

Prescription Image

eHR
Drug
Record

LEVEL 1 : The most primitive type of record sharing is by users that do not use any system at all, allowing the submission of prescription image only



010043

診所/衛生機構
Clinic/Institution

正楷姓名

Name (in block letters)

年齡/性別

Age/Sex

病歷編碼

Morb. Code

身份證號碼

I.D. No.

團隊護理碼

Team Care Status Code

身份類別 (公務員/公務員家屬/退休公務員/退休公務員家屬) * 刪除不適用者

Status (*GS/DGS/Pen/D of Pen) *Delete as inappropriate.

其他

Others (Please specify)

醫生處方及指示 Prescription, instructions, etc.
(Please cover out unused space)

Amoxil 2g PO Stat 1 hr pre-op
(For Antibiotic Prophylaxis
Before dental procedure)

日期

Date

DH 336 (Rev. 11/03)

DR. DOCTOR

Prescription
(* .PDF/* .TXT)

Example of a handwritten, non-computer generated prescription.

Prescription generated via Clinic Solution

Medication – Level 1 Record

What data?	Definition	Data Type (code)	Example (Certified Level 1)
Prescribing institution identifier	A unique identifier for the prescribing institution from whom the drug order was made	CE	PMH
Prescribing institution name	Name of the healthcare institution who issued the drug order	CE / ST	Princess Margaret Hospital, Hospital Authority
Prescription report (PDF)	Report of the prescription in the form of PDF image	ED	*.pdf
Prescription report (Text)	Prescription report in text format	TX	*.txt

Medication – Level 1 Record

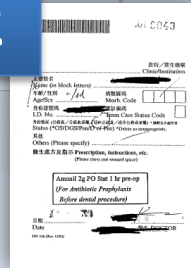
What data?	Definition	Data Type (code)	Example (Certified Level 1)
Prescribing institution identifier	A unique identifier for the institution from whom the drug is prescribed	CE	PMH
Prescribing institution name	name of the institution who issue the drug order	CE / ST	Princess Margaret Hospital, Hospital Authority
Prescription report (PDF)	Report of the prescription in the form of PDF image	ED	*.pdf
Prescription report (Text)	Prescription report for text	TX	*.txt

1

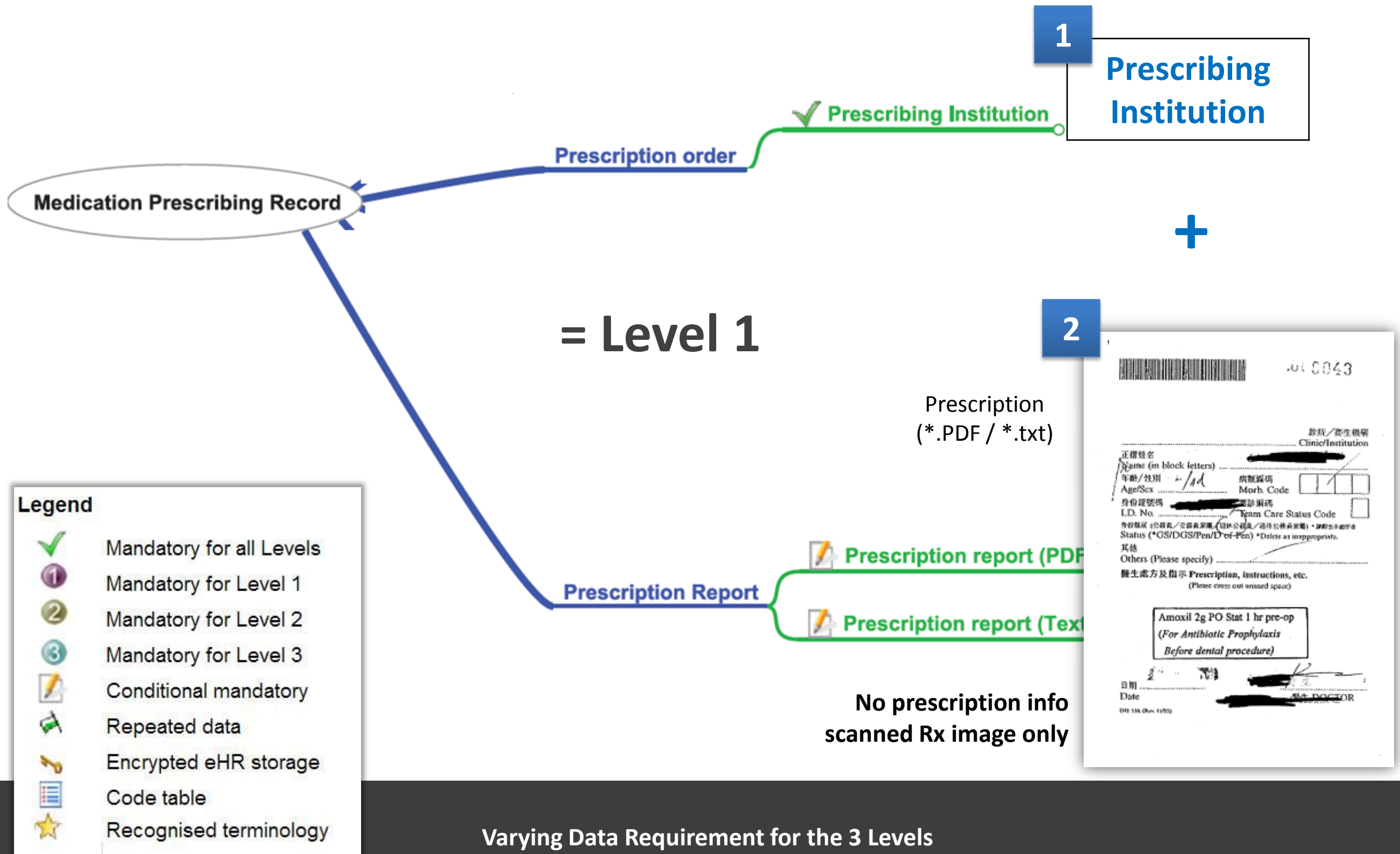
Prescribing Institution

2

**Prescription
(* .PDF)**



What data can be submitted : The Prescribing Record Data Set



0010043

診所/衛生機構
Clinic/Institution

正體姓名
Name (in block letters)

年齡/性別
Age/Sex

病類碼
Morb. Code

身份證號碼
I.D. No.

團隊護理碼
Team Care Status Code

身份類別 (公務員/公務員家屬/退休公務員/退休公務員家屬) *Delete as inappropriate.
Status (*GS/DGS/Pen/D of Pen) *Delete as inappropriate.

其他
Others (Please specify)

醫生處方及指示 Prescription, instructions, etc.
(Please cross out unused space)

Amoxil 2g PO Stat 1 hr pre-op
(For Antibiotic Prophylaxis
Before dental procedure)

日期
Date

醫生
DR. DOCTOR

Level 1

Prescription Image

No prescription info, scanned Rx
image only



So when this information is sent by the healthcare provider to eHR Medication Prescribing Record...

The eHR Viewer (Prescribing History)

The screenshot displays the eHR Viewer interface for a patient's prescribing history. The patient's details are: DOB: 1916, Age: 96 years, Sex: F. The interface includes a navigation menu on the left with categories like Clinical Notes & Summary, Problem & Procedure, Medication, Laboratory Record, and Radiology Record. The main area shows a table of prescribing history with columns for Date, Medication, and Institution. A scanned prescription image is overlaid on the table, showing a barcode, patient information, and a prescription for Amoxil 2g PO Stat 1 hr pre-op. The text 'Level 1' is overlaid on the image, and a note states 'No prescription info scanned Rx image only'. The footer includes links for Contact Us, Privacy Policy, and Disclaimer, along with the HKSAR GOVT logo.

Level 1

*.PDF or *.TXT file

No prescription info scanned Rx image only

Amoxil 2g PO Stat 1 hr pre-op
(For Antibiotic Prophylaxis Before dental procedure)

09-Oct-2011 Prescription (PDF) HKE

Contact Us Privacy Policy Disclaimer

醫健通 health HKSAR GOVT

This is what it will look like on the eHR Record

Note: this is a only a mock-up, future eHR viewer may look different.

Level 2

Submitting your Prescribing / Dispensing Record to eHR



No mapping



LEVEL 2 : The 2nd method of submitting eHR medication record is by sending the local computerised text-based information to eHR, without mapping to the standard drug table (HKMTT)

Medication – Level 2 Record

Proposed Name	Definition	Data Type (code)	Example (Certified Level 2)
Prescription date/time	Datetime when the prescription was made	TS	6/12/2010
Prescribing institution identifier	A unique identifier for the prescribing institution from whom the drug order was made	CE	PMH
Prescribing institution name	Name of the healthcare institution who issued the drug order	CE / ST	Princess Margaret Hospital, Hospital Authority
Prescription order number	Unique prescription ID assigned by the healthcare institution	ST	MOETMH123456700
Prescriber identifier	A unique identifier for the healthcare professional who prescribed the drug	CX	1234567890
Prescriber's prefix	Prefix of the name of the healthcare professional who prescribed the drug	ST	Dr.
Prescriber's English Surname	Surname in English of the healthcare professional who prescribed the drug	XPN	CHAN
Prescriber's English Given Name	Given name in English of the healthcare professional who prescribed the drug	XPN	Tai Man
Prescriber's Chinese Name	Full Name in Chinese of the healthcare professional who prescribed the drug. Encoding method : unicode	XPN	陳大文
Prescriber's Chinese Name Suffix	Suffix of the Chinese name of the healthcare professional who prescribed the drug	ST	醫生
Prescribed drug code - local terminology	Local code of the prescribed drug developed by the healthcare provider	CE/IS	PARA01
Prescribed drug description - local terminology	Local description of the prescribed drug developed by the healthcare provider	CE/IS	PARACETAMOL TABLET 500MG
Dose Instruction	The entire combined dose instruction information of an ordered drug; the syntax should contain the following information of the prescription order: - route of administration - dose - frequency - duration of treatment, or treatment start and end date	ST	(1) 1-2 tablet(s) when required (2) 1 capsule(s) daily
Special Instruction (Freetext)	Additional information relating to the use of the prescribed drug	TX	"omit if vomiting or diarrhoea"
Prescription report (PDF)	Prescription report in Portable Document Format (PDF)	ED	*.pdf
Prescription report (Text)	Prescription report in text format	TX	*.txt

Medication – Level 2 Record

Proposed Name	Definition	Data Type (code)	Example (Certified Level 2)
Prescription date/time	Datetime when the prescription was made	TS	6/12/2010
Prescribing institution identifier	A unique identifier for the institution that made the prescription	ST	MOETMH123456700
Prescribing institution name	Name of the healthcare institution	ST	MOETMH123456700
Prescription order number	Unique prescription ID assigned by the healthcare institution	ST	MOETMH123456700
Prescriber identifier	A unique identifier for the healthcare professional who prescribed the drug	CX	1234567890
Prescriber's prefix	Prefix of the name of the healthcare professional who prescribed the drug	ST	Dr.
Prescriber's English Surname	Surname in English of the healthcare professional who prescribed the drug	XPN	CHAN
Prescriber's English Given Name	Given name in English of the healthcare professional who prescribed the drug	XPN	Tai Man
Prescriber's Chinese Name	Full Name in Chinese of the healthcare professional who prescribed the drug. Encoding method : unicode	XPN	陳大文
Prescriber's Chinese Name Suffix	Suffix of the Chinese name of the healthcare professional who prescribed the drug	ST	醫生
Prescribed drug code - local terminology	Local code of the prescribed drug developed by the healthcare provider	CE/IS	PARA01
Prescribed drug description - local terminology	Local description of the prescribed drug developed by the healthcare provider	CE/IS	PARACETAMOL TABLET 500MG
Dose Instruction	The entire combined dose instruction information of an ordered drug: the syntax should contain the following information of the prescription order: - route of administration - dose - frequency - duration of treatment, or treatment duration	ST	(1) 1-2 tablet(s) when required (2) 1 capsule(s) daily
Special Instruction (Freetext)	Additional information relating to the drug	ST	"omit if vomiting or diarrhoea"
Prescription report (PDF)	Prescription report in Portable Document Format (PDF)	TX	*.pdf
Prescription report (Text)	Prescription report in text format	TX	*.txt

1

Prescription

When? Institution name? Order no?

