

Primary Sense Reports – PHASES High CVD Risk Screening, Recall and Treatment Practice Report V2

Report - release 2.51

Overview

Please note this is the second iteration of the report. It has been simplified and now includes a new CV risk score developed by PHASES so **table 1 may have more patients than before**. Tables 3 and 4 have been swapped in order.

This report was developed as part of the **PHASES project** in Queensland, a statewide initiative to reduce cardiovascular disease (CVD) by improving primary care. It stands for **Preventing Heart Attacks and Stroke Events through Surveillance** and uses digital tools like Primary Sense, practice support, and community campaigns to empower general practices to identify, prevent, and manage CVD risks earlier. The project's aim is to strengthen primary care's role in preventive healthcare and improve long-term health outcomes for Queenslanders. [PHASES with Primary Sense: Project Overview](#)

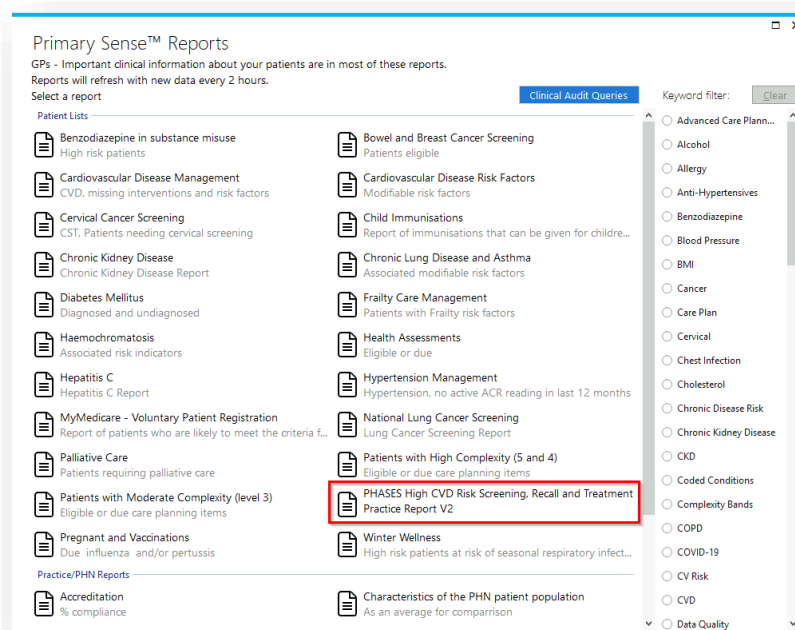
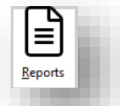
Primary Sense can assist with the project success by providing data-driven insights to general practitioners (GPs) at the point of care and facilitating early intervention by helping GPs and other primary care providers identify patients at high risk for CVD, enabling proactive guidance on lifestyle and behaviour modifications before conditions become severe.

This report has 4 tables. Due to the criteria for each table, patients should only appear in 1 table. Where patients are automatic high risk but also have CVD, CVD is used to determine which guideline therapy and targets are applied.

Using the report

To open the report, click on the 'Reports' tile in the desktop app.

Double click 'PHASES High CVD Risk Screening, Recall and Treatment Practice Report V2' under the 'Patient Lists' section.



General Information

- The tabs at the top of the page can be clicked to bring up relevant information.

Which patients are included in this report?

What data is in this report?

How do we use this report?

- The results can be filtered by clicking on each column. Clicking on columns will rearrange the results alphabetically, chronologically or from high to low or low to high.
- The 'Search' function can help you find specific content
- Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed.
- The table can be exported to Excel or CSV for further analysis. 'Export To CSV (SMS)' will create a patient recall list for use with HotDoc© or other compatible applications.
- Applications such as Google Sheets or Libre Office can be used to view and filter the export if Excel is unavailable.

Aboriginal and Torres Strait Islander Patients who may be considered for Advance Care Planning and/or Palliative Care Planning

Information about this table

Show

25

patients per page

Export To Excel

Export To CSV

Export To CSV (SMS)

Search:

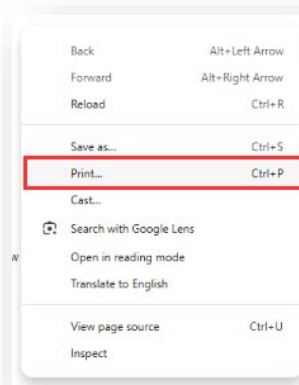
Remove	ACG Score	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age	Indicated By DX - condition	Chronic Condition Count	Frailty and/or Decline Indicators	# Meds	GPMP	RACF	Veteran	Lives alone / Carer	Last EDS
Remove	4	John Jones	0435246678	2024-08-15	2025-04-30	Dr Smith	Clinic A	75	Intraepidermal carcinoma, Multiple Sclerosis	9	Nutritional deficiencies,	13	Y	N	N	N	2024-02-16

Showing 1 to 1 of 1 entries

Previous

Next

- Any filters applied to the data at the time, will be carried over when exported.
- All reports that are generated are automatically saved to a folder on your practice computer.
- The report can be printed by right clicking the mouse button while hovering the cursor over the report and selecting the 'Print' option.



Try searching by a month or year e.g. '08' or '2023' to find a last visit dates in a particular range, or by 'GP name' to bring up patients with a specific regular GP.

Report Content

Which patients are included in this report?

Which patients are included in this report?

What data is in this report?

How do we use this report?

What are ACG patient complexity levels?

- Patients aged 30–79 yrs old.
- Patients at potentially at **high risk** of a CVD event (according to the 2023 Australian CVD Risk Calculator or PHASES/Primary Sense High-Risk Calculator, applied in precedence order), not on guideline-recommended therapy.
- Patients with prior CVD not on guideline-recommended therapy.
- Patients likely to be at high CVD risk **despite** having missing or insufficient risk factors to enable a risk-score calculation.
- Patients at high CVD risk (including prior CVD) on guideline-recommended therapy but not meeting treatment targets.
- Patients with a documented reason for a visit in the past 18 months.
- Patients with nursing home MBS items or recorded as palliative are excluded.

About the risk calculators used in this report

- **AusCVD 2023 calculator** — where a valid AusCVD 2023 risk score has been recorded, this result is used first to identify high-risk untreated patients in **Table 1**. It is also used to identify patients for **Table 3** when the available information suggests the patient is likely to be high risk despite some missing risk factors.
- **PHASES Primary Sense Calculator** — where no valid AusCVD 2023 score has been recorded, the PHASES Primary Sense calculator is used as the next step in the hierarchy. It is used to identify patients for **Table 1** when the required risk factors are available but no risk score has been recorded. The PHASES/Primary Sense calculator is a pre-screening and recall tool. It identifies patients who may be at high CVD risk but does not establish a diagnosis or make a treatment decision. No risk score is displayed in this report. Patients identified through either method require clinical assessment, review of their risk factors and application of the relevant clinical guidelines.

Important: Regardless of which calculator identified a patient, all recalled patients must have their CVD risk confirmed using the AusCVD 2023 guidelines before clinical decisions are made.

Example of data returned in the table for patients with CV risk not on dual therapy **Note:** Patient and clinic data is test data.

Table 1. High CVD risk, no prior CVD, not on therapy

These patients will benefit from timely review of their CVD risk and preventive treatment.

Information about this table

Show

25

patients per page

Export To Excel

Export To CSV

Export To CSV (SMS)

Search:

Remove	ACG Complexity	Patient Name	Patient Phone	Last Visit	Existing Appointment	GP Name	Clinic	Age	Sex	ATSI	TC/HDL Ratio	SBP	Diabetes	Smoking Status	Last Heart Health Check	Last Care Plan Billing Date
Remove	4	Taylor, Donald	0423419953	2026-07-15	2026-10-12	Dr Lee	Main St	76	F	N	2.0	117		Ex		
Remove	3	More, Tracey	0423423951	2026-06-30	2026-09-21	Dr Jones	Main St	55	F	N	2.0	126		Smoker		2025-09-29
Remove	3	Trump, June	0445419913	2026-08-07		Dr Jones	Parade St	67	F	N	7.6	149		Ex		2026-03-19
Remove	2	Walker, Lorna	0435199532	2026-07-30	2026-11-07	Dr Lee	Main St	66	F	N	3.1	166		Smoker	2026-01-02	
Remove	3	Curry, Tobias	0421419853	2026-07-17	2026-11-20	Dr Lee	Parade St	64	M	N	3.5	140	Y	Non		

What data is in this report?