2

Prescriber

3

Drug
(Local terminology)

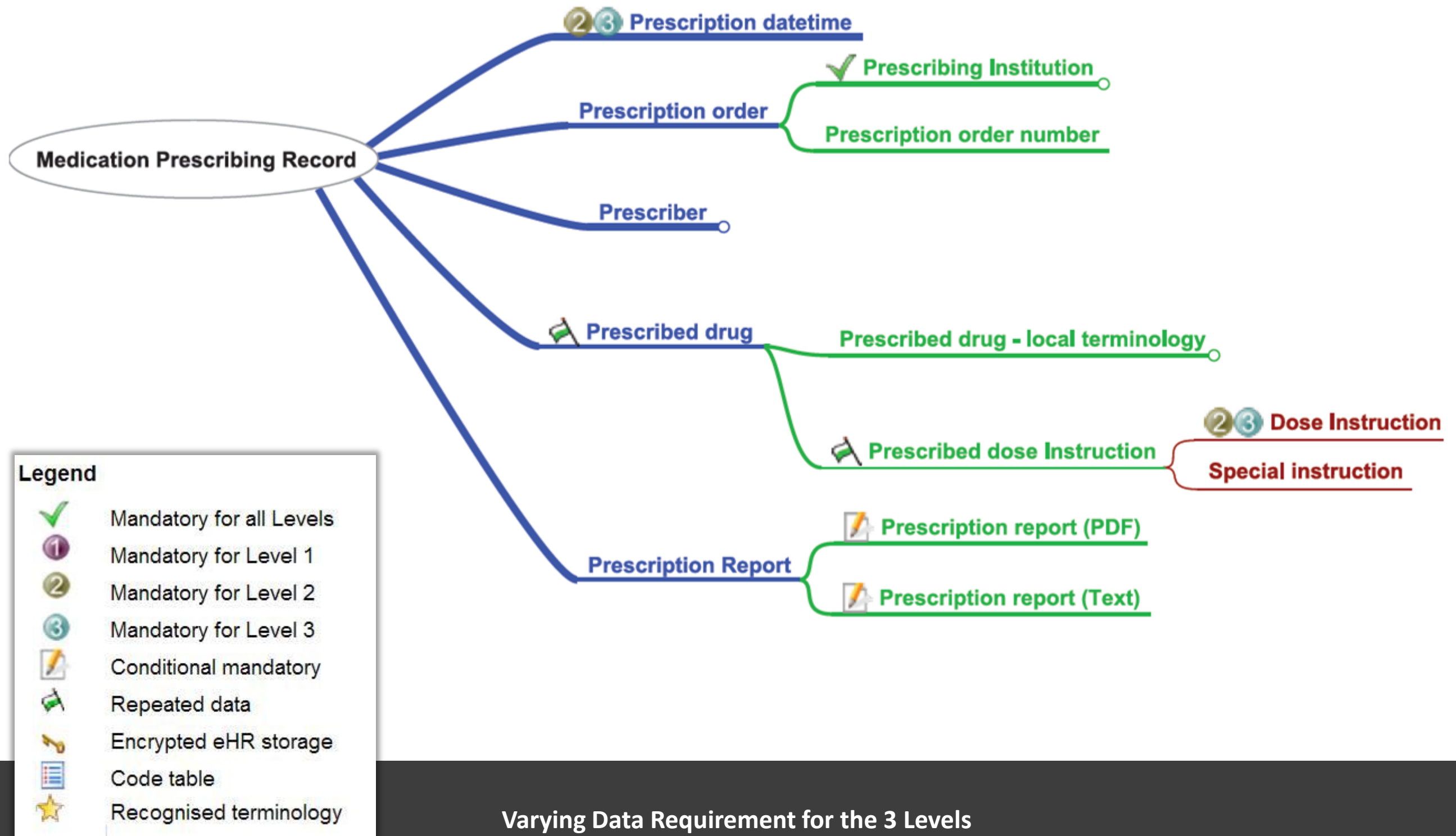
4

Dose
Instruction

5



What data can be submitted : The Prescribing Record Data Set



Varying Data Requirement for the 3 Levels

Clinical Management System [CMS] Last failed logon: 21-May-2012 15:18 (VH_HAHO) Last successful logon: 21-May-2012 15:10 (VH_HAHO)

File Clinical Investigation Enquiry Booking DT Report Doc./Print Other System Info. Admin.

Logoff Close PSP Dx/Px Disc Info Disc Sum Rx Modify Rx Reminder Letter/Doc PMI Next Pat

Prescription/OP Prescription

+Reminder MKC **Unknown** Details **Alert**

0-Aug-1988 1804369(0) SOP SOPD0015941(V)

Drug Name ⓘ Browse History Drug Set Standard Regimen

Drug Folder Advance Search OP Drug List Therapeutic Class(es) \$ Related Drugs

Warfarin
Tablet (Sodium)

Oral Anticoagulants

Regimen Type

DAILY
WEEKLY
MONTHLY
CYCLIC
STEP UP/DOWN

Ready VH MED AUGUST. LIU

Medication prescribing on an MOE system

File Edit View Page Tools Window Help

Page: 1 of 1

Zoom: 117 %

Name: ()

Sex: F Age: 55y Pat. Status: Nil H.K.I.D.: M864369(0)

Address: Rm 88888 99/F Blk ZZ WAI MING HOUSE, YUK MING COURT, 10 CHIU SHUN ROAD, TSE ...

Case No.: SOPD-00-15941(V)

Order Date: 21-May-2012 Next Appt.: Nil

2908 MEDICINE
Medical Special OPD

Drug Allergy: (1)ASPIRIN

Prescription

	Chargeable Unit
* 1. WARFARIN SODIUM tablet oral : 4.5 mg daily for 8 weeks	1
Total Chargeable Units :	1

Medication prescribing on an MOE system. In most cases, doctor will not specify the actual strength and product on the prescription.

Electronic Patient Record (build 20080102) - Windows Internet Explorer

http://cs4-test/epr_uat/Content/login_validator.asp

File Edit View Favorites Tools Help

Electronic Patient Record (build 20080102)

病人New tree PATIENT, 1F 47y DOB:2-May-1961 A123456(7)

Patient Name

Virology

Immunology

Anatomical Path

Specialty Profile

Medical

DM

Immunology

Liver

Renal

Thyroid

Anaesthetic

SARS

TBCU

Tissue Typing

Abnormal Result

Numerical

Non-numerical

Radiology Record

Radiology Result

Private Hospital Radiology Result

Radiology Appointment

Medication

Prescribing History

By Order

By Drug Items

Formulary Management

Dispensing History

By Order

By Drug Items

Functional Outcome

Rehabilitation Outcome

Search by Prescribing Date Range

Legend

Search: Last 2 years Hospital: All Specialty: All go reset

01/01/2011 26/02/2011

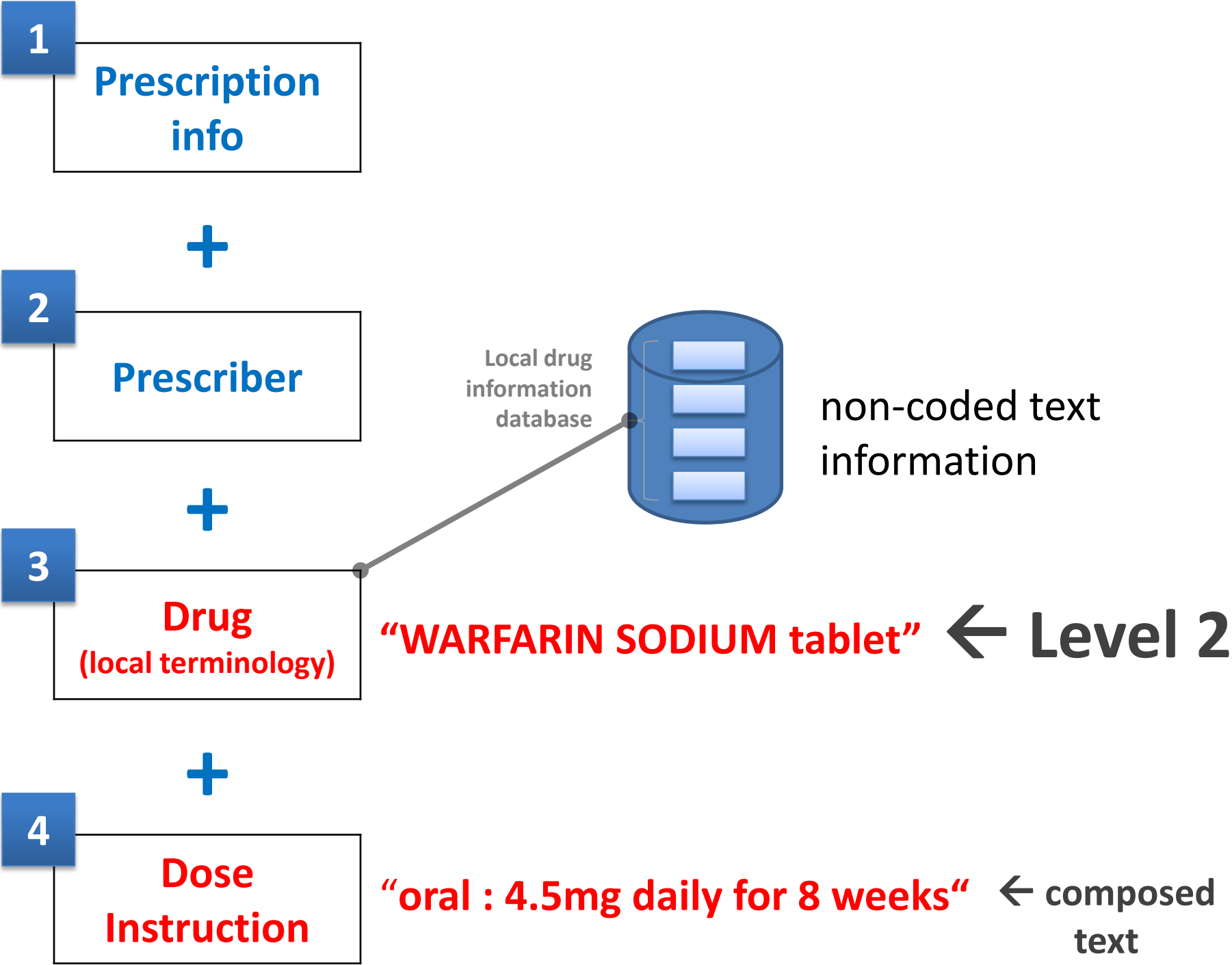
WARFARIN SODIUM tablet
Oral : 4.5 mg daily for 8 weeks