Which patients are included in this report?

What data is in this report?

How do we use this report?

What are ACG patient complexity levels?

- Patient demographics: name, date of birth, age, sex, and Aboriginal and Torres Strait Islander status
- Patient phone number
- GP name
- TC/HDL ratio (*High CVD risk, no prior CVD, not on therapy* and *Missing risk factors but likely high risk*)
- LDL cholesterol (*Prior CVD not on therapy* and *High CVD risk (including prior CVD) not at target*)
- Systolic blood pressure (all)
- Smoking status (all)
- Diabetes status (*High CVD risk, no prior CVD, not on therapy*, *Prior CVD not on therapy*, and *Missing risk factors but likely high risk*)
- Date of last visit
- Next appointment date (where booked beyond the report date)
- Last Heart Health Check date
- Last Care Plan date and Last Care Plan Review date

How do we use this report?

Which patients are included in this report?

What data is in this report?

How do we use this report?

What are ACG patient complexity levels?

This report identifies your patients most likely to experience a heart attack, stroke or death in the next five years. By prioritising the recall, assessment, and treatment of this small but high-risk group, your practice can have the greatest impact on preventing this from happening.

When you recall a patient: calculate their CVD risk score using the **AusCVD 2023 calculator**. This is the clinically recommended tool and must be used to confirm risk before making any treatment decisions.

About the calculators used in this report: Patients in Tables ***High CVD risk, no prior CVD, not on therapy***, ***Prior CVD not on therapy*** and ***High CVD risk (including prior CVD) not at target*** are identified using the AusCVD 2023 calculator. Patients in ***Missing risk factors but likely high risk*** are identified using the PHASES Primary Sense calculator. These are **pre-screening tools only** — they help identify patients who may be at high risk where risk factor data is incomplete or unavailable. They are not intended for clinical risk determination and should not replace a full risk assessment. All patients identified through this report should have their risk formally assessed using AusCVD 2023 at the point of recall.

Clinical decision support statement: *The PHASES tools and resources are intended to support clinical decision-making and quality improvement. They do not replace the need for individual clinical assessment, professional judgement, or discussion with patients. Clinicians should consider each patient's circumstances and apply relevant clinical guidelines when making care decisions.*

Other information on using the report

- The 'Search' function can help you find specific content.
- The 'Existing Appointment' column displays patient appointments that have been booked for dates beyond the report.
- The 'Last Visit' column displays the date the patient last had an appointment at the practice.
- The 'Remove' column provides the option to selectively remove individual patients from this type of report for the next twelve months.
- The report can be exported as an Excel or CSV file by clicking the 'Export to Excel' or 'Export to CSV' tabs.
- All reports that are generated are automatically saved to a folder on your practice computer.
- The report can be printed by clicking the right mouse button while hovering the cursor over the report and selecting the 'print' option.

What are ACG Complexity Levels?

Which patients are included in this report?

What data is in this report?

How do we use this report?

What are ACG patient complexity levels?

- There are five complexity levels, ranging from 1 to 5. For data analysis purposes, there is a sixth level, level 0. Level 0 is for those patients with no recorded diagnoses or significantly incomplete or missing data.
- Level 1 indicates a very low level of complexity with no known risks for poor health outcomes, level 5 is the highest complexity. Patients with level 5 complexity typically have significant multi-morbidity and polypharmacy and are at greatest risk of poor health outcomes.
- Levels overview:
 - Level 5: High complexity, characterized by instability, multimorbidity, polypharmacy or patients requiring end-of-life care.
 - Level 4: High to moderate complexity, characterized by multimorbidity.
 - Level 3: Moderate complexity. Patients typically have at least 1 chronic condition and are at risk of progressive deterioration.
 - Level 2: Low to moderate complexity. Patients typically have one risk factor.
 - Level 1: Low complexity. Patients are generally healthy and only present because of acute, time-limited conditions or minor issues.
 - Level 0: no or only invalid diagnosis.
- Patients with higher levels of complexity are more likely to be hospitalized than those with lower levels. However, complexity is not directly related to the risk of being hospitalized. Many Primary Sense reports therefore include both estimates.
- If the complexity of a patient is calculated from results that are more than 12 months old, the level will be displayed in brackets, e.g. (3), rather than 3.
- If there is insufficient information to calculate a complexity level, the result will be displayed as 'N/A'.
- The complexity levels of patients in this report were calculated with the Johns Hopkins ACG tool. The ACG is underpinned by a robust evidence base of >30 years of practical application. The tool is used in 20 countries and has been validated in different healthcare settings, including general practice.

Information about these tables

The report includes 4 tables.

Diagnosis/Conditions referenced from patient Clinical Information System (CIS) are:

- CVD
- Diabetes
- Familial hypercholesterolemia
- CKD (References eGFR/ACR results)

The report includes statements:

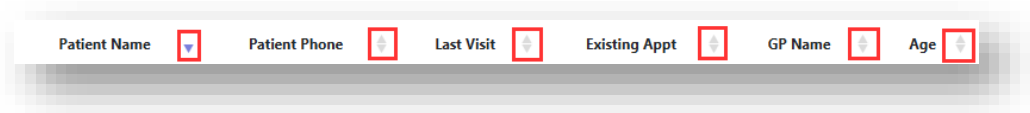
Disclaimer: Clinical decision support - not a substitute for clinical judgement. The PHASES tools and resources are intended to support clinical decision-making and quality improvement. They do not replace the need for individual clinical assessment, professional judgement, or discussion with patients.

Clinicians should consider each patient's circumstances and apply relevant clinical guidelines when making care decisions.

Clinical reminder: All patients in this report must have their CVD risk confirmed according to the AusCVD 2023 guidelines at the point of recall. This report is a pre-screening tool only. For patients without prior CVD and without a known high-risk condition, the GP should complete an AusCVD 2023 assessment where clinically appropriate. Patients with prior CVD or known high-risk conditions, such as familial hypercholesterolaemia or CKD stage 3, should be managed according to relevant guidelines and do not require a primary-prevention risk score.

This report is a pre-screening tool only — it identifies patients for recall, not for treatment decisions.

Arrows at the top of each column can be used to reverse the ordering.



Columns Returned

Standard across all tables:

Remove	ACG Complexity	Patient Name	Patient Phone	Last Visit	Existing Appointment	GP Name	Clinic	Age	Sex	ATSI
1 Remove	2 4	3 Taylor, Donald	0423419953	4 2026-07-15	5 2026-10-12	6 Dr Lee	7 Main St	8 76	9 F	10 N

1. **'Remove'** - Patients can be removed from the report for 12 months, by clicking 'Remove.' This action cannot be reversed.
2. **'ACG Complexity'** - the complexity bands formed by combining the ACGs to measure overall morbidity burden on a scale of 0-5, with 5 being the most complex/morbidity burden. See [The Johns Hopkins ACG® Version 12.0 User Documentation](#) if you have access to the PHI Intranet for more information on ACG data.
3. Patient demographic data.
4. **'Last Visit'** - displays the date the patient last had an appointment at the practice.
5. **'Existing Appt'** - displays patient appointments that have been booked for dates beyond the report.
6. **'GP Name'** - the GP who has most accessed the patient record. See User Guide for rules.
7. **'Clinic'** - most attended clinic if data is shared.
8. **'Age'** - Patient age at time the report is run (to protect patient confidentiality, the age of all patients older than 90 years are displayed as 90).
9. **'Sex'** – F = Female, M = Male, O = Other, U = Unknown, N = Not Recorded
10. **'ATSI'** - patients identified as: Aboriginal, Aboriginal/Torres Strait Islander or Torres Strait Islander will display 'Y'. If not, then 'N'

Table 1 - High CVD risk, no prior CVD, not on therapy

These patients will benefit from timely review of their CVD risk and preventive treatment.