19/10/2007	TMH	HAEM	Discharge	TMH8206
19/10/2007	20/10/2007		✓	DEXAMETHASONE tablet F oral : 12 mg daily for 2 days
19/10/2007	25/10/2007	IND	✓	NEURONTIN (GABAPENTIN) capsule <Special Drug> oral : 200 mg tds for 1 weeks
19/10/2007	19/10/2007		✓	MELPHALAN tablet oral : 4 mg daily for 1 days
19/10/2007	25/10/2007		✓	ORALUBE solution buccal : 5 ml qid for 1 weeks
19/10/2007	25/10/2007	IND	✓	PANTOLOC (PANTOPRAZOLE SODIUM SESQUIHYDRATE) tablet <Special Drug> oral : 20 mg daily for 1 weeks
19/10/2007	25/10/2007		✓	THYMOL GARGLE COMPOUND mouthwash 1 in 4 buccal : 10 ml qid for 1 weeks
19/10/2007	25/10/2007		✓	VITAMIN B COMPLEX tablet oral : 1 tablet(s) tds for 1 weeks
12/09/2007	TMH	MHEM	Out-patient	TMH6502a
12/09/2007	25/09/2007		✓	ALLOPURINOL tablet oral : 300 mg daily for 2 weeks
12/09/2007	25/09/2007		✓	DOLOGESIC tablet oral : 1 tablet(s) qid for 2 weeks
12/09/2007	25/09/2007		✓	HOLOPON (HYOSCINE METHOBROMIDE) tablet oral : 1 mg tds prn (50%) for 2 weeks
12/09/2007	25/09/2007	IND		PANTOLOC (PANTOPRAZOLE SODIUM SESQUIHYDRATE) tablet <Special Drug> oral : 20 mg daily for 2 weeks
12/09/2007	25/09/2007			... tablet <Unregistered Drug Named Pat Only>

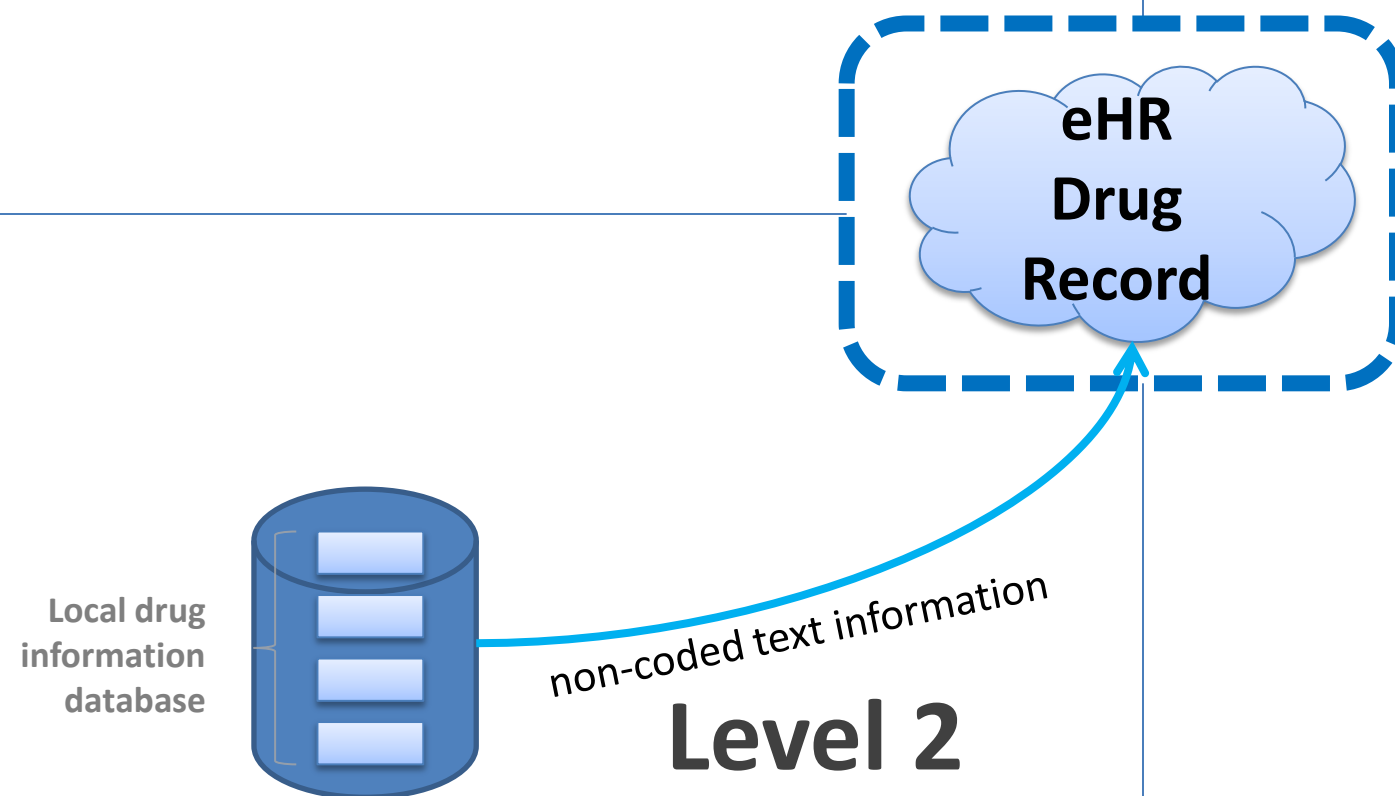
1 x Prescribing Line

HA-ePR Medication Prescribing History : the prescribing information will be recorded as per the prescribing order made by the doctor.

Level 2 Prescribing Record – computerised local text info, no mapping to HKMTT



Level 2 Prescribing Record – computerised local text info, no mapping to HKMTT



No mapping

The eHR Viewer (Prescribing History)

The screenshot displays the eHR Viewer interface for Prescribing History. The patient's details are: 16, Age: 96 years, Sex: F. The interface includes a navigation menu on the left with categories like Clinical Notes & Summary, Problem & Procedure, Medication, Laboratory Record, and Radiology Record. The main content area shows a table of prescribing history for Queen Mary Hospital.

Date	Medication	Institution
05-Apr-2012	Elantan (isosorbide monoitrate) 20mg tablet 20mg bd oral for 24 weeks Pepcidine (Famotidine) 20mg tablet 20mg bd oral for 24 weeks 7.5mg nocte prn oral for 24 weeks	QMH
05-Feb-2012	Pepcidine (Famotidine) 40mg tablet 40mg bd oral for 3 days Multivitamin tablet 1 tab daily oral for 3 days Lactulose Liquid 10ml tid prn oral for 3 days	Dr. Hui Wing Yan Clinic
02-Feb-2012	WARFARIN SODIUM tablet Oral : 4.5mg daily for 8 weeks	
09-Oct-2011	Prescription (PDF)	

Annotations on the screenshot:

- Level 2**: Points to the medication name 'WARFARIN SODIUM tablet'.
- Drug (Local terminology)**: Points to the medication name 'WARFARIN SODIUM tablet'.
- Dose instruction (composed text)**: Points to the dosage 'Oral : 4.5mg daily for 8 weeks'.

The interface also includes a footer with links for Contact Us, Privacy Policy, and Disclaimer, and the ehealth logo with the text '香港特別行政區政府 HKSAR GOVT'.

This is what it will look like on the eHR Record

Note: this is only a mock-up, future eHR viewer may look different.

moepms1001 (160.19.76.14)

moepms1001

Pharmacy Management System/Express Dispensing System - [Order Entry]

File Edit PMS Functions Enquiry File Maintenance System Configuration CARS CDDH Window

☐ Patient Name ☐ HKID ☐ Other Doc. ☐ DOB (Age) ☐ Sex ☐ Case No. ☐ Ticket Date & No.

☐ Spec(Sub-spec) ☐ Ward(Bed) ☐ Code (Doctor Name) ☐ PHS Spec ☐ Ward ☐ Patient Cat. ☐ Rx Type ☐ Pregnancy ☐ Contraindication ☐ Checking

Warfarin Sodium tablet

Dosage: 4.5 MG Daily Frequency: DAILY PRN: Route/Site: ORAL Duration: 8 Weeks Quantity: TAB

4.5 mg daily for 8 weeks

☐ Fixed Period ☐ Single Use Special Instruction:

Action Status: Dispense by Pharmacy

UnZoom Edit Regimen Line Repl

Prescription Item Details Label Preview

Item Code	Drug Name	Form Description	Strength	Volume	Total Dose
Dosage	Frequency	Suppl. Frequency	PRN	Route/Site	Duration
WARF02	WARFARIN SODIUM	TABLET	3MG		56
1	TABLET(S)	DAILY	M	ORAL	8 Week(s)
WARF01	WARFARIN SODIUM	TABLET	1MG		84
1.5	TABLET(S)	DAILY	M	ORAL	8 Week(s)

<Ctrl+A> to add item ; <Ctrl+D> to delete item

The prescription will then be taken to a pharmacy for medication dispensing, and often that will result in the dispensing of multiple medicines according to the prescribing order.

moepms1001 (160.19.76.14)

moepms1001

Pharmacy Management System/Express Dispensing System - [Order Entry]

File Edit PMS Functions Enquiry File Maintenance System Configuration CARS CDDH Window

Patient Name

HKID

Other Doc.

DOB (Age)

Sex

Case No.

Ticket Date & No.

Spec(Sub-spec)

Ward(Bed)

Code (Doctor Name)

PHS Spec

Ward

Patient Cat.

Rx Type

Pregnancy

Contraindication

Checking

Warfarin Sodium tablet

Advanced Option

Preparation

Dosage

Daily Frequency

PRN

Route/Site

Duration

Quantity

4.5

MG

DAILY

ORAL

8

Weeks

TAB

4.5 mg daily for 8 weeks

Fixed Period

Single Use

Special Instruction

zoom

Action Status

Dispense by Pharmacy

UnZoom

Edit Regimen Line

Repl

Prescription

Item Details

Label Preview

Item Code	Drug Name	Form Description	Strength	Volume	Total Dose					
Dosage	Frequency	Suppl. Frequency	PRN	Route/Site	Duration	Total Qty/ Issue Qty				
WARF02	WARFARIN SODIUM	TABLET	3MG		56	TABL				
1	TABLET(S)	DAILY		M	ORAL	+	8	Week(s)	56	TAB
WARF01	WARFARIN SODIUM	TABLET	1MG		84	TABL				
1.5	TABLET(S)	DAILY		M	ORAL	+	8	Week(s)	84	TAB

<Ctrl+A> to add item ; <Ctrl+D> to delete item

1 x Prescribing Line

2 x Dispensing Line

The prescription will then be taken to a pharmacy for medication dispensing, and often that will result in the dispensing of multiple medicines according to the prescribing order.

Pharmacy Management System/Express Dispensing System - [Order Entry]

File Edit PMS Functions Enquiry File Maintenance System Configuration CARS CDDH Window

Patient Name: [Redacted] HKID: [Redacted] Other Doc.: [Redacted] DOB (Age): [Redacted] Sex: F Case No.: SOPD0015941V Ticket Date & No.: 21/05/2012 0111

Spec(Sub-spec): [Redacted] Ward(Bed): [Redacted] Code (Doctor Name): [Redacted] PHS Spec: MED Ward: [Redacted] Patient Cat.: OT Rx Type: 0 Pregnancy Contraindication: [Redacted] Alert: Drug On Hand

Warfarin Sodium tablet

Dosage: 4.5 MG Daily Frequency: DAILY PRN: [Redacted] Route/Site: ORAL Duration: 8 Weeks Quantity: TAB

4.5 mg daily for 8 weeks

Fixed Period [] Single Use [] Spec Instr: [Redacted]

Action Status: Dispens

WARFARIN SODIUM TABLET 3MG

口服每日一次，每次一粒

UnZoom Edit Regimen Line Replace

Prescription Item Details

小心放置，以免兒童誤服

WARF02 56 TAB

WARFARIN SODIUM TABLET 3MG

口服每日一次，每次一粒

藥物需要避光

邵衛 SOPD0015941V 21/05/2012

0111_****

將軍澳醫院 MED OT ITD 1/1

Refresh

Pharmacy View [X] 7X 10 Drug Conversion

Await SFI payment [X]

No. of Coupon 2

Chinese No. of la(b)el

Save item CAPD Remarks Save Rx

Remove item Refill Suspend Cancel

The prescription will then be taken to a pharmacy for medication dispensing, and often that will result in the dispensing of multiple medicines according to the prescribing order.