- No prior CVD
- Age/group band:
 - Aboriginal and/or Torres Strait Islander people aged 30–79 years, inclusive
 - OR people with diabetes aged 35–79 years, inclusive
 - OR all other eligible patients aged 45–79 years, inclusive
- **Risk status:** High CVD risk — using the following precedence hierarchy:
 - a. 2023 Australian CVD Risk Calculator = High
 - b. PHASES / Primary Sense High-Risk Calculator = True (if no 2023 score available)
- *Intermediate risk patients are no longer included in this table.*
- **Therapy status** Missing any one or more of the following therapies: antihypertensive; lipid lowering
- **Recency:** ≥1 recorded consultation within the last 18 months (reason for visit/diagnosis) OR any medication prescribed within the last 18 months from report date
- Blank means unavailable or not extracted. A blank value must not be interpreted as “No”.

11 TC/HDL Ratio	12 SBP	13 Diabetes	14 Smoking Status	15 Last Heart Health Check	16 Last Care Plan Billing Date
2.0	117		Ex		
2.0	126		Smoker		2025-09-29
7.6	149		Ex		2026-03-19
3.1	166		Smoker	2026-01-02	
3.5	140	Y	Non		

11. **‘TC/HDL Ratio’** – latest Total Cholesterol to HDL Ratio result
12. **‘SBP’** – Latest recorded Systolic Blood Pressure
13. **‘Diabetes’** – Y displayed if diagnosis in CIS (Type 1 and gestational diabetes diagnosis are excluded due to the heart foundation calculation acknowledging overestimates with Type 1 diabetics)
14. **‘Smoking Status’** - Smoker, Non = Non-smoker, Ex = Ex-smoker, N/A if no record in CIS
15. **‘Last Heart Health Check’** - last billed MBS item 699 Heart Health Assessment
16. **‘Last Care Plan Billing Date’** – last billed 721 GP Management Plan (GPMP) or 965 Prepare GP Chronic Condition Management Plan or 732 Review of GPMP or Team Care Arrangements (TCA) or 967 Review GP Chronic Condition Management Plan

Table 2 - Prior CVD not on therapy

Without guideline therapy, many of these patients face a second event — with a significantly higher risk of death or permanent disability.

- **Age / group band:** Patients aged 30–79 years, inclusive.
- **Prior CVD diagnosis** recorded in the patient record
- **Therapy status:** Missing any one or more of the following therapies: antiplatelet; antihypertensive; lipid lowering
- **Recency:** ≥1 recorded consultation within the last 18 months (reason for visit/diagnosis) OR any medication prescribed within the last 18 months from report date
- Blank means unavailable or not extracted. A blank value must not be interpreted as “No”.

LDL ¹¹	TC/HDL Ratio ¹²	SBP ¹³	Diabetes ¹⁴	Smoking Status ¹⁵	Last Heart Health Check ¹⁶	Last Care Plan Billing Date ¹⁷
1.9 mmol/L	3.6	161	Y	Ex		2026-06-24
1.6 mmol/L	3.5	132	Y	Smoker	2026-06-30	2026-01-21
3.0 mmol/L	3.2	110		Ex		
2.3 mmol/L	4.1	136		Non		2026-07-21

11. **‘LDL’** – latest Low-Density Lipoprotein result
12. **‘TC/HDL Ratio’** – latest Total Cholesterol to HDL Ratio result
13. **‘SBP’** – Latest recorded Systolic Blood Pressure
14. **‘Diabetes’** – Y displayed if diagnosis in CIS (Type 1 and gestational diabetes diagnosis are excluded due to the heart foundation calculation acknowledging overestimates with Type 1 diabetics)
15. **‘Smoking Status’** - Smoker, Non = Non-smoker, Ex = Ex-smoker, N/A if no record in CIS
16. **‘Last Heart Health Check’** - last billed MBS item 699 Heart Health Assessment
17. **‘Last Care Plan Billing Date’** – last billed 721 GP Management Plan (GPMP) or 965 Prepare GP Chronic Condition Management Plan or last billed 732 Review of GPMP or Team Care Arrangements (TCA) or 967 Review GP Chronic Condition Management Plan

Table 3 - Missing risk factors but likely high risk

These patients have incomplete risk-factor information and will benefit from completion of their risk assessment.