Pharmacy Management System/Express Dispensing System - [Order Entry]

File Edit PMS Functions Enquiry File Maintenance System Configuration CARS CDDH Window

Patient Name HKID Other Doc. DOB (Age) Sex Case No. Ticket Date & No.

Spec(Sub-spec) Ward(Bed) Code (Doctor Name) PHS Spec Ward Patient Cat. Rx Type Pregnancy Contraindication Checking Alert Drug On Hand

Warfarin Sodium tablet

Dosage Daily Frequency PRN Route/Site Duration Quantity

4.5 MG DAILY ORAL 8 Weeks TAB

4.5 mg daily for 8 weeks

Fixed Period Single Use Spec Instr

Action Status Dispens

WARFARIN SODIUM TABLET 1MG

口服每日一次，每次一粒半

UnZoom Edit Regimen Line Replace

Prescription Item Details

小心放置，以免兒童誤服

WARF01 84 TAB

WARFARIN SODIUM TABLET 1MG

口服每日一次，每次一粒半

藥物需要避光

邵衛 SOPD0015941V 21/05/2012

0111_****

將軍澳醫院 MED OT ITD 1/1

Refresh

Pharmacy View 7X 10 Drug Conversion

Await SFI payment

No. of Coupon 2

Chinese No. of la(b)el

Save item CAPD Remarks Save Rx

Remove item Refill Suspend Cancel

The prescription will then be taken to a pharmacy for medication dispensing, and often that will result in the dispensing of multiple medicines according to the prescribing order.

Patient Name

New tree PATIENT, 1(病人)

Search by Dispensing Date Range and Case Type Legend Print

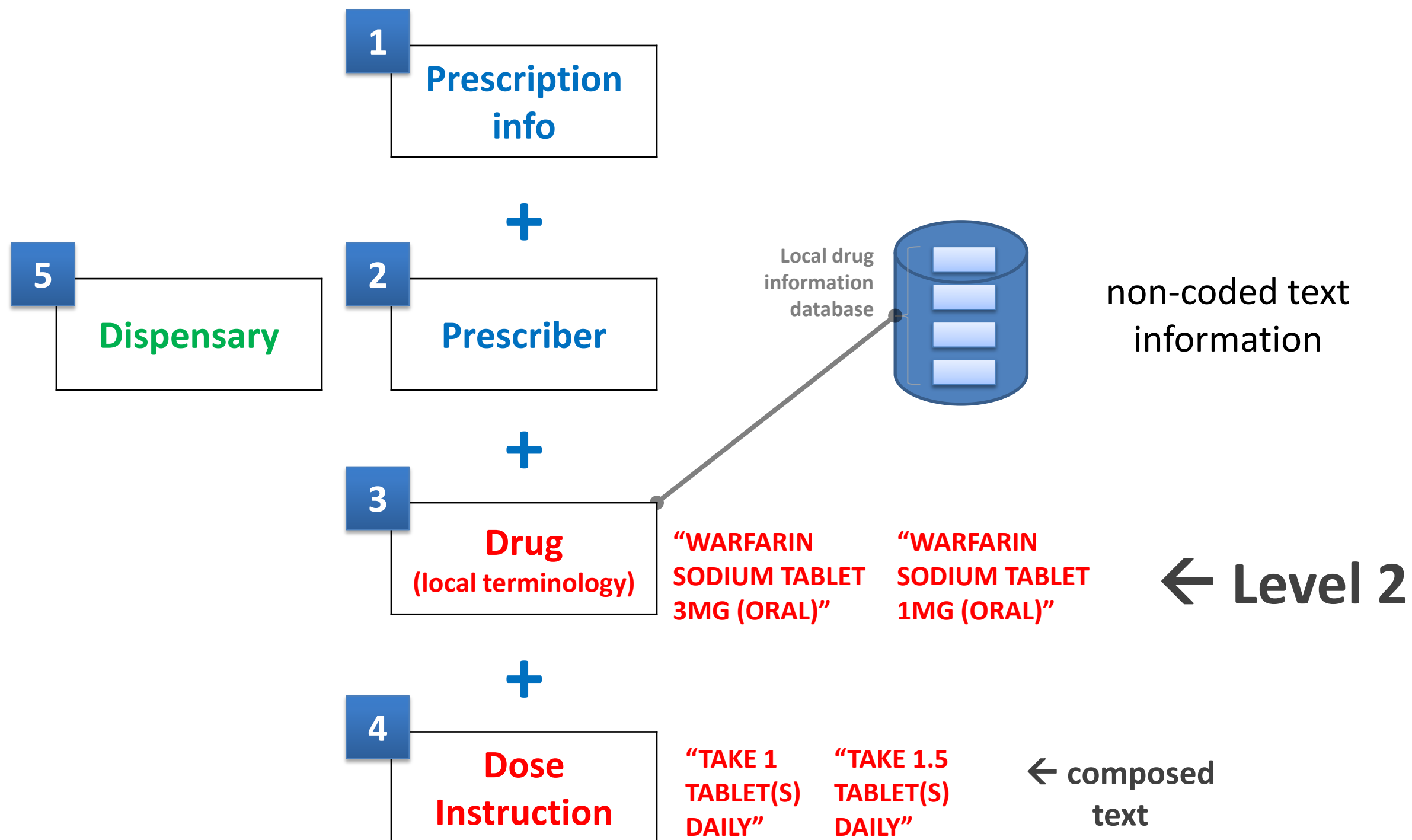
Search: Last 2 years Hospital: All Specialty: All Case Type: All

Dispensing Date Range		Medication	Instructions
01/01/2011	26/02/2011	WARFARIN SODIUM TABLET 3MG (ORAL)	TAKE 1 TABLET(S) DAILY
01/01/2011	26/02/2011	WARFARIN SODIUM TABLET 1MG (ORAL)	TAKE 1.5 TABLET(S) DAILY
21/07/2007		TMH OP MED	
31/07/2007	13/08/2007	THALIDOMIDE TABLET 50MG (ORAL)	TAKE 2 TABLET(S) AT BEDTIME
21/07/2007		TMH OP MED	
21/07/2007	22/07/2007	DEXAMETHASONE TABLET 4MG (ORAL)	TAKE WITH / AFTER MEAL 3 TABLET(S) DAILY
21/07/2007	27/07/2007	GABAPENTIN CAPSULE 100MG (ORAL)	TAKE 2 CAPSULE(S) THREE TIMES DAILY
21/07/2007	21/07/2007	MELPHALAN TABLET 2MG (ORAL)	TAKE 1 HR BEFORE MEAL/EMPTY STOMACH 2 TABLET(S) DAILY
21/07/2007	27/07/2007	ORALUBE (OR EQUIV) SOLUTION (BUCCAL)	RETAIN IN MOUTH 5 ML FOUR TIMES DAILY
21/07/2007	27/07/2007	PANTOPRAZOLE (SODIUM SESQUIHYDRATE) TABLET 20MG (O	TAKE 1 HR BEFORE MEAL/EMPTY STOMACH 1 TABLET(S) DAILY
21/07/2007	27/07/2007	THYMOL GARGLE COMPOUND MOUTHWASH 1 IN 4 (BUCCAL)	GARGLE 10 ML FOUR TIMES DAILY
21/07/2007	27/07/2007	VITAMIN B COMPLEX TABLET (ORAL)	TAKE 1 TABLET(S) THREE TIMES DAILY
21/07/2007		TMH IP MED	
21/07/2007	24/07/2007	AMITRIPTYLINE HCL (Oral)	Tablet 25MG: Take 1 TABLET(S) at night for 3 day(s) QTY -3 TAB.
21/07/2007	24/07/2007	BENZYLAMINE HCL (Topical)	Lozenges 3MG: Suck 1 NUMBER(S) three times daily for 3 day(s) QTY -9 TAB.
21/07/2007	24/07/2007	VITAMIN B COMPLEX (Oral)	Tablet: Take 1 TABLET(S) three times daily for 3 day(s) QTY -9 TAB.

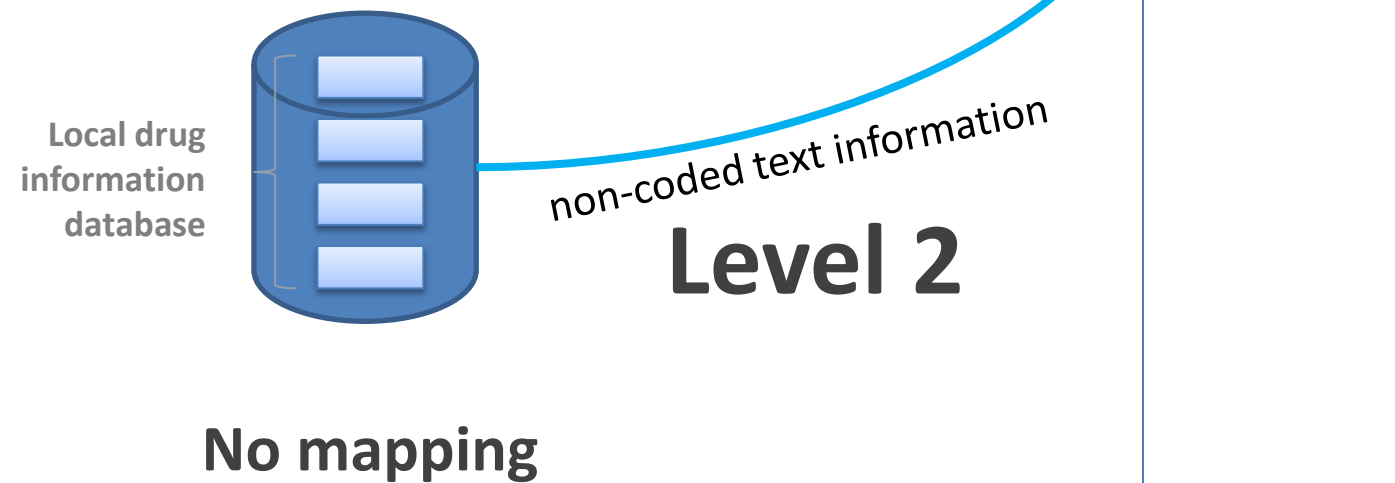
2 x Dispensing Line

HA-ePR Dispensing Record : a prescribing activity may lead to one or more dispensing record. The significance of this is it provides more accurate and precise details on how a patient received a drug treatment.

Level 2 Dispensing Record – computerised local text info, no mapping to HKMTT




Corresponding dispensing record will be sent to eHR



So when this information is sent by the healthcare provider to eHR Medication Prescribing Record...

The eHR Viewer (Dispensing History)

The screenshot shows a web browser window with the URL <http://portal.ehr.gov.hk:20621/group/EVE/eve-rxd>. The page title is "eve-rxd - ehr.gov.hk". The user is logged in as "KA MAN WONG" and can click "Log out". The main navigation bar includes "Viewer", "PPP Programmes", "Administration", and "Information". The "Viewer" tab is active, showing a patient record for "Age : [redacted] Sex : F". The "Dispensing History" section is selected, showing a table of medication dispenses. The table has columns for "Date", "Medication", and "Institution". The "Medication" column contains two entries for "WARFARIN TABLET" with different dosages and instructions. The "Institution" column lists "QMH", "Dr. Hui Wing Yan Clinic", "ABC Pharmacy", and "HKE".

Level 2 

Coded information, full interoperability

Drug
(Local terminology)

Dose instruction
(composed text)

Date	Medication	Institution
05-Apr-2012		QMH
05-Feb-2012		Dr. Hui Wing Yan Clinic
02-Feb-2012	WARFARIN TABLET 3MG (ORAL) TAKE 1 TABLET(S) DAILY FOR 8 WEEKS WARFARIN TABLET 1MG (ORAL) TAKE 1.5 TABLET(S) DAILY FOR 8 WEEKS	ABC Pharmacy
09-Oct-2011	Dispensing Record (PDF)	HKE

Contact Us | Privacy Policy | Disclaimer

This is what it will look like on the eHR Record

Note: this is only a mock-up, future eHR viewer may look different.

Level 3

Submitting your Prescribing / Dispensing Record to eHR

Medication – Level 3 Record

Proposed Name	Definition	Data Type (code)	Example (Certified Level 3)
Prescription date/time	Datetime when the prescription was made	TS	6/12/2010
Prescribing institution identifier	A unique identifier for the prescribing institute from whom the drug order will be made	CE	PMH
Prescribing institution name	name if the institution who issue the drug order	CE / ST	Princess Margeret Hospital, Hospital Authority
Prescription order number	Unique prescription ID assigned by the healthcare institution	ST	MOETMH123456700
Prescriber identifier	A unique identifier for the healthcare professional who prescribed the drug	CX	1234567890
Prescriber's prefix	Prefix of the name of the practitioner who prescribed the drug	ST	Dr.
Prescriber's English Surname	Surname in English as indicated on the identity / travel document of the practitioner who prescribed the drug	XPN	CHAN
Prescriber's English Given Name	Given name in English as indicated on the identity / travel document of the practitioner who prescribed the drug	XPN	Tai Man
Prescriber's Chinese Name	Full Name in Chinese of the healthcare professional who prescribed the drug. Encoding method : unicode	XPN	陳大文
Prescriber's Chinese Name Suffix	Suffix of the Chinese name of the practitioner who prescribed the drug	ST	醫生
Prescribed drug - recognised terminology name	Recognised terminology / classification set for the prescribed drug	CE/IS	HKCTT
Prescribed drug identifier - recognised terminology	Unique identifier of the prescribed drug in the recognised terminology	CE/IS	HKCTTID
Prescribed drug description - recognised terminology	Description of the prescribed drug in recognised terminology	CE/IS	Panadol (paracetamol) oral tablet 500 mg
Prescribed drug code - local terminology	Local code of the prescribed drug developed by the healthcare provider	CE/IS	PARA01
Prescribed drug description - local terminology	Local description of the prescribed drug developed by the healthcare provider	CE/IS	PARACETAMOL TABLET 500MG
Dose Instruction	The entire combined dose instruction information of an ordered drug; the syntax should contain the following information of the prescription order: - route of administration - dose - frequency - duration of treatment, or treatment start and end date	ST	(1) 1-2 tablet(s) when required (2) 1 capsule(s) daily
Special Instruction (Freetext)	Additional information relating to the use of the medication	TX	"omit if vomiting or diarrhoea"
Prescription report (PDF)	Prescription report in Portable Document Format (PDF)	ED	*.pdf
Prescription report (Text)	Prescription report in text format	TX	*.txt

Medication – Level 3 Record

Proposed Name	Definition	Data Type	Example (Certified Level 3)
		(code)	
Prescription date/time	Datetime when prescription was made	TS	6/12/2010
Prescribing institution identifier	A unique identifier for the institution made		
Prescribing institution name	name of the institution		
Prescription order number	Unique prescription ID assigned by the healthcare institution	ST	MOETMH123456700
Prescriber identifier	A unique identifier for the healthcare professional who prescribed the drug	CX	1234567890
Prescriber's prefix	Prefix of the name of the practitioner who prescribed the drug	ST	Dr.
Prescriber's English Surname	Surname in English indicated on the identity / travel document of the practitioner who prescribed the drug.	XPN	CHAN
Prescriber's English Given Name	Given name in English indicated on the identity / travel document of the practitioner who prescribed the drug.	XPN	Tai Man
Prescriber's Chinese Name	Full Name in Chinese indicated on the identity / travel document of the practitioner who prescribed the drug. Encoding method : unicode	XPN	陳大文
Prescriber's Chinese Name Suffix	Suffix of the Chinese name of the practitioner who prescribed the drug	ST	醫生
Prescribed drug - recognised terminology name	Recognised terminology / classification set for the prescribed drug	CE/IS	HKCTT
Prescribed drug identifier - recognised terminology	Unique identifier for the prescribed drug		
Prescribed drug description - recognised terminology	Description of the prescribed drug		(amol) oral tablet 500 mg
Prescribed drug code - local terminology	Local code of the prescribed drug developed by the healthcare provider	CE/IS	PARA01
Prescribed drug description - local terminology	Local description of the prescribed drug developed by the healthcare provider	CE/IS	PARACETAMOL TABLET 500MG
Dose Instruction	The entire combined dose instruction information of an ordered drug; the syntax should contain the following information of the prescription order: - route of administration - dose - frequency - duration of treatment	ST	(1) 1-2 tablet(s) when required (2) 1 capsule(s) daily
Special Instruction (Freetext)	Additional information		"omit if vomiting or diarrhoea"
Prescription report (PDF)	Prescription report in Portable Document Format (PDF)		*.pdf
Prescription report (Text)	Prescription report in text format	TX	*.txt

1

Prescription

When? Institution name? Order no?

2

Prescriber

3

Drug
(Local terminology)

+

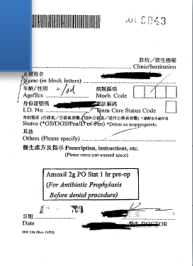
Drug
(Recognised terminology)

4

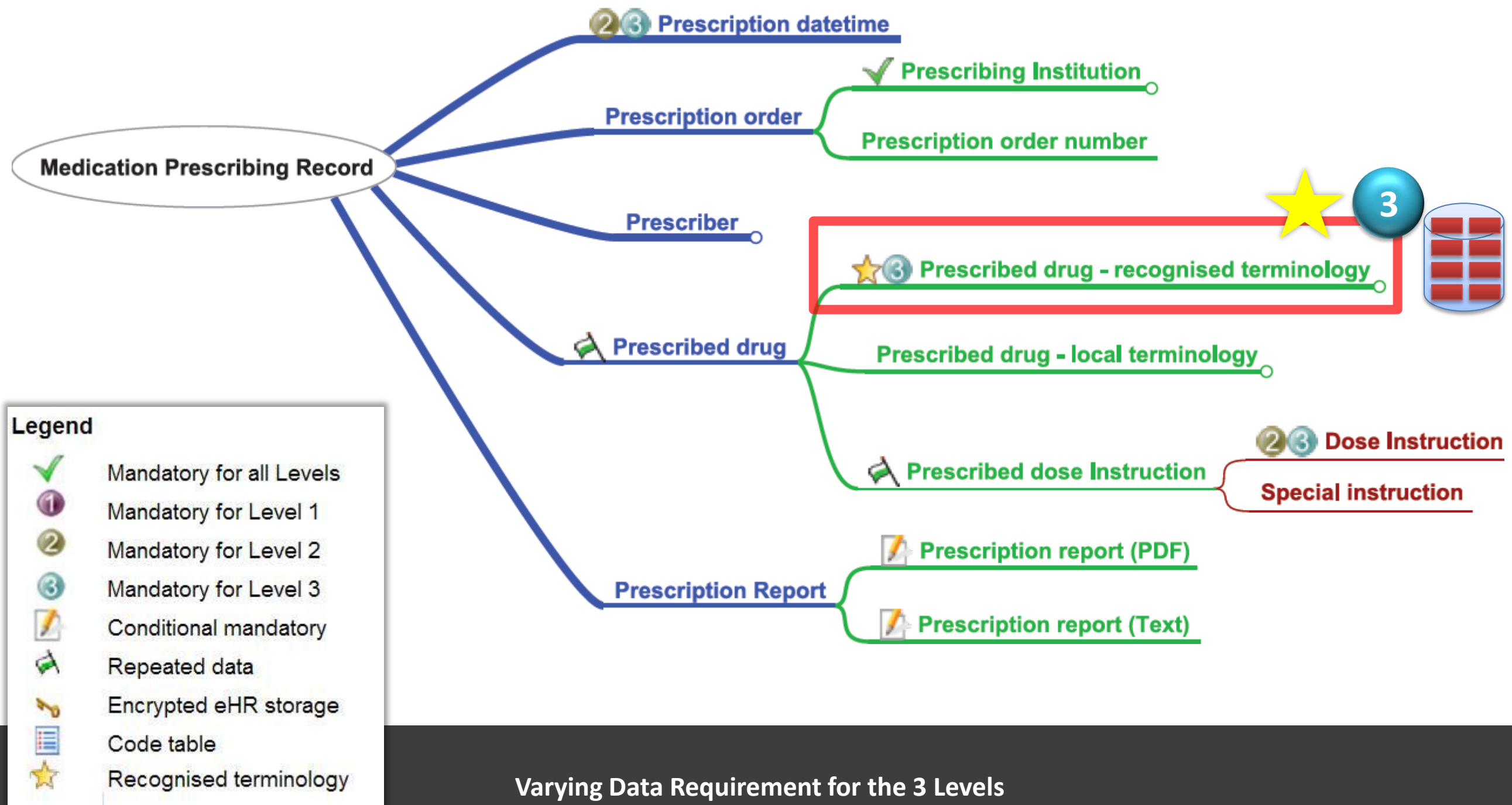
Dose
Instruction

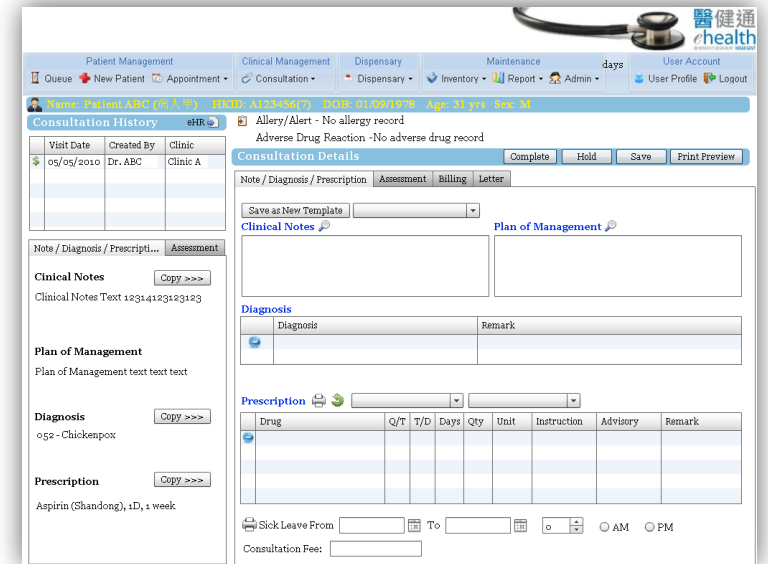
±

5

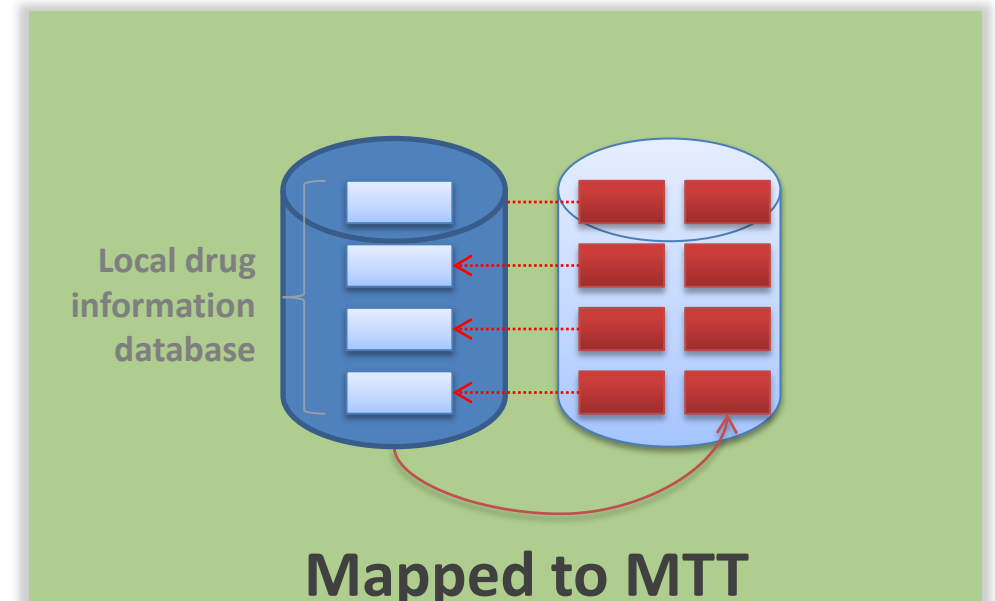


What data can be submitted : The Prescribing Record Data Set





MOE OnRamp & CMS Adaptation Modules



LEVEL 3 : The 3rd and RECOMMENDED method of submitting eHR medication record is map local drug information to the standard drug table (HKMTT), or by adopting one of the eHR Applications, which are already supported by HKMTT...