Patients with missing or incomplete risk factors who meet at least one of the following:

- Male aged ≥ 75 years
- Male or female aged ≥ 70 years who is a current smoker
- Any person aged ≥ 70 years with diabetes
- Aboriginal and Torres Strait Islander person aged ≥ 55 years who is a current smoker or has diabetes
- Male aged ≥ 65 years with both: Systolic BP ≥ 150 mmHg AND Total cholesterol:HDL ratio ≥ 5
- Any person aged ≥ 60 years with all three of: current smoker AND elevated BP (systolic > 140 mmHg or diastolic > 90 mmHg) AND TC:HDL ratio > 5
- **Recency:** At least one consultation within the past 2 years
- Blank means unavailable or not extracted. A blank value must not be interpreted as "No".

11 TC/HDL Ratio	12 SBP	13 Diabetes	14 Smoking Status	15 Last Heart Health Check	16 Last Care Plan Billing Date
2.0	117		Ex		
2.0	126		Smoker		2025-09-29
7.6	149		Ex		2026-03-19
3.1	166		Smoker	2026-01-02	
3.5	140	Y	Non		

11. **'TC/HDL Ratio'** – latest Total Cholesterol to HDL Ratio result
12. **'SBP'** – Latest recorded Systolic Blood Pressure
13. **'Diabetes'** – Y displayed if diagnosis in CIS (Type 1 and gestational diabetes diagnosis are excluded due to the heart foundation calculation acknowledging overestimates with Type 1 diabetics)
14. **'Smoking Status'** - Smoker, Non = Non-smoker, Ex = Ex-smoker, N/A if no record in CIS
15. **'Last Heart Health Check'** - last billed MBS item 699 Heart Health Assessment
16. **'Last Care Plan Billing Date'** – last billed 721 GP Management Plan (GPMP) or 965 Prepare GP Chronic Condition Management Plan or last billed 732 Review of GPMP or Team Care Arrangements (TCA) or 967 Review GP Chronic Condition Management Plan

Table 4- High CVD risk (including prior CVD) not at target

Patients on therapy but not at target remain at significantly elevated risk. Optimising treatment here is the next most impactful step after initiating therapy.

- **Age / group band:** Patients aged 30–79 years, inclusive.
- **Risk status:** High CVD risk — using the following precedence hierarchy:
 - a. 2023 Australian CVD Risk Calculator = High
 - b. PHASES / Primary Sense High-Risk Calculator = True (if no 2023 score available)

Also includes patients with prior CVD.

- **Therapy status:** On guideline-recommended therapy (active prescription within the past 18 months)
- **Not at target — meets at least one of the following:**
 - On lipid-lowering therapy AND LDL $\geq$ 1.8 mmol/L (no prior CVD), or LDL $\geq$ 1.4 mmol/L (prior CVD)
 - On antihypertensive therapy AND systolic BP $\geq$ 140 mmHg
 - Current smoker
- Recency: $\geq$ 1 recorded consultation within the last 18 months (reason for visit/diagnosis) OR any medication prescribed within the last 18 months from report date
- **If the CVD visit reason is missing, the patient cannot be classified reliably, and the clinical record should be reviewed.**
- Blank means unavailable or not extracted. A blank value must not be interpreted as “No”.

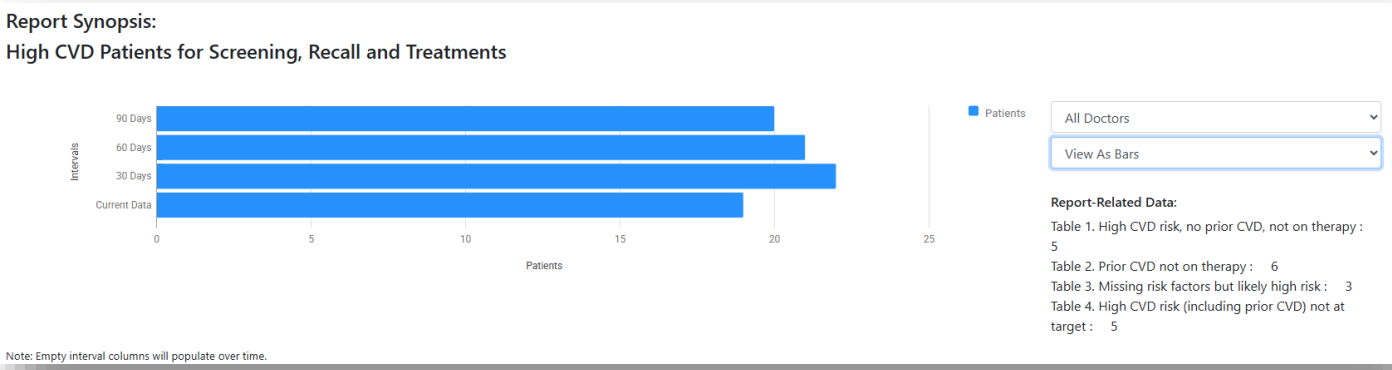
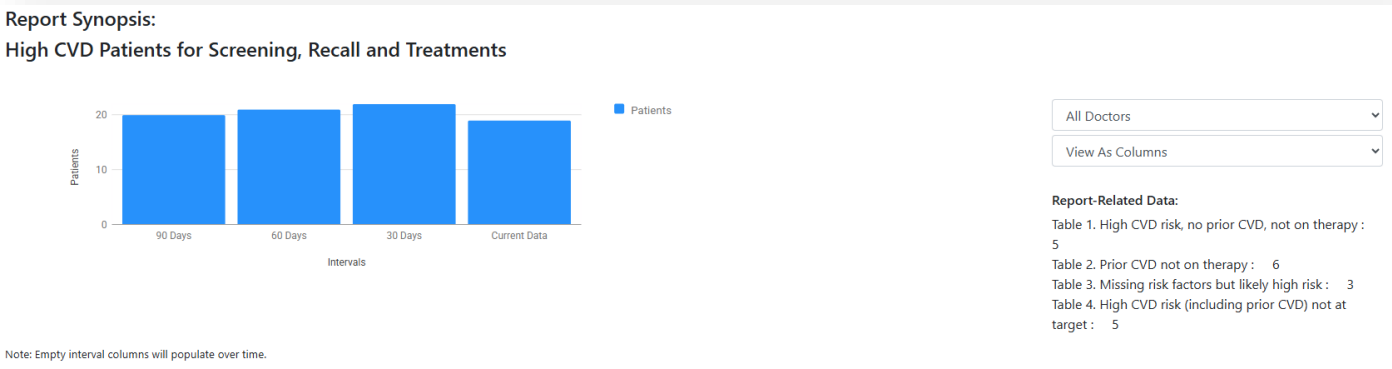
LDL > 1.8 mmol/L no prior CVD OR LDL > 1.4 mmol/L prior CVD	SBP $\geq$ 140 mmHg	Smoking Status	Last Heart Health Check	Last Care Plan Billing Date
11 1.9 mmol/L	12 143	13 Ex	14	15 2026-06-26
2.4 mmol/L	137	Non	2026-06-02	2026-08-04
3.1 mmol/L	145	Smoker		
2.3 mmol/L	168	Ex		

11. **‘LDL’** – latest Low-Density Lipoprotein result
12. **‘SBP’** – Latest recorded Systolic Blood Pressure
13. **‘Smoking Status’** - Smoker, Non = Non-smoker, Ex = Ex-smoker, N/A if no record in CIS
14. **‘Last Heart Health Check’** - last billed MBS item 699 Heart Health Assessment
15. **‘Last Care Plan Billing Date’** – last billed 732 Review of GPMP or Team Care Arrangements (TCA) or 967 Review GP Chronic Condition Management Plan

Report Synopsis

Note: Empty interval columns will populate over time.