[REDACTED] ([REDACTED])

HKIC: [REDACTED]

DOB: [REDACTED]

Age: [REDACTED]

Sex: **F**Ward: **5A-X12**

Adm:

Medication Order Entry*Order Date: 21-May-2012*

Display



No Allergy Record.

Drug Name:

Prescription

✖ warfarin sodium (Teva) tablet — 5 mg — daily — oral — for 2 weeksDosage: mg Freq.: ☐ PRN Route: Duration: Qty.(optional): tablet

Special Inst.:



Discharge Prescription 出院藥單

Name: [REDACTED]
Address: Flat A, Block 1, eHR Building, HK
DOB: 01-Jan-1991
Sex: F

HKIC: [REDACTED]

Age: [REDACTED]

Ward: 5A-X12



Medical Record no: HN888888(A)

Order Date: 30-May-2011

Alert Allergy Information

Drug Allergy: Augmentin
Adverse Drug Reaction: Cataflam (diclofenac potassium)
Alert: (1) On Steroid (2) G6PD Deficiency

Prescription

Dispense in Hospital

1. **warfarin sodium (Teva) tablet**
5 mg – daily – oral – for 2 weeks
2. **Flagyl** (metronidazole) tablet
400 mg – twice daily – oral – for 1 week
3. **Klacid** (clarithromycin) tablet
500 mg – twice daily – oral – for 1 week

Drug Terminology by HKMTT ← Level 3

Dose instruction ← composed text

Purchase at Community

1. **Fosamax** (alendronate sodium) tablet
70mg – before breakfast (on every Monday) – oral – for 4 weeks

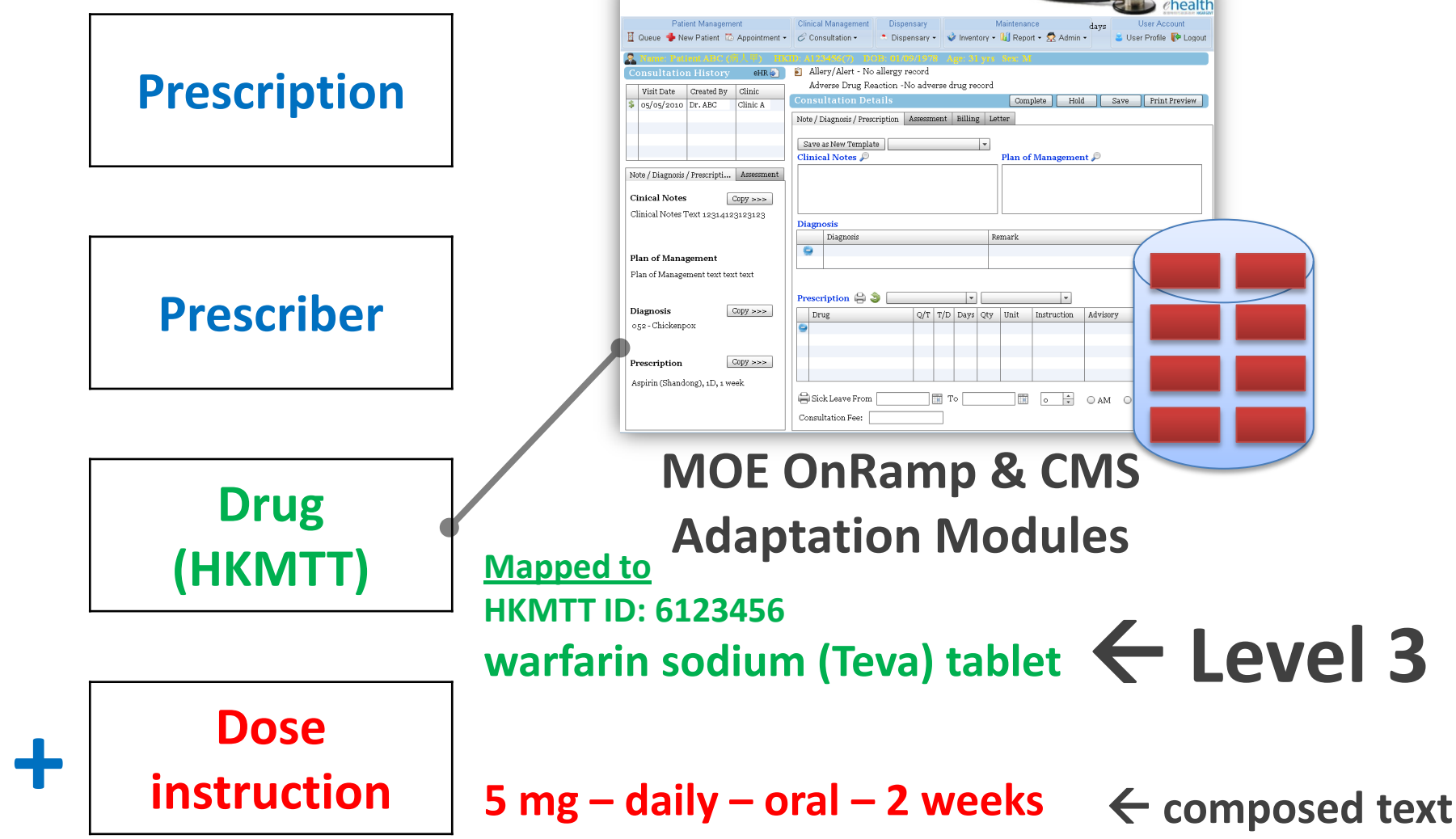
Patient Own Drug

1. **Adalat Retard** (nifedipine) tablet
20 mg – twice daily - oral – for 4 weeks

Generic substitution is allowed unless otherwise specified

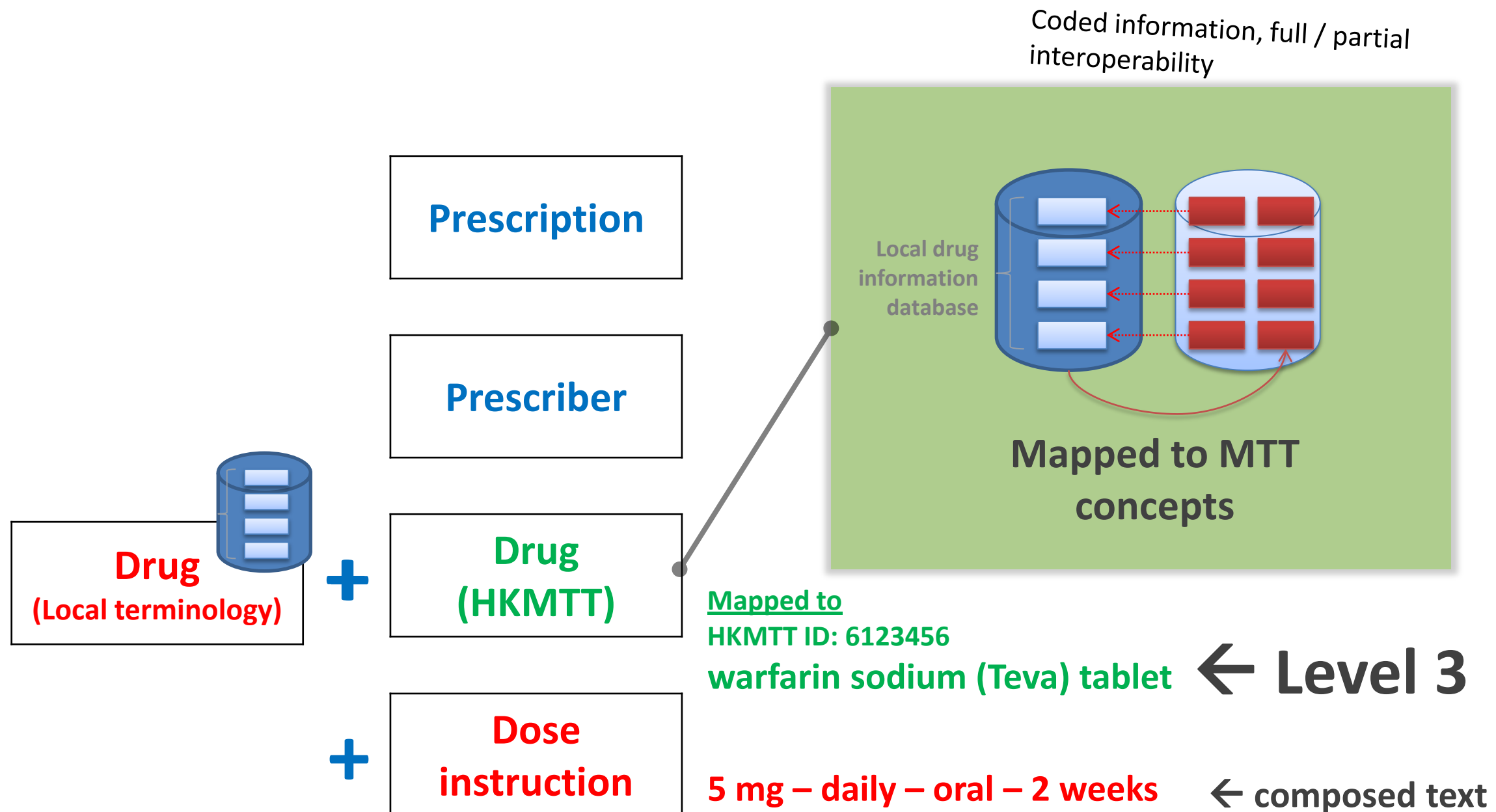
Pharmacy Use Only			
Input by:	Filled by:	Checked by:	Issued by:

Level 3 Prescribing Record – Coded information, full / partial interoperability

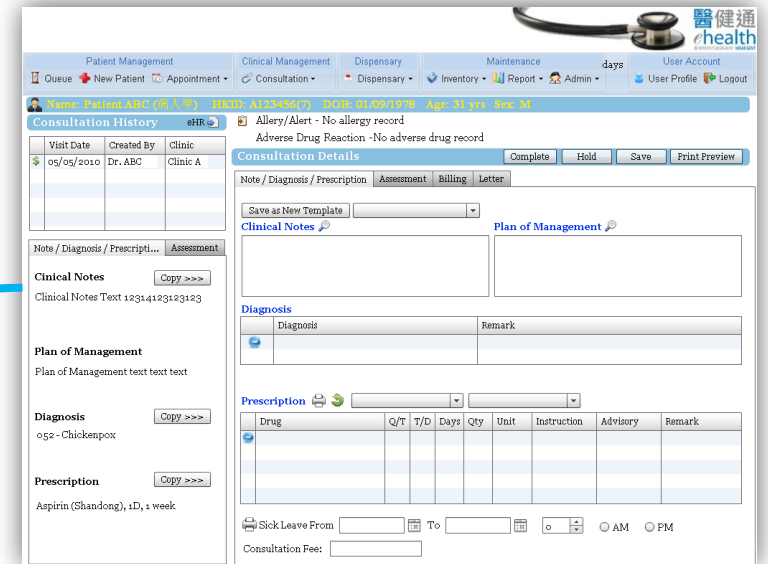


Level 3 Prescribing Record – Coded information, full / partial interoperability

Level 3 Prescribing Record – Coded information, full / partial interoperability



Level 3 Prescribing Record – Coded information, full / partial interoperability



Level 3

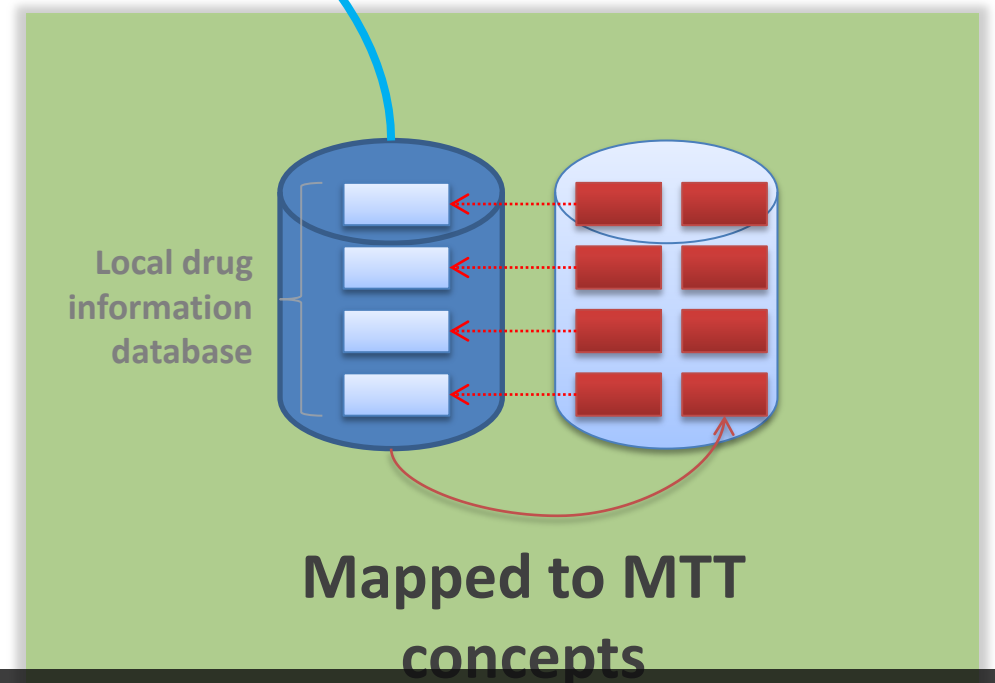
Full interoperability

MOE OnRamp & CMS Adaptation Modules



Level 3

Coded information, full / partial interoperability



So when this information is sent by the healthcare provider to eHR Medication Prescribing Record...

The eHR Viewer (Prescribing History)

The screenshot displays the HKMTT Level 3 web application. The browser address bar shows the URL <http://portal.ehr.gov.hk:20621/group/EVE/eve-rxo>. The application header includes a 'Viewer' tab and navigation links for 'PPP Programmes', 'Administration', and 'Information'. The patient header shows fields for 'DOB', 'Age', and 'Sex: F', along with a 'Details' link and buttons for 'Allergy & ADR', 'Close Record', and 'Select Participant'.

The left sidebar contains a navigation menu with categories: 'All', 'Local', 'Non-Local'; 'Clinical Notes & Summary'; 'Problem & Procedure'; 'Medication'; 'Laboratory Record'; 'Radiology Record'; and 'Immunisation Record'. The 'Medication' category is selected, showing 'Prescribing History'.

The main content area displays a table of prescribing history. The table has columns for 'Date', 'Medication', and 'Institution'. The first row shows a prescription for 'warfarin sodium (Teva) tablet' at '5 mg - daily - oral - 2 weeks' from 'QMH' dated '05-Apr-2012'. The second row shows a list of medications from '05-Feb-2012' at 'Dr. Hui Wing Yan Clinic'. The third row shows a prescription for 'Tussidex liquid' at '20mg bd oral for 5 days' from 'Dr. Ma Lok Kei Clinic' dated '09-Oct-2011'.

Two blue arrows point from text annotations to the first row of the table. One arrow points to the medication name 'warfarin sodium (Teva) tablet', and the other points to the dose instruction '5 mg - daily - oral - 2 weeks'.

HKMTT ID: 6123456

Level 3

Dose instruction syntax
(composed text)

Coded information, full interoperability

This is what it will look like on the eHR Record
Note: this is a only a mock-up, future eHR viewer may look different.

What is **Dose Instruction**?

Recommended information to be included as part of the
“Dose Instruction” data.

SAMPLE

Prescription

10 November, 2010

To Pharmacist in charge,

re: [REDACTED] Female/ 7Y

Clinic Number: 000001

Diagnosis: [REDACTED]

Please dispense the following medication(s):

(1) PREDNISOLONE 10MG TDS X 3 DAYS;

THEN 10MG BD X 1 DAY;

THEN 10MG QD X 1 DAY.

(2) ELOMET OINTMENT APPLY TO AFFECTED AREA(S) QD PRN X 1 TUBE

(3) EMULSIFYING OINTMENT X 1 BOT

Regard

Prescribed
dose

frequency

duration

PRN

Prescribed
quantity

Dose Instructions

Dr. [REDACTED]

Specialist in Paediatrics

MBBS(Kerala), FHKC Paed, FHKAM(Paediatrics), DCH(London), Dip Derm Sc(Wales), FRCP
(Glasg)

Name: CHAN, ORANGE (陳香橙)
Sex: F Age: 81y Pat. Status: Nil H.K.I.D.:M152672(9)
Address: Rm 88888 99/F Blk ZZ PO YAN HSE PO LAM EST, TSEUNG KWAN O

Case No.: SOPD-00-75831(Z)

Order Date:11-Apr-2002 Next Appt.:Nil

3409

MEDICINE

門診藥單 Out-Patient Prescription

醫院 醫院管理局
Virtual Hospital 3 HOSPITAL
AUTHORITY

Reprint Prescription

1. METHYL SALICYLATE COMPOUND (ANALGESIC BALM) ointment 20g
topical : tds for 1 weeks, dispense 1 tube
2. PARACETAMOL (PANADOL) tablet
oral : 500 mg q6h prn for 1 weeks
3. DEQUALINIUM CHLORIDE (DEQUADIN) lozenges
topical : 250 microgram(s) qid prn for 1 weeks *fix period**
4. SODIUM CHLORIDE eye drops 0.9% 10ml
eye : 1 drop(s) bd for 1 weeks

Prescribed quantity

= Dose Instructions

duration

PRN

frequency

Prescribed
route

Prescribed
dose

Generic substitution is allowed unless otherwise specified.

Doctor's Signature

For Pharmacy Use Only

KO HELEN

Dr. code: Nil
Medical Officer

Filled by

Checked by

Issued by

MOEVH 0201380146

請先攜藥單到繳費處繳付藥費，如有經濟困難，請聯絡醫務社工；如無需繳付藥費，請於領取藥單當天取藥，此藥單有效期為四個工作天。

Please produce the prescription at the Shroff Counter for drug payment. If financial aid is required, please contact a medical social worker. If drug charge is exempted, please collect medications on the same day when the prescription is received. The prescription is valid for 4 working days.

請往地下專科藥房取藥

專科藥房取藥時間為：

星期一至五： 上午九時至下午七時
星期六、日及公眾假期： 上午九時至下午一時

注意

病人如選擇前往其他醫院管理局轄下之藥房取藥，其他藥房可能未有儲存及不能提供此藥單上之某些藥物，敬希垂注。

Printed by: CMS IT (VH3)

Medical Officer

Printed on: 14-Oct-2008 12:29 pm

Please go to G/F Out-Patient Pharmacy

Out-Patient Pharmacy Service Hours:

Monday to Friday: 9:00 am to 7:00 pm
Saturday, Sunday and Public Holidays: 9:00 am to 1:00 pm

Attention

If the patient chooses to fill this prescription at other pharmacies of the Hospital Authority, some medications prescribed may not be available and could not be supplied depending on stock availability.
Thank you for your attention.

Page 1 of 1

Order No.: MOEVH 0201380146

Reprinted on : 14-Oct-2008 12:29 pm

Total Chargeable Units : --

Page 1 of 1

1

0010043

診所/衛生機構
Clinic/Institution

正體姓名
Name (in block letters)

年齡/性別
Age/Sex

身份證號碼
I.D. No.

病類碼
Morb. Code

團隊護理碼
Team Care Status Code

身份類別 (公務員/公務員家屬/退休公務員/退休公務員家屬) *Delete as inappropriate.

其他
Others (Please specify)

醫生處方及指示 Prescription, instructions, etc.
(Please cross out unused space)

Amoxil 2g PO Stat 1 hr pre-op
(For Antibiotic Prophylaxis
Before dental procedure)

日期
Date

DRH 53A (Rev. 11/09)

Prescription Image

Level 1

Full interoperability

MOE OnRamp & CMS Adaptation Modules

醫健通
ehealth

Patient Management Clinical Management Dispensary Maintenance days User Account

Queue New Patient Appointment Consultation Dispensary Inventory Report Admin User Profile Logout

Home Patient ABC 123 456 789 1011121314151617181920 Age: 31 yrs Sex: M

Consultation History eHR

Visit Date	Created By	Clinic
05/05/2010	Dr. ABC	Clinic A

Allergy/Alert - No allergy record
Adverse Drug Reaction - No adverse drug record

Consultation Details Complete Hold Save Print Preview

Note / Diagnosis / Prescription Assessment Billing Letter

Save as New Template

Clinical Notes Plan of Management

Clinical Notes Text 12345678901234567890

Plan of Management Plan of Management text text text

Diagnosis 052 - Chickenpox

Prescription Aspirin (Shandong), 1D, 1 week

Drug	Q/T	T/D	Days	Qty	Unit	Instruction	Advisory	Remark

Sick Leave From To o a AM PM

Consultation Fee:

Level 3

No prescription info, scanned Rx image only

eHR
Drug
Record

Coded information, full / partial interoperability

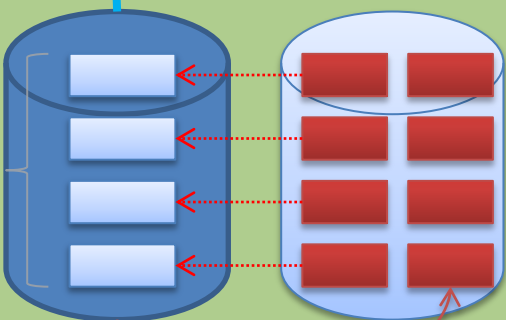
Local drug
information
database

non-coded text information

Level 2

No mapping

Local drug
information
database



Mapped to MTT
concepts

3-Levels-4-Approaches of submitting your Prescribing / Dispensing Record



Medications : Submitting your **Prescribing** & **Dispensing** Records




Johnny Wong
Pharmacist, eHRISO

Appendix I : Prescribing Record (Data Set)




eHR Sharable Data - Prescribing Record

Form	Entity Name	Definition	Data Type (code)	Data Type (description)	Validation Rule	Code Table	Data requirement (Certified Level 1)	Data requirement (Certified Level 2)	Data requirement (Certified Level 3)	Example (Certified Level 1)	Example (Certified Level 2)	Example (Certified Level 3)
Prescribing Record	Prescription datetime	Datetime when the prescription was made	TS	Time stamp			NA	M	M	6/12/2010	6/12/2010	6/12/2010
Prescribing Record	Prescribing institution identifier	A unique identifier for the prescribing institution from whom the drug order was made	CE	Coded element			M	M	M	PMH	PMH	PMH
Prescribing Record	Prescribing institution name	Name of the healthcare institution who issued the drug order	ST	String	[Prescribing institution name] should be the corresponding description of [Prescribing institution identifier] in the Provider Index		M	M	M	Princess Marageret Hospital, Hospital Authority	Princess Marageret Hospital, Hospital Authority	Princess Marageret Hospital, Hospital Authority
Prescribing Record	Prescription order number	Unique prescription ID assigned by the healthcare institution	ST	String			NA	O	O		MOETMH123456700	MOETMH123456700
Prescribing Record	Prescriber identifier	A unique identifier for the healthcare professional who prescribed the drug	CE	Coded element			NA	M	M		1234567890	1234567890
Prescribing Record	Prescriber's prefix	Prefix of the name of the healthcare professional who prescribed the drug	CE	Coded element		Healthcare staff English name prefix	NA	M	M		Dr.	Dr.
Prescribing Record	Prescriber's English Surname	Surname in English of the healthcare professional who prescribed the drug	ST	String			NA	M	M		CHAN	CHAN
Prescribing Record	Prescriber's English Given Name	Given name in English of the healthcare professional who prescribed the drug	ST	String			NA	M	M		Tai Man	Tai Man
Prescribing Record	Prescriber's Chinese Name	Full Name in Chinese of the healthcare professional who prescribed the drug. Encoding method : unicode	ST	String			NA	M	M		陳大文	陳大文
Prescribing Record	Prescriber's Chinese Name Suffix	Suffix of the Chinese name of the healthcare professional who prescribed the drug	CE	Coded element		Healthcare staff Chinese name suffix	NA	M	M		醫生	醫生
Prescribing Record	Prescribed drug - recognised terminology name	Recognised terminology / classification set for the prescribed drug	CE	Coded element	If eHR value = HKCTT, allowable nature is "Pharmaceutical product"; if eHR value = SNOMED CT, allowable hierarchy is "Pharmaceutical / biologic product"	Recognised terminology name - pharmaceutical product	NA	NA	M			HKCTT
Prescribing Record	Prescribed drug identifier - recognised terminology	Unique identifier of the prescribed drug in the recognised terminology	CE	Coded element	[Prescribed drug identifier - recognised terminology] should be included in the selected recognised terminology of the "Recognised terminology name - pharmaceutical product" code table.		NA	NA	M			234556

eHR Sharable Data - Prescribing Record

Form	Entity Name	Definition	Data Type (code)	Data Type (description)	Validation Rule	Code Table	Data requirement (Certified Level 1)	Data requirement (Certified Level 2)	Data requirement (Certified Level 3)	Example (Certified Level 1)	Example (Certified Level 2)	Example (Certified Level 3)
Prescribing Record	Prescribed drug description - recognised terminology	Description of the prescribed drug in recognised terminology	CE	Coded element	[Prescribed drug description - recognised terminology] should be the corresponding description of [Prescribed drug identifier - recognised terminology] in the selected recognised terminology		NA	NA	M			Panadol (paracetamol) oral tablet 500 mg
Prescribing Record	Prescribed drug code - local terminology	Local code of the prescribed drug developed by the healthcare provider	ST	String			NA	O	O		PARA01	PARA01
Prescribing Record	Prescribed drug description local terminology	Local description of the prescribed drug developed by the healthcare provider	ST	String			NA	M	M		PARACETAMOL TABLET	PARACETAMOL TABLET 500MG
Prescribing Record	Dose Instruction	The entire combined dose instruction information of an ordered drug; the syntax should contain the following information of the prescription order: - route of administration - dose - frequency - duration of treatment, or treatment start and end date	ST	String			NA	M	M		(1) 1-2 tablet(s) when required (2) 1 capsule(s) daily (3) 5 mL once a day in the morning for 1 week (4) 500 mg QID 4/52 (5) 2 drop(s) orally twice a day for 2 weeks	(1) 1-2 tablet(s) when required (2) 1 capsule(s) daily (3) 5 mL once a day in the morning for 1 week (4) 500 mg QID 4/52 (5) 2 drop(s) orally twice a day for 2 weeks
Prescribing Record	Special Instruction	Additional information relating to the use of the prescribed drug	ST	String			NA	O	O		omit if vomiting or diarrhoea	omit if vomiting or diarrhoea
Prescribing Record	Prescription report (PDF)	Prescription report in Portable Document Format (PDF)	ED	Encapsulated data			Mandatory if : - [Prescribed drug - recognised terminology name] and [Prescribed drug description - local terminology] is blank, AND - [Prescription report (Text)] is blank	O	O			

eHR Sharable Data - Prescribing Record




Form	Entity Name	Definition	Data Type (code)	Data Type (description)	Validation Rule	Code Table	Data requirement (Certified Level 1)	Data requirement (Certified Level 2)	Data requirement (Certified Level 3)	Example (Certified Level 1)	Example (Certified Level 2)	Example (Certified Level 3)
Prescribing Record	Prescription report (Text)	Prescription report in text format	TX	Text			Mandatory if : - [Prescribed drug - recognised terminology name] and [Prescribed drug description - local terminology] is blank, AND - [Prescription report (PDF)] is blank	O	O			

Appendix II : Dispensing Record (Data Set)

eHR Sharable Data - Dispensing Record

Form	Entity Name	Definition	Data Type (code)	Data Type (description)	Validation Rule	Code Table	Data requirement (Certified Level 1)	Data requirement (Certified Level 2)	Data requirement (Certified Level 3)	Example (Certified Level 1)	Example (Certified Level 2)	Example (Certified Level 3)
Dispensing Record	Dispensing Date/time	The date when the drug is dispensed	TS	Time Stamp			N/A	M	M	8/12/2010	8/12/2010	8/12/2010
Dispensing Record	Dispensing institution identifier	A unique identifier for the dispensing institute from whom the drug supply was made	CE	Coded Element			M	M	M	PMH	PMH	PMH
Dispensing Record	Dispensing institution name	Name of the healthcare institution who dispensed the drugs	CE	Coded Element	[Dispensing institution name] should be the corresponding description of [Dispensing institution identifier] in the Provider Index		M	M	M	Princess Margaret Hospital, Hospital Authority	Princess Margaret Hospital, Hospital Authority	Princess Margaret Hospital, Hospital Authority
Dispensing Record	Prescribing institution identifier	A unique identifier for the prescribing institution from whom the drug order was made	CE	Coded Element			N/A	O	O		PMH	PMH
Dispensing Record	Prescribing institution name	Name of the healthcare institution who issued the drug order	CE	Coded Element	[Prescribing institution name] should be the corresponding description of [Prescribing institution identifier] in the Provider Index		N/A	O	O		Princess Margaret Hospital, Hospital Authority	Princess Margaret Hospital, Hospital Authority
Dispensing Record	Prescription order number	A unique number assigned for each drug order issued by individual healthcare institute. One drug order would include multiple prescribed drugs. This is also required for information on drug dispensary.	ST	String data			N/A	O	O		MOETMH123456700	MOETMH123456700
Dispensing Record	Prescriber identifier	A unique identifier for the healthcare professional who prescribed the drug	CE	Coded Element			N/A	M	M		1234567890	1234567890
Dispensing Record	Prescriber's prefix	Prefix of the name of the healthcare professional who prescribed the drug	CE	Coded Element		Healthcare staff English name prefix	N/A	M	M		Dr.	Dr.
Dispensing Record	Prescriber's English surname	Surname in English of the healthcare professional who prescribed the drug	ST	String data			N/A	M	M		CHAN	CHAN
Dispensing Record	Prescriber's English given name	Given name in English of the healthcare professional who prescribed the drug	ST	String data			N/A	M	M		Tai Man	Tai Man
Dispensing Record	Prescriber's Chinese name	Full Name in Chinese as indicated of the healthcare professional who prescribed the drug. Encoding method : unicode	ST	String data			N/A	M	M		陳大文	陳大文
Dispensing Record	Prescriber Chinese name suffix	Suffix of the Chinese name of the healthcare professional who prescribed the drug	CE	Coded Element		Healthcare staff Chinese name suffix	N/A	M	M		醫生	醫生
Dispensing Record	Dispensed drug - recognised terminology name	Recognised terminology / classification set for the dispensed drug	CE	Coded Element	If eHR value = HKCTT, allowable nature is "Pharmaceutical product"; if eHR value = SNOMED CT, allowable hierarchy is "Pharmaceutical / biologic product"	Recognised terminology name - pharmaceutical product	N/A	N/A	M			HKCTT
Dispensing Record	Dispensed drug identifier - recognised terminology	Unique identifier of the dispensed drug in the recognised terminology	CE	Coded Element	[Prescribed drug identifier - recognised terminology] should be included in the selected recognised terminology of the "Recognised terminology name - pharmaceutical product" code table.		N/A	N/A	M			234566
Dispensing Record	Dispensed drug description - recognised terminology	Description of the dispensed drug in recognised terminology	CE	Coded Element	[Prescribed drug description - recognised terminology] should be the corresponding description of [Prescribed drug identifier - recognised terminology] in the selected recognised terminology		N/A	N/A	M			Panadol (paracetamol) oral tablet 500 mg
Dispensing Record	Dispensed drug code - local terminology	Local code of the dispensed drug developed by the healthcare provider	ST	String data			N/A	O	O		PARA01	PARA01
Dispensing Record	Dispensed drug description - local terminology	Local description of the dispensed drug developed by the healthcare provider	ST	String data			N/A	M	M		PARACETAMOL TABLET 500MG	PARACETAMOL TABLET 500MG

eHR Sharable Data - Dispensing Record

Form	Entity Name	Definition	Data Type (code)	Data Type (description)	Validation Rule	Code Table	Data requirement (Certified Level 1)	Data requirement (Certified Level 2)	Data requirement (Certified Level 3)	Example (Certified Level 1)	Example (Certified Level 2)	Example (Certified Level 3)
Dispensing Record	Dose instruction	The entire combined dose instruction information of an ordered drug; the syntax should contain the following information of the dispensed medications: - route of administration - dose - frequency - duration of treatment, or treatment start and end date	ST	String data			N/A	M	M		(1) 1-2 tablet(s) when required (2) 1 capsule(s) daily (3) 5 mL once a day in the morning for 1 week (4) 500 mg QID 4/52 (5) 2 drop(s) orally twice a day for 2 weeks	(1) 1-2 tablet(s) when required (2) 1 capsule(s) daily (3) 5 mL once a day in the morning for 1 week (4) 500 mg QID 4/52 (5) 2 drop(s) orally twice a day for 2 weeks
Dispensing Record	Dispensing Remarks	Additional information relating to each dispensed drug	TX	Text			N/A	O	O		omit if vomiting or diarrhoea	omit if vomiting or diarrhoea
Dispensing Record	Dispensary report (PDF)	Dispensing report in Portable Document Format (PDF)	ED	Encapsulated data			Mandatory if : - [Dispensed drug - recognised terminology name] and [Dispensed drug description - local terminology] is blank, AND - [Dispensing report (Text)] is blank	O	O			
Dispensing Record	Dispensary report (text)	Dispensing report in text format	TX	Text			Mandatory if : - [Dispensed drug - recognised terminology name] and [Dispensed drug description - local terminology] is blank, AND - [Dispensing report (PDF)] is blank	O	O	