- Table 1. High CVD risk, no prior CVD, not on therapy :
- Table 2. Prior CVD not on therapy :
- Table 3. Missing risk factors but likely high risk :
- Table 4. High CVD risk (including prior CVD) not at target :



Code, Data Field and Table Information

General

Field	Table
ACG Score	ps.acgpatient table

Excluded patients

Palliative Care	Table
A28011 - Palliative care	ICPCCode in ED.VisitReason table
A68004 Referral;palliative care	ICPCCode in ED.VisitReason table
A46020 - Consult;palliative care	ICPCCode in ED.VisitReason table
Nursing Home Patients RACF mbs.MBSItem 731, 90001, 90020, 90035, 90043, 90051, 90092, 90093, 90095, 90096, 90183, 90188, 90202, 90212, 92026, 92070, 92027, 92071	ED.MBSBilledRecord

Diagnosis/Conditions

ICPCCode sourced from in ED.VisitReason or ED.ClinicalHistory table.

ICPC ClassificationID from ref.ICPCCode and ref.icpcClassification .

Diagnosis/Condition	Table ref.ICPC
CVD	ED.VisitReason or ED.ClinicalHistory Ref.ICPCclassification = 11
Familiar Hypercholesterolemia	ED.VisitReason or ED.ClinicalHistory ref.ICPCCode T93020
Diabetes	ED.VisitReason or ED.ClinicalHistory Ref.diabetes where type is 2 or 3

MBS items Heart and Health Checks

MBS – last date if known	Table
699 Heart Health Assessment	ED.MBSBilledRecord
721 GP Management Plan (GPMP), 965 Prepare GP Chronic Condition Management Plan, 732 Review of GPMP or Team Care Arrangements (TCA), 967 Review GP Chronic Condition Management Plan	ED.MBSBilledRecord

Observations

	Table
Systolic BP Diastolic BP	ED.observation
CV risk (BP only as it links to the new Heart Foundation calculator (AusCVD) and result can be written back to the patient record, MD still uses Framingham) CV Score =>5 where recorded 2025-01-01 and onwards CV risk via Framingham is =>15 High risk: ≥15%	ED.observation from BP Extracted data only.

Medication

Sourced from ed.medication referencing Ref.ATCCode

Field	Table
Antithrombic – Direct factor Xa inhibitors	ed.medication ref.atcclassification

Direct thrombin inhibitors Platelet aggregation inhibitors excl. heparin Vitamin K antagonists	where level3id = 224
Antihypertensive – calcium channel blockers and diuretics ace inhibitors, plain angiotensin ii antagonists, combinations ace inhibitors, combinations beta blocking agents, other combinations other agents acting on the renin-angiotensin system antiadrenergic agents, centrally acting beta blocking agents and thiazides other antihypertensives arteriolar smooth muscle, agents acting on beta blocking agents and other diuretics beta blocking agents, thiazides and other diuretics antihypertensives and diuretics in combination non-selective calcium channel blockers antiadrenergic agents, peripherally acting selective calcium channel blockers with mainly vascular effects angiotensin ii antagonists, plain selective calcium channel blockers with direct cardiac effects low-ceiling diuretics, thiazides beta blocking agents	ed.medication Ref.atcclassification where level2id = 21, 22, 25, 26, 27
Lipid lowering – Bile acid sequestrants Fibrates HMG CoA reductase inhibitors HMG CoA reductase inhibitors in combination with other lipid modifying agents HMG CoA reductase inhibitors, other combinations Nicotinic acid and derivatives Other lipid modifying agents	ed.medication Ref.atcclassification ID = 28

Combinations of the above drugs are also used. Some may not be available on PBS as yet.

Pathology

Field	Table
ACR LOINCClassificationID = 22	Ref.loinccode
eGFR LOINCClassificationID = 10	ED.pathologyresult
Cholesterol LOINCClassification = 1	
HDLRatio LOINCClassification = 6	
HDL LOINCClassification = 7	
LDL LOINCClassification = 20	